Common Sense Initiative

Mike DeWine, *Governor* Joseph Baker, *Director*
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Business Impact Analysis

Agency, Board, or Commission Name: Ohio Department of Medicaid

Rule Contact Name and Contact Information: Tommi Potter, Ohio Department of Medicaid, Rules@Medicaid.ohio.gov

Regulation/Package Title (a general description of the rules' substantive content):

HCBS Policy Electronic Visit Verification

Rule Number(s): 5160-1-40, 5160-32-01, 5160-32-02, 5160-32-03, 5160-32-04

Date of Submission for CSI Review: 03-04-2024

Public Comment Period End Date: 03-11-2024

Rule Type/Number of Rules:

New/4 rules
Amended/____ rules (FYR? ___)
No Change/____ rules (FYR? ___)
Rescinded/1 rules (FYR? No)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. **R.C. 106.03 and 106.031 require agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.**

   Which adverse impact(s) to businesses has the agency determined the rule(s) create?

   The rule(s):

   a. ☒ **Requires a license, permit, or any other prior authorization to engage in or operate a line of business.**

   b. ☐ **Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.**

   c. ☒ **Requires specific expenditures or the report of information as a condition of compliance.**

   d. ☒ **Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.**

Regulatory Intent

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

   The rescinded and subsequent new rules provide definitions of terminology unique to the Electronic Visit Verification (EVV) implementation, specifies services subject to EVV requirements, establishes operational requirements for providers of those services and outlines the regulatory foundation for using an alternate data collection component from what is provided by the Department. The changes to the rule provide additional flexibility and clarity for providers who are required to use EVV. The proposed rules reduce administrative burdens for providers.

3. **Please list the Ohio statute(s) that authorize the agency, board or commission to adopt the rule(s) and the statute(s) that amplify that authority.**

   Section 5164.02 of the Ohio Revised Code.

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

   The rules implement federal requirements. Congress enacted the 21st Century Cures Act under Section 1903 of the Social Security Act (42 U.S.C. 1396b) which requires Medicaid programs to implement EVV for home and community-based services. The EVV system implemented must capture the type of service provided, the time the service is provided, the location of service delivery, and the person providing the service. Failure to implement a compliant EVV system will result in a reduction in the federal funding for Medicaid services.

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

   The rules are consistent with and do not exceed federal requirements.

6. **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)?**

   State plan and Home and community-based services are integral to the provision of long-term services and supports. The rule chapter is a key component in compliance with the 21st Century Cures Act under Section 1903 of the Social Security Act (42 U.S.C. 1396b) and provides transparence in service delivery and payment, ensuring that individuals receive the medically necessary services they need, and that the department reimburses providers appropriately for the services provided.

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

   ODM will measure the success of OAC 5160-32-01, 5160-32-02, 5160-32-03, 5160-32-04 through improved payment accuracy and a reduction in fraud, waste, and abuse.

   ODM will also measure the success by demonstrating continued compliance with federal requirements.

8. **Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931?**
   If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.
   No.

Development of the Regulation

9. **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.

   The following entities participated in the development of the EVV rules:
   - Ohio Department of Aging
   - Ohio Department of Developmental Disabilities

   In addition, feedback received from providers and individuals receiving services since the initial implementation of the program in 2018 was collected and reviewed for incorporation into the updates for the program.

   As a result of the feedback received from providers and individuals receiving services, proposed changes to program requirements were shared publicly in January 2024 with a webinar in which 172 providers and individuals receiving services attended.

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

Changes listed below resulted from stakeholder feedback received. These proposed changes were announced to stakeholders during the January 2024 webinar:

Rule changes:

- Simplifying structure,
- Presenting in plain language, and
- Decreasing restrictive requirements.

Privacy Considerations:

- Limited use of GPS technology. Person receiving services chooses and gives written permission for GPS use in their home
- EVV devices will no longer be distributed directly to the person receiving services. They will be sent to providers who will have responsibility of maintenance, care, and distributing to their own direct care workers.

Administrative burden reduction:

- Requiring FMS vendors to become alt EVV vendors. This will allow self-directed workers to only need to use one system for timekeeping and EVV documentation.
- Removing the requirement of the person receiving services validating the visit.
- Adding a voluntary scheduling feature for providers to allow input of direct care worker schedules.

Alignment with federal requirements:

- Exempting telehealth services (state plan OAC rule chapter 5160-12)
- Exempting live-in direct care workers (following ODM's exemption process for request and approval)

11. 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.

12. 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? ***Alternative regulations may include performance-based regulations, which define the required outcome, but do not dictate the process the regulated stakeholders must use to comply.***

Alternative regulations were not considered by the department. The program structure meets compliance with the 21st Century Cures Act under Section 1903 of the Social Security Act (42 U.S.C. 1396b), in the least administratively burdensome manner.

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

ODM is the only entity authorized to enact the regulations contained in the amended rules. The amended rules were reviewed by Ohio Medicaid policy development staff, Office of Legal Services, and the Office of Legislation to ensure there was no duplication.

14. **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.**

    ODM is using email and ODM's website to communicate rule updates to providers and other stakeholders. ODM has a strong partnership with stakeholder organizations to ensure providers are aware of the changes included in this amendment.

Adverse Impact to Business

15. **Provide a summary of the estimated cost of compliance with the rule(s). Specifically, please do the following:**
    a. **Identify the scope of the impacted business community, and**

    The business community impacted by the amended rule includes Medicaid fee-for-service and managed care providers of personal care and home health services.

    b. **Quantify and identify the nature of all adverse impact (e.g., fees, fines, employer time for compliance, etc.).**
    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.

    - General administrative expenses for training providers on the use of EVV program requirements.
    - If use of an alternate data collection component is requested by a provider, the provider must satisfy all the technical and business requirements of ODM.
    - Providers submit the request for live-in caregiver exemption.
    - If the use of an alternate EVV vendor is requested, the provider will notify ODM.
    - Signed consent to use GPS will be obtained by the provider.
    - FMS vendors will obtain certification as an alternate vendor.
    - Failure to comply with EVV program requirements may result in denial of payment or post payment review penalty.

    The adverse impacts are difficult to quantify and are dependent on time required for compliance.

16. **Are there any proposed changes to the rules that will <u>reduce</u> a regulatory burden imposed on the business community? Please identify. *(Reductions in regulatory burden may include streamlining reporting processes, simplifying rules to improve readability, eliminating requirements, reducing compliance time or fees, or other related factors).***

    The following proposed changes to the rule will reduce a regulatory burden:

- Removing the requirement of the person receiving services validating the visit.
- Adding a voluntary scheduling feature for providers to allow input of direct care worker schedules.
- Exempting telehealth services (state plan OAC Rule Chapter 5160-12)
- Exempting live-in direct care workers (following ODM's exemption process for request and approval)

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

ODM is federally required to implement and operate an EVV program that is incompliance with the 21st Century Cures Act under Section 1903 of the Social Security Act (42 U.S.C. 1396b). Failure to comply with this federal statue will result in decreased federal program funding.

Regulatory Flexibility

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

No. The underlying federal requirement does not provide any exemptions or alternative means of compliance for small businesses. Reimbursement policies are applied uniformly, and no exceptions are made based on the provider's size.

19. 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.

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

- ODM offers state issued devices at no cost to providers selecting this option.
- Training is available to providers through self-paced online modules.
- One-on-one technical assistance is offered to providers at the request of a provider.
- EVV contact information for technical or billing related questions and concerns, enrollment information, reporting Medicaid fraud can be found on ODM's website here: https://medicaid.ohio.gov/families-and-individuals/citizen-programs-and-initiatives/evv/contact-information

TO BE RESCINDED

5160-1-40 **Electronic visit verification (EVV).**

(A) For purposes of this rule, the following definitions shall apply:

(1) "Agency provider" means any of the following:

(a) For the purposes of the Ohio home care waiver, state plan home health services, and private duty nursing, an agency provider is a medicare home health agency described in rule 5160-12-03 of the Administrative Code or an otherwise accredited home health agency as described in rule 5160-12-03.1 of the Administrative Code.

(b) For purposes of the individual options (IO) waiver or the level one waiver administered by the Ohio department of developmental disabilities (DODD), an agency provider has the same meaning as in rule 5123:2-2-01 of the Administrative Code.

(c) For purposes of the PASSPORT waiver, an agency provider has the same meaning as in rule 173-39-02 of the Administrative Code.

(d) For purposes of services provided through a managed care organization, an agency provider has the same meaning as paragraphs (A)(1)(a) and (A)(1)(c) of this rule.

(2) "Aggregator component" is the portion of the EVV system that stores the data collected from each visit for purposes of analysis and claims payment.

(3) "Data collection component" is the portion of the EVV system that collects data related to the visit and includes the EVV mobile data collection device or the EVV data collection application provided by the department. Once collected, the data is then sent to the aggregator component.

(4) "Alternate data collection component" is an alternate to the data collection component provided by the department and is provided by an agency provider satisfying all requirements as defined in this rule.

(5) "Direct care worker" refers to the person providing the service to the individual. The direct care worker may be an employee of an agency or a non-agency provider.

(6) "Electronic visit verification" (EVV) is the use of technology, including a mobile device or application utilizing global positioning system (GPS) technology, telephony or manual visit entry, to verify the data elements related to the delivery of a medicaid-covered service.

(7) "EVV mobile data collection device" is a mobile device that is used by the direct care worker to record visit data, including GPS coordinates at the start and end of the visit. For providers using the data collection component provided by the department, the EVV mobile data collection device is provided to an individual receiving services subject to EVV requirements.

(8) "EVV data collection application" is the software provided by the department's contracted entity that can be installed on a mobile device owned by the provider or direct care worker to collect visit information.

(9) "Exceptions" are data integrity alerts identified by the data collection component, alternate data collection component, or aggregator component.

(10) "EVV system" refers to the combination of the data collection component or the alternate data collection component and the aggregator component used by a provider to comply with EVV requirements established by the department.

(11) "Home care attendant services" has the same meaning as in rule 5160-44-27 of the Administrative Code.

(12) "Home health aide services" has the same meaning as in rule 5160-12-01 of the Administrative Code.

(13) "Home health nursing" has the same meaning as in rule 5160-12-01 of the Administrative Code.

(14) "Homemaker personal care" has the same meaning as, and is billed in accordance with, rule 5123-9-30 of the Administrative Code.

(15) "IO waiver" refers to the waiver described in rule 5160-40-01 of the Administrative Code.

(16) "IO waiver nursing" is a nursing service provided in accordance with rule 5123:2-9-39 of the Administrative Code.

(17) "Level one waiver" refers to the waiver described in rule 5160-42-01 of the Administrative Code.

(18) "Medicaid ID" is the twelve digit unique medicaid ID assigned by the department.

(19) "MyCare waiver" refers to the waiver described in rule 5160-58-02.2 of the Administrative Code.

(20) PASSPORT has the same meaning as in rule 5160-31-02 of the Administrative Code or the state-funded component of the PASSPORT program created under section 173.522 of the Revised Code.

(21) "PASSPORT home care attendant" has the same meaning as in rule 173-39-02.4 of the Administrative Code.

(22) "PASSPORT waiver nursing" has the same meaning as in rule 173-39-02.22 of the Administrative Code.

(23) "Personal care aide services" has the same meaning as in rules 173-39-02.11 and 5160-46-04 of the Administrative Code.

(24) "Personal identification number" (PIN) is the unique identifier assigned to each individual in an EVV system operated by the department's contracted entity. The PIN is referred to as "client ID."

(25) "Private duty nursing" has the same meaning as in rule 5160-12-02 of the Administrative Code.

(26) "Reason codes" are standard codes used to explain a manual visit entry or edit or an acknowledgment of an exception.

(27) "RN assessment" has the same meaning as in rule 5160-12-08 of the Administrative Code.

(28) "Waiver nursing services" has the same meaning as in rule 5160-44-22 of the Administrative Code.

(B) Providers of the following services are required to utilize EVV unless otherwise provided in paragraph (C) of this rule.

(1) Home health nursing;

(2) Home health aide;

(3) Private duty nursing;

(4) RN assessment;

(5) Waiver nursing services provided pursuant to the Ohio home care waiver, the PASSPORT program, the IO waiver, or the MyCare waiver;

(6) Personal care aide services provided pursuant to the Ohio home care waiver, the PASSPORT program, or the MyCare waiver;

(7) Home care attendant services provided pursuant to the Ohio home care waiver or the MyCare Waiver;

(8) PASSPORT home care attendant services; and

(9) Homemaker personal care provided pursuant to the level one and IO waivers.

(C) EVV requirements do not apply to participant directed services.

(D) The department will provide an EVV system to all providers of services specified in paragraph (B) of this rule. The system will include a data collection component and an aggregator component.

(1) A data collection component provided by the department must be used by all providers except for providers using a qualifying alternate data collection component approved pursuant to paragraph (E) of this rule. The data collection component provided by the department shall consist of the following:

(a) An EVV mobile data collection device provided by the department to the individual receiving a service specified in paragraph (B) of this rule; or

(b) An EVV data collection application provided by the department for use with the provider or direct care worker's personal device.

(i) Any costs incurred for equipment or data services shall not be the responsibility of the department or the individual receiving services.

(ii) The GPS functionality of the device must be turned on for the purposes of the data collection application when the application is used to collect visit data.

(iii) Data services connected to the provider or direct care worker's personal device shall be used to transmit visit data from the application in near real time. Internet services purchased by individuals receiving Medicaid services subject to EVV requirements shall not be used to transmit data.

(iv) The device used with the application must comply with all device requirements found at www.medicaid.ohio.gov/Initiatives/ElectronicVisitVerification.aspx.

(v) If the application is consistently unavailable or GPS coordinates are consistently not collected, the department may require the provider to use the EVV mobile data collection device provided by the department.

(2) The provider shall do the following:

(a) Utilize the EVV mobile data collection device or application provided by the department to capture the GPS coordinates at the start and end of the visit as the primary method for collecting visit data. In the event the EVV mobile data collection device or application is not available at the time of the visit, telephony should be used. If neither the device, application, nor telephony are available, manual visit entry must be used as the last alternative for recording the visit data. Where telephony is used, the telephone number from which the call is placed will be used in lieu of GPS coordinates.

(b) Collect, for each visit, the following data:

(i) Information to identify the individual receiving the service;

(ii) Information to identify the direct care worker providing the service, and an associated provider, as applicable;

(iii) The time the visit starts;

(iv) The location at the start of the visit;

(v) The service provided;

(vi) The time the visit ends;

(vii) The location at the end of the visit.

(c) Except for services provided pursuant to paragraphs (A)(14) and (A)(16) of this rule where manual visit entry is used to capture service delivery information described in this paragraph, the verification must be collected through a signature of the individual receiving the service. The provider must maintain all documentation required by Chapter 5160-12, 5160-44, 5160-45 or 5160-46 of the Administrative Code, as appropriate,

to support the manual visit entry. The documentation must be made available to the department or the department's designee upon request, as required by rule 5160-1-17.2 of the Administrative Code.

(3) The aggregator component must be used by all providers subject to EVV requirements.

(a) Any exceptions noted in the aggregator component must be resolved using appropriate reason codes before a claim for a visit will be paid. The department may require that claims for services match visit data prior to adjudication for payment.

(b) A provider using a qualifying alternate data collection component pursuant to paragraph (E) of this rule must submit data to the aggregator component in a format and at a frequency specified by the department on the department's website, www.medicaid.ohio.gov/Initiatives/ElectronicVisitVerification.aspx.

(E) Alternate data collection component

(1) An agency provider may choose to use a qualifying alternate data collection component that is approved by the department or its designee. In order to be considered a qualifying alternate data collection component, the provider must:

(a) Establish a primary method for collecting visit data that utilizes a data collection component to capture GPS coordinates at the start and end of the visit as a primary method for collecting visit data. Additionally, providers must have a minimum of two alternative methods for recording visit data, one of which must be manual visit entry.

(b) Collect, for each visit, the data elements contained in paragraphs (D)(2)(b) and (D)(2)(c) of this rule.

(c) Satisfy all technical specifications found on the department's website, www.medicaid.ohio.gov/Initiatives/ElectronicVisitVerification.aspx.

(d) Satisfy all business requirements found on the department's website, www.medicaid.ohio.gov/Initiatives/ElectronicVisitVerification.aspx.

(e) Identify all exceptions using standard codes found on the department's website, www.medicaid.ohio.gov/Initiatives/ElectronicVisitVerification.aspx.

(f) Use the reason codes found on the department's website, www.medicaid.ohio.gov/Initiatives/ElectronicVisitVerification.aspx.

(g) Successfully complete the approval process found on the department's website, www.medicaid.ohio.gov/Initiatives/ElectronicVisitVerification.aspx.

(h) Successfully complete alternate system aggregator training found on the department's website, https://medicaid.ohio.gov/INITIATIVES/Electronic-Visit-Verification#1894220-alternate-system.

(i) Except for services provided pursuant to paragraphs (A)(14) and (A)(16) of this rule, provide the ability to collect a voice verification and an electronic signature verification at the end of the visit.

(2) If a provider is unable to obtain approval of a qualifying alternate data collection component, the provider must use the EVV system provided by the department until certification is successfully obtained.

(3) If a provider disagrees with a decision not to approve a qualifying alternate data collection component, the provider may request an administrative reconsideration pursuant to rule 5160-70-02 of the Administrative Code.

(4) The department may require re-approval of any qualifying alternate data collection component in circumstances including, but not limited to, the following:

(a) A change in data requirements that must be transmitted to the aggregator component.

(b) Failure to maintain compliance with the department's requirements.

(c) During a required re-approval process, the department may require the provider to use the EVV system provided by the department.

(5) Any costs related to the development, approval and testing of a qualifying alternate data collection component shall not be the responsibility of the state.

(F) Required training.

(1) Providers enrolled prior to the implementation of EVV in Ohio who are not using an alternate data collection system shall complete all training required by the department prior to gaining access to the EVV system.

(2) All providers not using an alternate data collection system who used the Sandata data collection component prior to May 6, 2019, must complete bridge training found on the department's website, https://medicaid.ohio.gov/INITIATIVES/Electronic-Visit-Verification/Training.

(3) Providers who stop using an approved alternate data collection component and begin using the EVV system provided by the department must complete all training required by the department prior to gaining access to the EVV system.

(4) Regardless of date of enrollment, providers must complete any additional training required by the department.

(G) Providers of the services specified in paragraph (B) of this rule shall do all of the following or be subject to the termination of their medicaid provider agreement:

(1) Comply with all provisions of this rule.

(2) Maintain, in the aggregator component, a current list of individuals subject to EVV requirements to whom they are providing services. The required data elements pertaining to the individuals that must be maintained include:

(a) Medicaid ID.

(b) Last name.

(c) First name.

(d) Language preference.

(e) One known address at which the individual may routinely receive services. Additional addresses may be maintained if the individual routinely receives services at multiple locations.

(f) Known phone number for telephony (if any).

(g) Association to appropriate payer using values found on the department's website, https://medicaid.ohio.gov/INITIATIVES/Electronic-Visit-Verification/.

(3) For agency providers, maintain a list of direct care workers subject to EVV requirements who are providing services to individuals enrolled in medicaid. The required data elements pertaining to the direct care workers that must be maintained include:

(a) Last name.

(b) First name.

(c) Social security number.

(d) PIN.

(e) Email address.

(4) For providers using the EVV system provided by the department, request devices for all individuals enrolled in medicaid to whom they are providing services subject to EVV requirements no later than two business days after the first service is provided unless the provider is using the EVV data collection application to collect visit information for the individual.

(5) For providers using the EVV data collection component provided by the department, notify the department or its designee when services will no longer be provided to an individual with an EVV mobile data collection device no later than forty-eight hours after the last service is provided.

(6) Utilize EVV for all services subject to the provisions of this rule.

(7) Report known or suspected tampering of devices to the department within two business days of discovery.

(8) Report any known or suspected falsification of EVV data to the department within two business days of discovery.

(9) Complete all required training.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5164.02
Prior Effective Dates:	01/01/2018, 09/26/2019, 06/12/2020 (Emer.), 02/07/2021

5160-32-01 **Electronic visit verification (EVV) program.**

(A) This rule establishes Ohio medicaid programs and program services subject to participation in the EVV program, required under Section 1903 of the Social Security Act (42 U.S.C. 1396b), as in effect on July 1, 2024.

(B) For purposes of this chapter, EVV is the use of technology to verify certain data elements related to the delivery of medicaid-covered services.

(C) Ohio medicaid services subject to the EVV program include any medicaid state plan or 1915 (c) home and community-based services (HCBS) waiver program meeting the following criteria:

(1) Service definition includes one of the following:

(a) Assistance with activities of daily living, as described in rule 5160-3-05 of the Administrative Code; or

(b) Includes activities provided by a licensed healthcare professional; and

(2) The service is provided in the home or community of the individual; and

(3) The service is measured and paid in units of hours, partial hours, or per assessment.

(D) The following are subject to the EVV program:

(1) Nursing facility-based level of care HCBS waiver programs:

(a) Programs:

(i) Ohio home care waiver, described in Chapter 5160-46 of the Administrative Code;

(ii) MyCare Ohio waiver, described in Chapter 5160-58 of the Administrative Code; and

(iii) Preadmission screening system providing options and resources today (PASSPORT) waiver, described in Chapter 5160-31 of the Administrative Code.

(b) Services:

(i) Choices home care attendant;

(ii) Enhanced community living;

(iii) Home care attendant;

(iv) Personal care aide; and

(v) Waiver nursing service.

(2) Developmental disabilities level of care-based waiver programs:

(a) Programs

(i) Individual options (IO) waiver, described in Chapter 5160-40 of the Administrative Code;

(ii) Level 1 waiver, described in Chapter 5160-41 of the Administrative Code; and

(iii) Self-empowered life funding (SELF) waiver, described in Chapter 5160-41 of the Administrative Code.

(b) Services

(i) Homemaker/personal care;

(ii) Participant-directed homemaker/personal care;

(iii) Residential respite, when billed in 15-minute units;

(iv) Waiver nursing delegation; and

(v) Waiver nursing service.

(3) State plan program services, described in Chapter 5160-12 of the Administrative Code.

(a) Home health services:

(i) Home health aide;

(ii) Home health nursing; and

(iii) Home health therapies.

(b) Private duty nursing.

(c) Registered nurse assessment.

(d) Registered nurse consultation.

(E) Exemptions

(1) Services provided using telehealth as the direct delivery method in accordance with rule 5160-1-18 of the Administrative Code are exempt from this rule.

(2) Live-in caregiver exemption: visits in which the direct care service worker is a resident of the same household as the individual are exempt from this rule when the EVV system reflects approval from ODM has been granted. To obtain approval, the service provider will submit the request using the exemption process found on ODM's website https://medicaid.ohio.gov/INITIATIVES/Electronic-Visit-Verification/.

(F) The Ohio department of aging, Ohio department of developmental disabilities, Ohio department of medicaid (ODM), and managed care entities are responsible to:

(1) Establish and maintain processes to ensure proper payment of claims paid by each entity, in accordance with EVV guidelines; and

(2) Provide assistance and education to service providers and program participants.

(G) Service providers billing for programs and services subject to the EVV program will comply with provisions of Chapter 5160-32 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5164.02

5160-32-02 **Electronic visit verification (EVV) data collection.**

(A) The Ohio department of medicaid (ODM) EVV system collects and maintains data for medicaid programs and services subject to participation in the EVV program.

(B) Data collection method option:

(1) Application installed on one of the following devices:

(a) An electronic device provided by ODM that is available at no cost to the service provider. ODM's contracted entity is responsible for electronic device distribution, collection, and ongoing maintenance activities.

(b) A mobile electronic device owned by the service provider or direct care worker.

(i) ODM is not responsible for any costs incurred.

(ii) Data services connected to the service provider or direct care worker owned device will be used to transmit visit data from the application to the data aggregator in near real time.

(iii) The device used with the application will comply with device qualifications found at https://medicaid.ohio.gov/resources-for-providers/special-programs-and-initiatives/electronic-visit-verification.

(2) Telephony: The use of a phone call to start or end a visit.

(3) Manual entry: Manual visit entry is only permissible in the event verification through a device with an application or telephony is not available or appropriate based on the immediate needs of the individual. It is not to be used for routine visit verification.

(4) Alternate vendor:

(a) Agency providers may utilize an alternate EVV system, as described in rule 5160-32-03 of the Administrative Code.

(b) Financial management service vendors contracted with ODM, the Ohio department of aging, the Ohio department of developmental disabilities,

or their designees will obtain and maintain certification as an alternate vendor.

(C) Visit data elements captured in accordance with Section 1093 of the Social Security Act (42 U.S.C. 1396b) include:

(1) The type of service performed;

(2) The individual receiving the service;

(3) The date of the service;

(4) The location of service delivery;

(5) The direct care worker providing the service; and

(6) The time the service begins and ends.

(D) Data aggregator:

(1) Collects and stores visit data, regardless of method of visit capture.

(2) Confirms visit data present in the EVV system contains all necessary elements.

(3) Confirms claims submitted to the payor are supported by the service provider's visit data.

(E) Global Positioning System (GPS) functionality of any application or device may be used only upon obtaining the signed consent of the individual receiving the service. Signed consent will be obtained annually, and GPS functionality cannot be activated if consent is not obtained for a respective annual period. The provider will maintain a copy of that signed consent. An individual who has provided consent for GPS functionality may revoke that consent at any time.

(F) The location of service delivery for each visit will be recorded by some other means, such as drop-down menus indicating the location of service in the home or community of the individual.

(G) It is the responsibility of the service provider to ensure accuracy of information entered into the EVV system. Missing visit data or details needing additional action by the service provider will result in a notification to the service provider, otherwise known as an exception.

(H) Claims cannot be substantiated for payment until all exceptions are resolved by the service provider and EVV visit data supports the claim. Unsubstantiated claims may

result in denial of payment or post payment review penalty. ODM will communicate with affected service providers at least three months prior to initiating the process of claims denial or post payment review penalty due to EVV as set forth in this paragraph, paragraph (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:	5164.02
Rule Amplifies:	5164.02

5160-32-03 **Alternate electronic visit verification (EVV) vendor.**

(A) An alternate EVV vendor may be used for EVV data collection.

(B) The state is not responsible for any costs related to the development, approval, testing, and utilization of a qualifying alternate EVV vendor.

(C) To use an alternate EVV vendor, agency providers should:

(1) Notify the Ohio department of medicaid (ODM) or it's contracted entity of the intent to seek ODM approval to utilize the selected alternate EVV vendor; and

(2) Complete alternate system aggregator training.

(D) The agency provider is responsible to ensure:

(1) The visit data in the aggregator is correct and reflects the visit as it occurred; and

(2) Billing is supported by visit data.

(E) System, technical, and business specifications to become an alternate EVV vendor are published on the ODM website https://medicaid.ohio.gov/resources-for-providers/special-programs-and-initiatives/electronic-visit-verification/alternate-system/alternate-system. Failure to meet the specifications at any time could result in Ohio certification revocation.

(F) A financial management service vendor contracted with ODM, the Ohio department of aging, and the Ohio department of developmental disabilities will obtain and maintain the alternate EVV vendor certifications.

(G) ODM may request re-approval of any alternate EVV system at any time.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

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Rule Amplifies:	5164.02

5160-32-04 **Electronic visit verification (EVV) program providers.**

(A) This rule establishes Ohio medicaid service provider requirements for services subject to EVV as described in rule 5160-32-01 of the Administrative Code.

(B) All providers and financial management service vendors will:

(1) Complete initial and ongoing training per Ohio department of medicaid (ODM) instructions published on the ODM website https://medicaid.ohio.gov/resources-for-providers/special-programs-and-initiatives.

(2) Create and maintain updated and accurate records of individuals receiving EVV subject services. Needed data elements in the EVV system include:

(a) First and last name;

(b) A minimum of one known address at which the individual may routinely receive services. For individuals participating in the address confidentiality program, in accordance with section 111.42 of the Revised Code, the address documented will be according to program policy and may include a post office box.

(c) Telephone number.

(d) Program billing identifier of the individual receiving the service:

(i) Medicaid identification number, otherwise known as Medicaid ID: the unique billing number assigned by ODM. The individual's medicaid ID is necessary for claims validation; or

(ii) PASSPORT information management system ID assigned by the Ohio department of aging for individuals temporarily enrolled in the state funded preadmission screening system providing options and resources today (PASSPORT) waiver program. When the individual receiving the service has been assigned a medicaid ID, the provider should update the EVV system with the individual's medicaid ID. Billed claims will not be validated unless the individual receiving the service has an active and valid medicaid ID entered into the system: or

(iii) An indicator that the individual receiving the service is a newborn, not yet assigned a medicaid ID. When the newborn receiving the

service has been assigned a medicaid ID, the provider should update the EVV system with the individual's medicaid ID. Billed claims will not be validated unless the newborn receiving the service has an active and valid medicaid ID entered into the system.

(e) Payer, program, and service provided. Valid values accepted are found on ODM's website https://medicaid.ohio.gov/INITIATIVES/Electronic-Visit-Verification/.

(3) Utilize EVV for all services described in rule 5160-32-01 of the Administrative Code.

(4) Report known or suspected tampering of devices to ODM upon discovery.

(5) Report any known or suspected falsification of EVV data to ODM upon discovery.

(C) Providers and financial management service vendors will create and maintain updated and accurate records of direct care workers providing services. Needed data elements in the EVV system include:

(1) First and last name.

(2) Social security number.

(3) Email address.

(D) State provided electronic device.

(1) A provider electing to request an electronic device provided by ODM will complete EVV training and submit the device request using https://etraconline.net/login.

(2) When a provider is no longer providing services requiring EVV or determines use of the state provided electronic device is no longer desired, the provider will initiate the return process. The return process can be found on ODM's website, https://medicaid.ohio.gov/INITIATIVES/Electronic-Visit-Verification/.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

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