Ohio | Common Sense Initiative

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Business Impact Analysis

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

Rule Contact Name and Contact Information:

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

HCBS Policy administered waiver programs services

Rule Number(s): 5160-44-31, 5160-45-04, 5160-45-06, and 5160-46-04

Included for informational purposes only: OAC 5160-36-04, 5160-45-03, and 5160-46-06.1.

Date of Submission for CSI Review: 04/28/2021

Public Comment Period End Date: 05/05/2021

Rule Type/Number of Rules:

New/___ rules

No Change/____ rules (FYR? ___)

Amended/ 4 rules (FYR? 1)

Rescinded/____ rules (FYR? ___)

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.** 5160-44-31, 5160-45-04, and 5160-46-04)

   b. ☒ **Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.** (OAC 5160-45-06)

   c. ☒ **Requires specific expenditures or the report of information as a condition of compliance.** 5160-44-31, 5160-45-04, 5160-45-06, and 5160-46-04)

   d. ☒ **Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.** (OAC 5160-45-06)

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.

   On March 9, 2020, Ohio Governor Mike DeWine declared a statewide state of emergency to protect the health, safety, and well-being of Ohioans from the dangerous effects of COVID-19. All citizens were urged to heed the advice of the Ohio Department of Health (ODH) and other emergency officials regarding this public health emergency. State agencies, including those serving individuals through Ohio Medicaid, were authorized to coordinate the State response to COVID-19, and to develop and implement procedures, including suspending or adopting temporary rules within an agency's authority, consistent with recommendations from ODH designed to prevent or alleviate this public health threat.

   To this end, the Ohio Department of Medicaid (ODM) sought and received approval from the Centers for Medicare and Medicaid Services (CMS) of an 1135 waiver on April 22, 2020 good through the end of the public health emergency, and two home and community-based services (HCBS) waiver Appendix Ks on May 14, 2020 effective for the period January 27, 2020 until six months after the end of the public health emergency. Also, Governor DeWine

signed Executive Order 2020-23D on June 11, 2020 authorizing related emergency rules affecting administration of the State's HCBS waivers; these emergency rules expired on October 11, 2020 and were replaced by permanent rules in both October and December 2020. Throughout this time, ODM and the Ohio Department of Aging (ODA) have been issuing joint provider and case management guidance consistent with the agencies' recent waiver alignment efforts.

Among other things, this business impact analysis (BIA) corrects recently promulgated permanent COVID-related rule provisions requiring CSIO review. It also includes rules that are subject to five-year review.

OAC 5160-44-31, "Ohio department of medicaid (ODM)-administered waiver programs: provider conditions of participation," sets forth the Ohio Department of Medicaid (ODM) provider conditions of participation for services outlined in OAC Chapters 5160-44 and 5160-46. It sets forth what a service provider shall and shall not do while providing services to individuals. This rule is being proposed for amendment to update policy related to the administration of ODM-administered HCBS waiver programs and the ongoing COVID-19 public health emergency. Paragraph (C) regarding electronic visit verification (EVV) is being modified to apply to all ODM-administered waivers instead of just the Ohio Home Care Waiver. Paragraph (F) is being amended to narrow the restrictions regarding who can be an ODM-administered waiver service provider if they are designated to serve or make decisions for an individual in any capacity involving declaration of a power of attorney, guardianship, or as an authorized representative or representative payee.

OAC 5160-45-04, "Ohio department of medicaid (ODM) -administered waiver program: provider enrollment process," sets forth the enrollment process for Ohio Department of Medicaid (ODM) -administered waiver service providers. This rule is being amended pursuant to five-year rule review. Proposed changes include updated terminology and rule-citations, so as not to duplicate requirements found in other Administrative Code rules.

OAC 5160-45-06, "Ohio department of medicaid (ODM) -administered waiver program: structural reviews of providers and investigation of provider occurrences," sets forth the process and requirements for conducting structural reviews of ODM-administered waiver service providers to ensure providers' compliance with ODM-administered waiver requirements. This rule is being proposed for amendment to update policy related to the administration of ODM-administered HCBS waiver programs and the ongoing COVID-19 public health emergency. Pursuant to Appendix K provisions, paragraph (B)(11) is added to permit ODM, at its sole discretion, to choose to suspend a provider's structural review.

OAC 5160-46-04, "Ohio home care waiver: definitions of the covered services and provider requirements and specifications," sets forth the definitions of services, provider requirements and specifications for the delivery of Ohio Home Care Waiver services. The

rule is being amended to correct a typographical error in paragraph (A)(8)(a)(ii) regarding a COVID-19 provision. Specifically, it will permit first aid to be provided by a course that is not solely through the internet and that may not have to include hands-on training by a certified first aid instructor with performance of a successful return demonstration of what was learned in the course.

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.**

   5162.03, 5164.02, 5166.02,

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.

   Yes. First, 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."

   The proposed rule changes reflected herein reinforce the protections put in place because of CMS' approval of the aforementioned Appendix Ks, and Executive Order 2020-23D emanating from the current COVID-19 public health emergency. They pertain to the administration of the waivers, directly impacting waiver eligibility, provider enrollment and oversight and case management. Together, the proposed rule changes will assist the State in assuring the health and welfare of waiver participants, as well as greater availability of and flexibilities for waiver service providers. 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 to render services.

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

These rules do not exceed federal requirements and are aligned with the CMS-approved waivers. They do not contain provisions not specifically required by the federal government.

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)?**

   The public purpose of these regulations is also to assure the health and welfare of individuals enrolled in an ODM-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 individuals, providers and case management agencies must meet.

7. **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 waiver participants, it will be evident through their continued access to providers, as well as health and welfare during the COVID-19 public health emergency.

   Second, success will be measured through provider availability and a provider's compliance with waiver provider standards. The expectation is that flexibility of provider requirements during the public health emergency will result provider availability and a reduced number of incidents that threaten the health and welfare of individuals participating in the waiver program. This is evidenced, in part, by few incidents and no adverse findings resulting from structural reviews and investigation of alleged provider occurrences.

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.

   ODM convenes a HCBS Rules Workgroup to draft and review OAC rules governing ODM-administered waivers. This stakeholder group meets in-person and by phone/ webinar and plays a critical role in ODM and ODA HCBS waiver policy development.

   The HCBS Rules Workgroup email group includes more than 800 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
Access Center for Independent Living
CareSource
CareStar
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 Aging
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

The workgroup was notified about most of the proposed actions and provided with a summary of the changes via email on March 2, 2021, followed by a webinar review on March 10, 2021. Additional proposed rule changes were shared by email on April 6, 2021.

10. 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 updating policy and practice, and in assuring the health and welfare of waiver participants throughout the COVID-19 public health emergency. The proposed rule changes will update rules and provider and case management guidance developed with stakeholder input. The Ohio Department of Aging and the Ohio Department of Developmental Disabilities have been ODM's partners throughout this process. OAC 5160-44-31 (F)(1) was modified from the earlier version per request during the March 10, 2021 stakeholder meeting to provide greater clarity.

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 to develop the rules or the measurable outcome of the rules.

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?

No alternative regulations were considered, as these regulations need to align with state and federal requirements and are required by CMS as part of approval of the 1915(c) waiver.

13. 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.

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

All regulations regarding the ODM HCBS waiver program are promulgated by ODM and implemented by ODM, their designees and providers, as appropriate. Where applicable, ODM has worked with other agencies to ensure there's no duplication among respective regulations.

15. 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.

HCBS waiver participants and service providers will be notified of plans to implement the rules in this package. Notification will occur via a variety of communication methods including ODM's issuance of emails to case management agencies and agency and independent providers, and electronic communication via the provider oversight contractor's (PCG) website.

Adverse Impact to Business

16. 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; and

Currently, there are approximately 3,994 non-agency personal care aides, 1,871 registered nurses (RN)/licensed practical nurses (LPN), and 74 home care attendants serving individuals enrolled on an ODM-administered waiver. There are also 766 Medicare-certified home health agencies, 72 otherwise-accredited agencies and approximately 374 ancillary service providers that also furnish services to individuals.

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

Under **OAC 5160-44-31**, providers are required to maintain an active, valid medicaid provider agreement as set forth in rule 5160-1-17.2 of the Administrative Code. ODM-administered waiver service providers are required to notify ODM or its designee within 24 hours when the provider is aware of issues that may affect the individual and/or the provider's ability to render services as directed in their person-centered services plan. Providers may incur costs related to the maintenance and retention of records related to services provided.

OAC 5160-45-04 requires someone to enroll as a Medicaid provider; this is a form of prior authorization to engage in a line of business. Such a requirement would be in accordance with other specific ODM administered waiver provider rules. Additionally, the provider applicant must complete and submit a provider application to ODM through its provider network management system web portal in accordance with the rules set forth in Chapter 5160-1 of the Administrative Code. Upon receipt of the provider application, ODM or its designee shall verify the provider applicant has submitted and meets all applicable ODM-administered waiver provider requirements set forth in Chapters 5160-1, 5160-44, 5160-45, 5160-46, and 5160-58 of the Administrative Code.

Under **OAC 5160-45-06**, Providers may be subject to costs associated with providing information for structural reviews and any corrective action associated with the results of such reviews. If ODM-administered waiver providers and contractors adhere to the ODM-administered waiver provider requirements, there should be little or no cost of compliance with this review. However, if the provider does not, and an incident or provider occurrence is reported, the provider will be subject to investigation and follow-up and could be subject to sanctions that could result in their inability to participate in the Medicaid waiver program.

Under **OAC 5160-46-04**,

- Home health agencies must be Medicare-certified or otherwise accredited by a national accreditation body. 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.
- Adult day health center must provide for replacement coverage due to theft, property damage and/or personal injury.
- Supplemental transportation service providers must possess a valid driver's license. Additionally, they must 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.

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 to1.5 FTEs. At $29 per hour, that could 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 by valuepenguin.com, average minimum coverage premiums range from $428 to $1,428 per year.

Costs related to the structural review requirements set forth in OAC 5160-45-06 may vary due to the length of reports prepared by the Ohio Department of Health for Medicare certification and by other national accreditation bodies. Depending on how many pages that must be copied, agencies would need to consider the following: cost per page, cost of the administrative time, postage and packaging (i.e., certified mail, priority mailing, etc.), tracking to ensure delivery, and any follow-up necessary. The amount could be less than $1.00 for the letter of certification, or up to and over $100 depending on the length of reports and plan of correction documents. SOURCE: *Ohio Council for Home Care and Hospice and LeadingAge Ohio.*

17. **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

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

No, not applicable to this program.

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 to this program.

20. **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.

DRAFT - NOT FOR FILING

5160-36-04 Program of all-inclusive care for the elderly (PACE): enrollment and disenrollment.

(A) Individuals eligible and seeking to enroll in PACE shall enroll in the manner established in rule 173-50-03 of the Administrative Code unless paragraph (B) of this rule applies.

(B) A participant may choose to voluntarily disenroll from PACE at any time without cause if the participant or the participant's authorized representative informs the PACE organization orally or in writing.

(1) Should a participant choose to voluntarily disenroll from PACE, ODA shall, prior to the participant's disenrollment, verify that the voluntary disenrollment was initiated by the individual or the individual's authorized representative.

(2) The voluntary disenrollment of a participant shall occur in the manner prescribed in rule 173-50-04 of the Administrative Code.

(C) Subject to paragraph (D) of this rule, ~~A~~ a PACE organization may ~~not~~ initiate the involuntary disenrollment of a participant if either of the conditions set forth in paragraphs (C)(1) or (C)(2) of this rule are met. ~~any of the following applies:~~

(1) The participant no longer meets the PACE requirements set forth in rule 173-50-02 of the Administrative Code.

(2) The participant meets the criteria for involuntary disenrollment set forth in rule 173-50-05 of the Administrative Code.

(3) The involuntary disenrollment of a PACE participant shall occur in the manner prescribed in rule 173-50-05 of the Administrative Code.

(D) ~~Once enrolled in PACE, an individual will not be disenrolled unless the individual requests disenrollment pursuant to paragraph (B) of this rule, moves out of state, or expires.~~ Once enrolled in PACE, a participant will not be disenrolled if disenrollment results in the loss of Medicaid eligibility, unless the participant requests disenrollment pursuant to paragraph (B) of this rule, moves out of state, or dies.

DRAFT - NOT FOR FILING

5160-44-31 Ohio department of medicaid (ODM)-administered waiver programs: provider conditions of participation.

(A) An ODM-administered waiver service provider shall maintain a professional relationship with the individuals to whom they provide services. Providers shall furnish services in a manner that is in accordance with the individual's approved person-centered services plan, is attentive to the individual's needs, and maximizes the individual's independence. A provider shall refrain from any behavior that may detract from the goals, objectives and services outlined in the individual's approved person-centered services plan and/or that may jeopardize the individual's health and welfare.

(B) An ODM-administered waiver service provider shall:

(1) Maintain an active, valid medicaid provider agreement as set forth in rule 5160-1-17.2 of the Administrative Code.

(2) Comply with all provider requirements set forth in Chapters 5160-44 and 5160-45 of the Administrative Code, and Chapter 5160-46 or 5160-58 of the Administrative Code, depending upon the waiver(s) for which the provider is rendering services. Provider requirements include:

(a) Provider enrollment as set forth in rule 5160-45-04 of the Administrative Code;

(b) Criminal record checks as set forth in rule 5160-45-07 or 5160-45-08, as applicable, and rule 5160-45-11 of the Administrative Code;

(c) Incident reporting as set forth in rule 5160-44-05 of the Administrative Code; and

(d) Provider monitoring, reviews and oversight as set forth in rules 5160-45-06 and 5160-45-09 of the Administrative Code.

(3) Be at least eighteen years of age, including the provider and its employees, if applicable.

(4) Be able to read, write, and understand English at a level that enables the provider to comply with all applicable program requirements.

(5) Be able to effectively communicate with the individual.

(6) Deliver services professionally, respectfully and legally.

(7) Ensure that individuals to whom the provider is rendering ODM-administered waiver services are protected from abuse, neglect, exploitation and other threats to their health, safety and well-being. Upon entering into a medicaid provider agreement, and annually thereafter, all providers including all employees who have direct contact with individuals enrolled on an ODM-administered waiver, must acknowledge in writing they have reviewed rule 5160-44-05 of the Administrative Code regarding incident management and related procedures.

(8) Work with the individual and case manager to coordinate service delivery, including:

(a) Agreeing to provide and providing services in the amount, scope, location and duration they have capacity to provide, and as specified on the individual's approved person-centered services plan.

(b) Participating in the development of a back-up plan in the event that providers are unable to furnish services on the appointed date and time.

(c) Contacting the individual and the case manager in the event the provider is unable to render services on the appointed date and time.

(i) In the case of an emergency or unplanned absence, the provider shall immediately activate the back-up plan as set forth in the individual's approved person-centered services plan, verify with the individual and notify the case manager with information about the absence.

(ii) In the event of a planned absence, the provider shall verify with the individual and notify the case manager no later than seventy-two hours prior to the absence with information about the absence.

(9) Upon request and within the timeframe prescribed in the request, provide information and documentation to ODM, its designee and/or the centers for medicare and medicaid services (CMS).

(10) Successfully complete ODM-mandated new provider training within ninety days after a new provider's medicaid enrollment date.

(11) Participate in all appropriate on-line or web-based provider trainings mandated or sponsored by ODM or its designees, including but not limited to those set forth in Chapters 5160-44, 5160-45, 5160-46 and 5160-58 of the Administrative Code.

(12) Be knowledgeable about and comply with all applicable federal and state laws, including the "Health Insurance Portability and Accountability Act of 1996" (HIPAA) regulations set forth in 45 C.F.R. parts 160 and 164 (as in effect on October 1, 2020), and the medicaid safeguarding information requirements set forth in 42 C.F.R. 431.300 to 431.306 (as in effect on October 1, 2020), along with sections 5160.45 to 5160.481 of the Revised Code.

(13) Ensure that the provider's contact information, including but not limited to address, telephone number, fax number and email address, is current. In the event of a change in contact information, the provider shall notify ODM via the medicaid information technology system (MITS) and its designee, no later than seven calendar days after such changes have occurred.

(14) Maintain and retain all required documentation related to the services delivered during the visit, including but not limited to: an individual-specific description and details of the tasks performed or not performed in accordance with the approved person-centered services plan and when required, the individual's plan of care.

(a) Verification of service delivery shall include, but not be limited to the date and location of service delivery, service start and end times, and the signatures of the provider and the individual or authorized representative.

(b) Acceptable signatures include, but are not limited to a handwritten signature, initials, a stamp or mark, or an electronic signature. Any accommodations to the individual's or authorized representative's signature shall be documented on the person-centered services plan.

(c) If the individual is unable to provide the signature required by this paragraph at the time of the service, the individual is to submit an electronic signature or standard signature via regular mail, or otherwise provide a signature in no instance any later than at the next face-to-face visit with the provider.

(15) Retain all records of service delivery and billing for a period of six years after the date of receipt of the

payment based upon those records, or until any initiated audit is completed, whichever is longer.

(16) Cooperate with ODM and its designee during all provider monitoring and oversight activities by being available to answer questions during reviews, and by assuring the availability and confidentiality of individual information and other documents that may be requested as part of provider monitoring activities.

(17) To the extent not otherwise required by rule 5160-44-05 of the Administrative Code, notify ODM or its designee within twenty-four hours when the provider is aware of issues that may affect the individual and/or provider's ability to render services as directed in the individual's person-centered services plan, including when:

(a) The individual consistently declines services;

(b) The individual plans to or has moved to another residential address;

(c) There are changes in the physical, mental and/or emotional status of the individual;

(d) There are changes in the individual's environmental conditions;

(e) The individual's caregiver status has changed;

(f) The individual no longer requires medically necessary services as defined in rule 5160-1-01 of the Administrative Code;

(g) The individual's actions toward the provider are threatening or the provider feels unsafe or threatened in the individual's environment;

(h) The individual is consistently noncompliant with physician orders, or is noncompliant with physician orders in a manner that may jeopardize his or her health and welfare;

(i) The individual's requests conflict with his or her person-centered services plan and/or may jeopardize his or her health and welfare; or

(j) Any other situation that affects the individual's health and welfare.

(18) Make arrangements to accept all correspondence sent by ODM or its designee, including but not limited to, certified mail.

(19) Maintain a current e-mail address with ODM and its designee in order to receive electronic notification of any rule adoption, amendment or rescission, and any other communications from ODM or its designee

(20) Submit written notification to the individual and ODM or its designee at least thirty calendar days before the anticipated last date of service if the provider is terminating the provision of ODM-administered waiver services to the individual. Exceptions include:

(a) The provider must submit verbal and written notification to the individual and ODM or its designee at least ten days before the anticipated last date of service if the individual has been:

(i) Admitted to a hospital;

(ii) Placed in an institutional setting; or

(iii) Incarcerated.

(b) ODM may waive advance notification for a provider upon request and on a case-by-case basis.

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

(22) Have a valid social security number and at least one of the following current, government-issued photographic identification cards:

(a) Driver license;

(b) State of Ohio identification card; or

(c) United States of America permanent residence card.

(C) A provider of nursing, personal care and home care attendant services under ~~the Ohio home care waiver~~ an ODM-administered waiver program shall verify service delivery using an ODM-approved electronic visit verification (EVV) system in accordance with rule 5160-1-40 of the Administrative Code.

(D) At no time, shall an ODM-administered waiver service provider:

(1) Engage in any behavior that causes or may cause physical, verbal, mental or emotional abuse or distress to the individual.

(2) Engage in any other behavior that may compromise the health and welfare of the individual.

(3) Engage in any activity or behavior that may take advantage of or manipulate the individual or his or her authorized representative, family or household members or may result in a conflict of interest, exploitation, or any other advantage for personal gain, including:

(a) Misrepresentation;

(b) Accepting, obtaining, attempting to obtain, borrowing, or receiving money or anything of value including, but not limited to gifts, tips, credit cards or other items;

(c) Being designated on any financial account including, but not limited to bank accounts and credit cards;

(d) Using real or personal property of another;

(e) Using information of another;

(f) Lending or giving money or anything of value;

(g) Engaging in the sale or purchase of products, services or personal items; and

(h) Engaging in any activity that takes advantage of or manipulates ODM-administered waiver program rules.

(4) Falsify the individual's signature, including using copies of the signature.

(5) Make fraudulent, deceptive or misleading statements in the advertising, solicitation, administration or billing of services.

(6) Submit a claim for waiver services rendered while the individual is hospitalized, institutionalized or incarcerated. The only exception is when the individual is receiving out-of-home respite as set forth on his or her person-centered services plan.

(E) While rendering services, an ODM-administered waiver service provider shall not:

(1) Take the individual to the provider's place of residence.

(2) Bring children, animals, friends, relatives, other individuals or anyone else to the individual's place of residence.

(3) Provide care to persons other than the individual.

(4) Smoke without the consent of the individual.

(5) Sleep.

(6) Engage in any activity that is not related to the provision of services to the extent the activity distracts from, or interferes with, service delivery. Such activities include, but are not limited to the following:

(a) Using electronic devices for personal or entertainment purposes including, but not limited to watching television, using the computer or playing games.

(b) Making or receiving personal communications.

(c) Engaging in socialization with persons other than the individual.

(7) Deliver services when the provider is medically, physically or emotionally unfit.

(8) Use or be under the influence of the following while providing services:

(a) Alcohol.

(b) Illegal drugs.

(c) Chemical substances.

(d) Controlled substances that may adversely affect the provider's ability to furnish services.

(9) Engage in any activity or conduct that may reasonably be interpreted as sexual in nature, regardless of whether or not it is consensual.

(10) Engage in any behavior that may reasonably be interpreted as inappropriate involvement in the individual's personal beliefs or relationships including, but not limited to discussing religion, politics or personal issues.

(11) Consume the individual's food and/or drink without his or her offer and consent.

(F) An ODM-administered waiver service provider shall not be designated to serve or make decisions for the

individual in any capacity involving a declaration for mental health treatment, general power of attorney, health care power of attorney, financial power of attorney, guardianship pursuant to court order, as an authorized representative, or as a representative payee as that term is described in paragraph (F)(3) of this rule, except in the following circumstances:

(1) A provider may be appointed by the court to serve as legal guardian for the individual pursuant to Chapter 2111. of the Revised Code ~~if the provider is a family member.~~unless the provider is an attorney or agency who would be serving in the role of guardian.

(2) A provider may serve as an authorized representative or pursuant to a declaration for mental health treatment, general power of attorney, health care power of attorney, financial power of attorney or guardianship if the provider is the individual's parent or spouse.

(3) A provider may serve as the individual's representative payee if the provider is the individual's parent or spouse. For purposes of this rule, "representative payee" means a parent or spouse the individual designates to receive and manage payments that would otherwise be made directly to the individual.

(4) A provider may be designated as an authorized representative or pursuant to a declaration for mental health treatment, general power of attorney, health care power of attorney, financial power of attorney or guardianship for the individual if:

(a) The provider was serving in that capacity prior to September 1, 2005; and

(b) The provider was the individual's paid medical provider prior to September 1, 2005; and

(c) The designation is not otherwise prohibited by law.

(G) An agency provider shall pay applicable federal, state and local income and employment taxes in compliance with federal, state and local requirements. Federal employment taxes include medicare and social security.

(H) Non-agency providers shall pay applicable federal, state and local income and employment taxes in compliance with federal, state and local requirements. Federal employment taxes include medicare and social security. On an annual basis, non-agency providers must submit an ODM-approved affidavit stating that they paid their applicable federal, state and local income and employment taxes.

(I) Failure to meet the requirements set forth in this rule may result in any of the actions set forth in rules 5160-44-05, 5160-45-06 and 5160-45-09 of the Administrative Code including termination of the medicaid provider agreement in accordance with rule 5160-1-17.6 of the Administrative Code. In the event ODM proposes termination of the medicaid provider agreement, the provider may be entitled to a hearing or review in accordance with Chapter 5160-70 of the Administrative Code.

DRAFT - NOT FOR FILING

5160-45-03 Ohio department of medicaid (ODM) -administered waiver program: individual rights and responsibilities.

Enrollment on an Ohio department of medicaid (ODM) -administered waiver is voluntary. Individuals enrolled on an ODM-administered waiver in accordance with rule 5160-46-02 of the Administrative Code shall be informed of their rights and responsibilities. Individuals also have choice and control over the arrangement and provision of home and community-based waiver services, and the selection and control over the direction of approved waiver service providers.

(A) Individual rights.

An individual enrolled in an ODM-administered waiver has the right to:

(1) Be treated with dignity and respect.

(2) Be protected from abuse, neglect, exploitation and other threats to personal health, safety and well-being.

(3) Appoint an authorized representative to act on their behalf in accordance with 5160-1-33 of the Administrative Code.

(4) Receive waiver services in a person-centered manner that is in accordance with an approved ~~all~~ person-centered services plan, is attentive to the individual's needs and maximizes personal independence.

(5) Conduct person-centered training of their waiver service providers.

~~(5)~~ (6) Choose his or her case management agency (CMA) and case managers, and

(a) Have the case manager explain what the ODM-administered waiver is, how it will assist the individual and what the individual's rights and responsibilities are;

(b) Participate with the case manager and the team in the person-centered ~~all~~ services plan development process, and when possible, lead the process;

(c) Request assistance with recruitment of providers;

(d) Be able to effectively communicate with the case manager and team and receive information in a manner that is easy to understand;

(e) Be able to meet privately with the case manager;

(f) Receive ongoing assistance from the case manager; and

(g) Be able to request changes in ~~case management agency and/or~~ case manager, as necessary.

(h) Be able to request changes in CMA, in accordance with paragraph (D) of this rule.

~~(6)~~ (7) Make informed choices regarding the services and supports he or she receives and from whom, including provider-managed agency providers, ~~and/or~~ non-agency providers, and/or participant-directed providers as those terms are defined in rule 5160-45-01 of the Administrative Code.

~~(7)~~ (8) Obtain the results of criminal records checks about current agency providers or provider applicants

pursuant to section 5164.342 of the Revised Code and rules 5160-45-07 and 5160-45-11 of the Administrative Code.

~~(8)~~ (9) Obtain the results of criminal records checks about current non-agency providers or provider applicants pursuant to section 5164.341 of the Revised Code and rules 5160-45-08 and 5160-45-11 of the Administrative Code.

~~(9)~~ (10) Access files, records or other information related to the individual's health care.

~~(10)~~ (11) Be assured of confidentiality of personal and sensitive health care information pursuant to relevant confidentiality and information disclosure laws.

~~(11)~~ (12) Request assistance with problems, concerns and issues, and suggest changes without fear of repercussion.

~~(12)~~ (13) Be fully informed about how to contact the case manager and ODM with problems, concerns, issues or inquiries.

~~(13)~~ (14) Be informed of the right to appeal decisions made by ODM or its designee about waiver eligibility or services pursuant to division 5101:6 of the Administrative Code.

(B) Individual responsibilities.

(1) Upon enrollment in an ODM-administered waiver, the individual must sign an ODM-approved waiver agreement accepting responsibility for the provisions in paragraphs (B)(1)(a) to (B)(1)(t) of this rule. The signature requirement in paragraph (B)(1) of this rule may be satisfied by an electronic signature or standard signature via regular mail, or otherwise in no instance any later than at the next face-to-face visit with the case manager.

(a) Participate in, and cooperate during assessments to determine eligibility and enrollment in the waiver and service needs.

(b) Decide who, besides the case manager, will participate in the service planning process.

(c) Participate in, and cooperate with, the case manager and team in the development and implementation of ~~all~~ person-centered services plans and plans of care.

(d) Participate in the recruitment, selection and dismissal of his or her providers.

(e) Participate in the development and maintenance of back-up plans that meet the needs of the individual.

(f) Work with the case manager and/or physician and the provider to identify and secure additional training within the provider's scope of practice in order to meet the individual's specific needs.

(g) Not direct the service provider to act in a manner that is contrary to relevant ODM-administered waiver program requirements, medicaid rules and regulations and all other applicable laws, rules and regulations.

(h) ~~Validate~~ Verify service delivery in a manner that includes, but is not limited to, the date and location

of service delivery, ~~arrival and departure~~start and end times ~~of the provider, the dated signature~~and the signatures of the provider and the ~~dated signature of the~~ individual or authorized representative. All signatures shall be obtained at the end of every visit or upon completion of the scheduled service. When services are rendered in multiple visits per day, signatures must be obtained upon completion of each visit.

(i) Notify the case manager when any change in provider is necessary. Notification shall include the end date of the former provider, and the start date of the new provider.

(j) Authorize the exchange of information for development of the ~~all~~ person-centered services plan with all of the individual's service providers, and in compliance with the "Health Insurance Portability and Accountability Act of 1996" (HIPAA) regulations set forth in 45 C.F.R. parts 160 and 164 (October 1, 2020) and the medicaid safeguarding information requirements set forth in 42 C.F.R. 431.000 to 431.306 (October 1, 2020) along with sections 5160.45 to 5160.481 of the Revised Code.

(k) Provide accurate and complete information including, but not limited to medical history.

(l) Utilize services in accordance with the approved ~~all~~ person-centered services plan.

(m) Communicate to the provider personal preferences about the duties, tasks and procedures to be performed, and when appropriate, about provider performance concerns.

(n) Report to the case manager any service delivery issues including, but not limited to, service disruption, complaints and concerns about the provider, and/or health and safety issues.

(o) Keep scheduled appointments and notify the provider and case manager if he or she is going to miss a scheduled visit or service.

(p) Treat the case manager, team and providers with respect.

(q) Report to the case manager any significant changes, as defined in rule 5160-45-01 of the Administrative Code, that may affect the provision of services.

(r) Report to the case manager, in accordance with rule ~~5160-45-05~~5160-44-05 of the Administrative Code, incidents that may impact the health and welfare of the individual.

(s) Work with the case manager and team to resolve problems and concerns.

(t) Refuse to participate in dishonest or illegal activities involving providers, caregivers and team members.

(2) When an individual receives services from an agency provider, the individual shall identify a location in his or her residence where a ~~file~~ recordcontaining a copy of his or her medication profile, if one exists, shall be safely maintained. The ~~file~~ record may also include the individual's medication administration record, treatment administration record, aide assignment, ~~all~~ person-centered services plan and plans of care.

(3) When an individual receives services from a non-agency provider, the individual shall identify a location

in his or her residence where a copy of the clinical record will be safely maintained.

(C) If the individual fails to meet the requirements set forth in paragraph (B) of this rule, and/or the health and welfare of the individual receiving services from a non-agency provider cannot be assured, then the individual may be required to receive services from only agency providers. The individual shall be afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

(D) An individual may change CMAs when just cause exists, at the sole discretion of ODM. The change may occur when the individual has requested the change and ODM has approved the request. The following provisions apply:

(1) The request was made by the individual, or by the individual's authorized representative.

(2) The request is voluntary.

(3) The change, if approved, will take effect on the last day of the month in which the request is made.

DRAFT - NOT FOR FILING

5160-45-04 Ohio department of medicaid (ODM) -administered waiver program: provider enrollment process.

(A) Ohio department of medicaid (ODM) -administered waiver provider applicants must successfully complete the provider enrollment process set forth in this rule and receive approval from ODM before furnishing services to an individual enrolled on an ODM-administered waiver. Services furnished before ODM approves and enrolls the provider applicant and before the provider is added to the approved person-centered services plan are not reimbursable.

(B) The provider applicant must complete and submit a ~~waiver~~ provider application to ODM through its ~~medicaid information technology system (MITS)~~ provider network management system web portal in accordance with the rules set forth in Chapter 5160-1~~-17.2~~ of the Administrative Code.

(C) Upon receipt of the ~~waiver~~ provider application, ODM or its designee shall verify ~~all of the following:~~the provider applicant has submitted and meets all applicable ODM-administered waiver provider requirements set forth in Chapters 5160-1, 5160-44, 5160-45, 5160-46, and 5160-58 of the Administrative Code.

~~(1)~~ (1) ~~The provider applicant submits and meets all applicable ODM-administered waiver provider requirements set forth in Chapters 5160-1, 5160-45 and 5160-46 of the Administrative Code.~~

~~(2)~~ (2) ~~The provider applicant has included a statement affirming the provider applicant is aware of, understands and agrees to all of the Administrative Code rules governing the ODM-administered waiver program.~~

~~(3)~~ (3) ~~The non-agency provider applicant, agency provider applicant and/or the agency's primary officer, director or owner are not on any federal or state exclusionary lists ODM considers when determining medicaid provider eligibility.~~

(D) ODM or its designee shall notify the provider applicant if the application does not contain all of the required documentation. The provider applicant shall have thirty calendar days from the date of written notification to submit the requested documentation. If the provider applicant does not submit the documentation within the prescribed time frame, ODM or its designee may reject the provider application.

(E) ODM shall enroll or deny enrollment of the provider applicant based upon its own review and the review and recommendation of its designee.

(F) ODM shall notify the provider applicant in writing of its decision. If ODM denies enrollment, it shall either issue the provider applicant appeal rights in accordance with Chapter 119. of the Revised Code, or reconsideration rights in accordance with rule 5160-70-02 of the Adminstrative Code. .

(G) When a current ODM-administered waiver service provider submits ~~its~~ itsmedicaid provider agreement revalidation application, ~~and/or~~ or applies for ~~an additional provider type(s), and/or speciality~~ a specialty(ies) under their current provider type, ODM shall ensure that criminal record check requirements set forth in Chapter 5160-45 of the Administrative Code are satisfied. ODM shall also review the provider's history, including but not limited to medicaid program compliance and performance. ODM may approve or deny revalidation based on its findings and in accordance with rule 5160-1-17.6 of the Administrative Code.

(H) When a former medicaid provider applies for enrollment to become an ODM-administered waiver provider, in addition to following the process outlined in paragraphs (A) to (F) of this rule, ODM shall also review the provider applicant's history including, but not limited to medicaid program compliance and performance. ODM may approve or deny enrollment based on its findings and in accordance with rules 5160-1-17.6 and 5160-1-17.7 of the Administrative Code.

DRAFT - NOT FOR FILING

5160-45-06 Ohio department of medicaid (ODM) -administered waiver program: structural reviews of providers and investigation of provider occurrences.

(A) The Ohio department of medicaid (ODM) or its designee shall continuously monitor every ODM-administered waiver provider. Monitoring activities shall include, but not be limited to:

(1) A structural review of compliance with all ODM-administered waiver provider requirements in accordance with paragraph (B) of this rule.

(2) Investigation of provider occurrences in accordance with paragraph (C) of this rule.

(B) Structural reviews.

(1) Medicare-certified and otherwise accredited agency providers as defined in rule 5160-45-01 of the Administrative Code are subject to reviews in accordance with their certification and accreditation bodies and may be exempt from a regularly scheduled structural review as determined by ODM. Upon request by ODM or its designee, medicare-certified and otherwise-accredited agency providers, shall make available within ten business days, all review reports and accepted plans of correction from the certification and/or accreditation bodies.

(2) All other agency providers are subject to structural reviews by ODM or its designee every two years after the provider begins furnishing billable services.

(3) All non-agency ODM-administered waiver providers are subject to structural reviews by ODM or its designee during each of the first three years after a provider begins furnishing billable services. Thereafter, and unless otherwise prescribed by either paragraph (B)(4) or (B)(5) of this rule, structural reviews shall be conducted annually.

(4) ODM or its designee may conduct biennial structural reviews of a non-agency ODM-administered waiver provider, when all the following apply:

(a) There were no findings against the provider during the provider's most recent structural review;

(b) The provider was not substantiated to be the violator in an incident described in rule 5160-44-05 of the Administrative Code;

(c) The provider was not the subject of more than one provider occurrence during the previous twelve months; and

(d) The provider does not live with an individual receiving ODM-administered waiver services.

(5) All ODM-administered waiver providers may be subject to an announced or unannounced structural review at any time as determined by ODM or its designee.

(6) Structural reviews may be conducted in person between the provider and ODM or its designee or via desk review, and in a manner consistent with paragraph (B)(3) of rule 5160-45-09 of the Administrative Code.

(7) All structural reviews use an ODM-approved structural review tool.

(8) Structural reviews shall not occur while the provider is furnishing services to an individual.

(9) The structural review process consists of the following activities:

(a) Except for unannounced structural reviews, the provider shall be notified in advance of the review to arrange a mutually acceptable time, date and location for the review. Advance notification shall also include identification of the time period for which the review is being conducted and a list of the type of documents required for the review.

(b) The provider shall ensure the availability of required documents and maintain the confidentiality of information about individuals enrolled on the ODM-administered waiver.

(c) ODM or its designee shall examine all substantiated incident reports or provider occurrences related to the provider. Documented findings of noncompliance shall be addressed during the review.

(d) The structural review shall include an evaluation of compliance with Chapter 5160-45 of the Administrative Code and Chapter(s) 5160-44, 5160-46, and/or 5160-58 of the Administrative Code, depending upon the waiver(s) under which the provider is furnishing services.

(e) A unit of service verification shall be conducted by ODM or its designee to ensure all waiver services are authorized, delivered and reimbursed in accordance with the approved person-centered services plan for the individual receiving waiver services.

(f) The provider's compliance with the home and community-based settings requirements set forth in rule 5160-44-01 of the Administrative Code will be evaluated, which will include interviews with individuals served in the setting.

(g) An evaluation shall be conducted to determine whether the provider has implemented all plans of correction approved since the last review. Failure to successfully complete all plans of correction and/or the existence of repeat violations may lead to additional sanctions including, but not limited to termination of their provider agreement.

(h) A final exit interview summarizing the overall outcome of the review will occur between the non-agency provider, or in the case of an agency provider, the agency administrator or his or her designee, and ODM or its designee at the conclusion of the review.

(10) The exit interview will be followed up with a written report to the provider from ODM or its designee. The report shall summarize the overall outcome of the structural review, specify the Administrative Code rules that are the basis for which noncompliance has been determined, and outline the specific findings of noncompliance. When findings are indicated, the provider shall respond in writing to the report in a plan of correction, including any individual remediation.

(11) ODM, at its sole discretion, may choose to suspend a provider's structural review.

(C) Provider occurrences.

(1) "Provider occurrence" means any alleged, suspected or actual performance or operational issue by a provider furnishing ODM-administered waiver services that does not meet the definition of an incident as set forth in rule 5160-44-05 of the Administrative Code. Provider occurrences include, but are not limited to alleged violations of provider eligibility and/or service specification requirements, provider conditions of participation, billing issues including overpayments, and medicaid fraud.

(2) Upon discovery, ODM or its designee shall investigate provider occurrences including requesting any

documentation required for the investigation.

(3) If ODM or its designee substantiates the provider occurrence, it shall notify the provider. The notification shall specify:

(a) The provider's action or inaction that constituted the provider occurrence;

(b) The Administrative Code rule(s) that support the finding(s) of noncompliance;

(c) What the provider must do to correct the finding(s) of noncompliance, including acknowledgement of technical assistance, required training, and any individual remediation;

(D) Plans of correction for structural reviews and provider occurrences.

(1) The provider must submit to ODM or its designee a plan of correction for all identified findings of noncompliance, including any individual remediation, within forty-five calendar days after the date on the written report.

(2) If ODM or its designee finds the provider's plan of correction acceptable, it shall acknowledge, in writing, to the provider that the plan addresses the findings outlined in the written report. If ODM or its designee determines that it cannot approve the provider's plan of correction, it shall inform the provider of this determination, in writing, require that the provider submit a new plan of correction and specify the required actions that must be included in the plan of correction. The provider must submit the new plan of correction within the prescribed timframes, not to exceed forty-five calendar days.

(3) ODM permits flexibility with the required timeframes for submission of plans of correction required in this paragraph, so long as it is documented in the provider's file.

(E) If the possibility of an overpayment is identified through the structural review and/or provider occurrence processes, ODM will conduct a final review, and as appropriate, issue all payment adjustments in accordance with rule 5160-1-19 of the Administrative Code.

(F) ODM may take action against the provider in accordance with rule 5160-45-09 of the Administrative Code for failure to comply with any of the requirements set forth in this rule.

DRAFT - NOT FOR FILING

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. Providers are also subject to the conditions of participation set forth in rule 5160-44-31 of the Administrative Code. 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) Paying bills and assisting with personal correspondence as directed by the individual; and

(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.

(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.

(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.

(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.

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

(a) May be the individual's legally responsible family member as that term is defined in rule 5160-45-01 of the Administrative Code if the legally responsible family member is employed by a medicare-certified, otherwise-accredited, or other ODM-approved agency.

(b) May be the foster caregiver of the individual if the foster caregiver is employed by a medicare-certified, otherwise-accredited, or other ODM-approved agency.

(c) 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.

(d) Comply with the additional applicable provider-specific requirements as specified in paragraph (A)(7) or (A)(8) of this rule.

(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. 484.80 (as in effect on October 1, 2020), and

(ii) Obtain and maintain first aid certification from a program that may be from a class that is solely internet-based, and that does not have to include 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) Face-to-face visits referenced in this paragraph may be conducted by telephone or electronically, unless the individual's needs necessitate a face-to-face visit.

(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. 484.80 (as in effect on October 1, 2020); 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 may ~~not~~ be solely internet-based and that does not have to include 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.

(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 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.

(e) ADHCS providers approved to provide services on the effective date of this rule may also furnish ADHCS described in paragraph (B) of this rule at the individual's place of residence, telephonically, or electronically.

(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 operate the adult day health center in compliance with all 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, 2020).

(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) Ensure all manufacturer's rebates have been deducted before requesting reimbursement for

supplemental adaptive and assistive device services.

(b) 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) 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 may be from a class that is soley through the internet, and does not have to include hands-on training from a certified first aid instructor and the performance of 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.

(4) 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 may be from a class that is soley through the internet, and does not have to include hands-on training from a certified first aid instructor and the performance of 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.

(5) 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.

(E) ODM is authorized to deem any provider certified by ODA or the Ohio department of developmental disabilities (DODD) to provide waiver services as having satisfied the requirements for approval by ODM for the same or similar services.

DRAFT - NOT FOR FILING

5160-46-06.1 Ohio home care waiver program: home care attendant services reimbursement rates and billing procedures.

(A) Definitions of terms used for billing and calculating home care attendant services (HCAS) rates.

(1) "Base rate," as set forth in column 3 of tables A and B of this rule, means the amount reimbursed by Ohio medicaid for the first thirty-five to sixty minutes of assistance with self-administration of medications and the performance of nursing tasks provided during a single visit.

(2) "Continuous nursing" means nursing services (waiver nursing and/or private duty nursing) that are more than four hours in length and during which personal care aide service tasks as described in paragraph (B)(1) of rule 5160-46-04 of the Administrative Code may be provided incidental to nursing services.

(3) "Group rate" means the amount that HCAS providers shall be reimbursed when the service is provided in a group setting.

(4) "Group setting" means a situation in which an HCAS provider furnishes HCAS in accordance with rule ~~5160-46-04.1~~5160-44-27 of the Administrative Code, and as authorized by the Ohio department of medicaid (ODM), to two or three individuals who reside at the same address.

(5) "HCAS visit" is a visit during which HCAS is provided in accordance with rule ~~5160-46-04.1~~5160-44-27 of the Administrative Code. An HCAS visit shall not exceed twelve hours or forty-eight units in duration.

(6) "Intermittent nursing" means nursing services (waiver nursing and/or home health nursing) that are four hours or less in length.

(7) "Medicaid maximum rate" means the maximum amount that shall be paid by the Ohio medicaid program for the service rendered. The base rate in column 3 and the unit rate in column 4 of table A of this rule, and the base rate in column 3 and the unit rates in column 5 of table B of this rule represent the medicaid maximum rates for HCAS.

(8) "Modifier", as set forth in column 4 of table A of this rule and column 4 of table B of this rule, means the additional two-alpha-numeric-digit billing code as set forth in paragraph (G) of this rule that HCAS providers shall use to provide additional information regarding service delivery.

(9) "Unit rate," as set forth in column ~~4~~ 5 of table A of this rule and column 5 of table B of this rule, means the amount reimbursed by Ohio medicaid for each fifteen minutes of HCAS delivered when the visit is:

(a) Greater than sixty minutes in length.

(b) Less than or equal to thirty-four minutes in length. Ohio medicaid will reimburse a maximum of only one unit if HCAS 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) Providers shall bill for reimbursement using table A when HCAS is provided in lieu of continuous nursing as described in paragraph (A)(2) of this rule. Personal care aide tasks are included in the unit rate.

DRAFT - NOT FOR FILING

Table A

Column 1	Column 2	Column 3	Column 4	Column 45
Billing code	Home care attendant service description	Base rate	Modifier	Unit rate
S5125	Assistance with self-administration of medications and/or the performance of nursing tasks (HCAS/N)	$25.95	N/A	$4.43 per fifteen minute unit of HCAS/N delivered during visit
S5125	HCAS/N (overtime)	$33.09	TU or UA	$6.22

(C) Providers shall bill for reimbursement using table B when HCAS is provided in lieu of intermittent nursing as described in paragraph (A)(6) of this rule. The first four units of HCAS shall be billed for at the base rate. Beginning with the fifth unit of HCAS, assistance with self-administration of medications and the performance of nursing tasks (HCAS/N) shall be billed at the HCAS/N unit rate; and personal care aide service tasks (HCAS/PC) shall be billed at the HCAS/PC unit rate using the U8 modifier. There is no base rate for HCAS/PC. The HCAS/PC service can only be rendered in conjunction with an HCAS/N service.

Table B

Column 1	Column 2	Column 3	Column 4	Column 5
Billing code	Home care attendant service description	Base rate	Modifier	Unit rate
S5125	HCAS/N	$25.95	N/A	$4.43 per fifteen minute unit of HCAS/N delivered during the visit
S5125	HCAS/PC	N/A	U8	$2.95 per fifteen minute of HCAS/PC delivered during the visit
S5125	HCAS/N (overtime)	$33.09	TU or UA	$6.22
S5125	HCAS/PC (overtime)	~~$33.09~~N/A	either TU or UA, and U8	$4.16

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

maximum rate.

(E) When HCAS/N and HCAS/PC are provided during an uninterrupted period of time, the visit shall be considered a single HCAS visit. An HCAS provider is entitled to only one base rate during an HCAS visit.

(F) HCAS providers shall be limited to a maximum of twelve hours or forty-eight units of HCAS during a twenty-four-hour period, regardless of the number of individuals enrolled on an ODM-administered waiver who are served.

(G) Required modifiers.

(1) The "HQ" modifier must be used when a provider submits a claim if HCAS was delivered in a group setting. Reimbursement at a group rate shall be the lesser of the provider's billed charge or seventy-five per cent of the medicaid maximum rate.

(2) The "TU" modifier must be used when a provider submits a claim for billing code S5125 and the entire ~~claim~~ visit is being billed as overtime.

(3) The "UA" modifier must be used when a provider submits a claim for billing code S5125 and only a portion of the ~~claim~~ visit is being billed as overtime.

(4) The "U2" modifier must be used when a provider submits a claim for a second HCAS visit to an individual enrolled on the Ohio home care waiver for the same date of service.

(5) The "U3" modifier must be used when the same provider submits a claim for three or more HCAS visits to an individual enrolled on the Ohio home care waiver for the same date of service.

(6) The "U8" modifier must be used when a provider submits a claim for an HCAS visit that is in lieu of intermittent nursing as described in paragraph (A)(6) of this rule, and for units of service that are HCAS/PC.

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