

Community Access Table of Contents

John R. Kasich, Governor

John B. McCarthy, Director

Ohio Department of Medicaid

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Introduction to Ohio Health Plan's Disability Policy Interagency EPubs

Chapter:

The Office of Ohio Health Plans, Bureau of Community Access oversees Medicaid Home and Community Based (HCBS) programs for Aged, Blind and Disabled individuals operated by state agencies other than ODJFS. As the federally-designated Single State Medicaid Agency (SSMA), ODJFS files rules on behalf of other state agencies or files authorizing rules that direct the operating agency to perform certain functions, including service definitions, provider qualifications, reimbursement rates and payment standards that meet federal Medicaid compliance.

The Bureau of Community Access directs policy and performs oversight and compliance monitoring of Medicaid State Plan services, administrative claiming and HCBS waiver services. Examples of the rules found in this Chapter include Medicaid HCBS waiver programs operated by the Ohio Department of MR/DD and the Ohio Department of Aging, Medicaid Administrative Claiming (MAC) programs operated by the Ohio Departments of Education and Health, and state plan Medicaid programs operated by the Ohio Department of Alcohol, Drug Addiction Services and Ohio Department Mental Health. Level of Care and Preadmission Screening rules for long-term care services are also found in this Chapter.

If you have any questions about the rules found in this chapter, please contact the Bureau of Community Access at 614-644-7130.

Medical Assistance Letters (MALs)

MAL 573 (Clarification Regarding Nursing Services through Medicaid School Program)

Medical Assistance Letter (MAL) 573

November 30, 2010

TO: All Eligible Medicaid School Providers
Ohio Department of Education
Ohio Association of County Boards of DD
Ohio Occupational Therapy Association
Ohio Provider Resource Association
Ohio Department of DD

FROM: Douglas E. Lumpkin, Director

SUBJECT: Clarification Regarding Nursing Services through Medicaid School Program

The Ohio Department of Job and Family Services (ODJFS) and the Ohio Department of Education (ODE) have received numerous inquiries about the nursing services provided to a child at school, specifically, about the level of nursing service for which reimbursement can be sought, and whether or not the level provided in school should be similar to the level provided at home. This guidance was developed to respond to these questions, and to provide clarification about nursing services allowable for Medicaid reimbursement through the Medicaid School Program (MSP).

MSP nursing services are not intended to replicate the amount, frequency and duration of nursing services provided in other settings, including the home setting. As part of the IEP process, the nurse employed or contracted by the school should assess the child's need for nursing service in order to access education. The assessment for nursing should determine the extent of nursing services appropriate for the child while in attendance at school independent of the services received at home. Therefore, the IEP must indicate the amount, frequency, and duration of the needed nursing service, and should only indicate the time that the nurse is actually performing/delivering a nursing service (eg. tube feeding, suctioning, and catheterizations). If there is a need for continuous nursing at school, as evident from the assessment, a nurse would be expected to be present with the child at all times.

In order to receive Medicaid reimbursement through the MSP, nursing services must have been determined medically necessary, as documented by a physicians order. In addition, the child's needs must be addressed through an IEP that includes nursing services as one of the related services.

Web Pages:

The Ohio Department of Education maintains information about the MSP that can be accessed through the ODE website at: www.ode.state.oh.us. Using the search field, search for the Medicaid School Program.

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Community Access"
- (3) Select "Medical Assistance Letters", and "MAL 573" (in the "Table of Contents" dropdown).

Questions:

Questions about this MAL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Long-Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

<http://ifs.ohio.gov/ohp>

(614) 466-6742

MAL 522 (August 14, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516)

Medical Assistance Letter No [522](#) is maintained in the General Information e-book.

MAL 516 (November 9, 2006 - Employee Education About False Claims Recovery)

Medical Assistance Letter No [516](#) is maintained in the General Information e- book.

Community Access Manual Transmittal Letters (CATLs)

CATL 11-01 (PASSPORT HCBS Medicaid Waiver Program Rules)

Community Access Transmittal Letter (CATL) 11-01

March 10, 2011

TO: All Interested Parties
FROM: Michael B. Colbert, Director
SUBJECT: Pre-admission screening system providing options today (PASSPORT) home and community based services (HCBS) Medicaid waiver program rules

The Ohio Administrative Code (OAC) rules dealing with the pre-admission screening system providing options today (PASSPORT) home and community based services (HCBS) Medicaid waiver program's covered services have been amended.

- [5101:3-1-06.1](#), **Home and Community-Based Service Waivers: PASSPORT** - rates have been amended to update the appendix with the addition of new service, enhanced community living.
- [5101:3-31-02](#), **Passport program definitions** - has been amended to clarify and update language. This rule sets forth the definitions used in preadmission screening system providing options and resources today (PASSPORT).
- [5101:3-31-03](#), **Eligibility for enrollment in PASSPORT**- has been amended to clarify and update language. This rule sets forth the eligibility for enrollment in the PASSPORT waiver program.
- [5101:3-31-04](#), **Enrollment process for pre-admission screening system providing options and resources today (PASSPORT)** - has been amended to clarify and update language. This rule sets forth the enrollment process for the PASSPORT waiver program.
- [5101:3-31-05](#), **PASSPORT HCBS waiver covered services** - has been amended to clarify and update language. This rule sets forth the services covered by the PASSPORT waiver program.
- [5101:3-31-06](#), **Provider conditions of participation for the PASSPORT HCBS waiver program**, has been amended to clarify and update language. This rule sets forth the conditions under which providers are able to participate in the PASSPORT waiver service program.
- [5101:3-31-07](#), **PASSPORT HCBS waiver rate setting**, has been amended to clarify and update language. This rule sets forth the methods used to determine provider rates for the PASSPORT home and community based services (HCBS) waiver program.

Instructions:

Remove as Obsolete	Insert Replacement
5101:3-1-06.1 (effective 09/30/2008)	<u>5101:3-1-06.1</u> (effective 03/17/2011)
5101:3-31-02 (effective 07/01/2006)	<u>5101:3-31-02</u> (effective 03/17/2011)
5101:3-31-03 (effective 07/01/2008)	<u>5101:3-31-03</u> (effective 03/17/2011)
5101:3-31-04 (effective 01/01/2006)	<u>5101:3-31-04</u> (effective 03/17/2011)
5101:3-31-05 (effective 07/28/2009)	<u>5101:3-31-05</u> (effective 03/17/2011)
5101:3-31-06 (effective 07/01/2006)	<u>5101:3-31-06</u> (effective 03/17/2011)
5101:3-31-07 (effective 07/01/2008)	<u>5101:3-31-07</u> (effective 03/17/2011)

Web Pages:

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- (3) Select "Community Access Manual Transmittal Letters" (in the "Table of Contents" dropdown).

Questions:

Questions about this CATL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Long Term Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTSS@jfs.ohio.gov

(614) 466-6742

CATL-MH 10-03 (Medicaid Covered Alcohol and Other Drug Treatment and Mental Health Services Rules)

Community Access Transmittal Letter (CATL-MH) 10-03

October 1, 2010

TO: Director, Ohio Department of Mental Health
Director, Ohio Department of Alcohol and Drug Addiction Services
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Medicaid Covered Alcohol and Other Drug Treatment and Mental Health Services Rules

The Ohio Department of Job and Family Services (ODJFS) is amending rules 5101:3-27-05, 5101:3-27-07, 5101:3-30-04 and 5101:3-30-06 of the Administrative Code. Two rules set forth the reimbursement for Medicaid covered services administered by the Ohio Department of Mental Health (ODMH) and Ohio Department of Alcohol and Drug Addiction Services (ODADAS). Two rules set forth the cost reconciliation requirements for Medicaid covered services administered by ODMH and ODADAS.

Rule [5101:3-27-05](#), entitled Reimbursement for community mental health Medicaid services. This rule is being amended in order to facilitate implementation, by the ODMH, of a fee schedule reimbursement methodology. This rule describes the reimbursement methodology for Medicaid covered community mental health services.

Rule [5101:3-27-07](#), entitled Cost reconciliation requirements for Medicaid covered community mental health services. This rule is being amended in order to institute a termination date for the cost reconciliation process implemented by the ODMH. This rule describes the cost reconciliation requirements for Medicaid covered community mental health services.

Rule [5101:3-30-04](#), entitled Reimbursement for community Medicaid alcohol and other drug treatment services. This rule is being amended in order to facilitate implementation, by the ODADAS, of a fee schedule reimbursement methodology. This rule describes the reimbursement methodology for community Medicaid alcohol and other drug treatment services.

Rule [5101:3-30-06](#), entitled Cost reconciliation requirements for Medicaid covered alcohol and other drug treatment services. This rule is being amended in order to institute a termination date for the cost reconciliation process implemented by the ODADAS. This rule describes the cost reconciliation requirements for Medicaid covered alcohol and other drug treatment services.

Instructions:

Remove as Obsolete	Insert Replacement
5101:3-27-05 (effective 09/01/2005)	5101:3-27-05 (effective 10/04/2010)
5101:3-27-07 (effective 09/01/2005)	5101:3-27-07 (effective 10/04/2010)
5101:3-30-04 (effective 09/01/2005)	5101:3-30-04 (effective 10/04/2010)
5101:3-30-06 (effective 09/01/2005)	5101:3-30-06 (effective 10/04/2010)

Web Pages:

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Questions:

Questions about this CATL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Long Term Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTSS@jfs.ohio.gov

(614) 466-6742

CATL-MRDD 10-02 (Home and Community-Based Services (HCBS) - Authorizing Rule)

Community Access Transmittal Letter (CATL-MRDD) 10-02

August 25, 2010

TO: Ohio Association of County Boards
Ohio Developmental Disabilities Council
Ohio Provider Resource Association
Department of Developmental Disabilities (DODD)
Ohio Legal Rights Service
Advocacy and Protective Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Home and community-based services (HCBS) - authorizing rule

The Ohio Department of Job and Family Services (ODJFS) rule [5101:3-41-16](#) of the Administrative Code entitled: Assistance to enable a county board of developmental disabilities to pay non-federal share of Medicaid expenditures for home and community-based services will become effective on September 1, 2010.

This rule authorizes the provisions in rule 5123:1-5-02 of the Administrative Code which sets forth the process county boards of developmental disabilities must follow to request assistance from the department of developmental disabilities (DODD) in the event of failure of a county property tax levy for HCBS services to individuals with developmental disabilities in that county.

OAC Rule [5101:3-41-16](#), Assistance to enable a county board of developmental disabilities to pay non-federal share of Medicaid expenditures for home and community-based services.

Instructions:

Insert /Replacement

5101:3-41-16 (effective 9/01/2010)
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Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

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- (1) Select "Ohio Health Plans - Provider."
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- (3) From the drop-down menu entitled "Table of Contents" at the top of the page, scroll to and select the desired CATL-MRDD 10-02.
- (4) Scroll through the CATL-MRDD to the desired rule number highlighted in blue and select the rule number.

Questions:

Questions about this CATL should be addressed to:

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Bureau of Long Term Care Services and Support

P.O. Box 182709
Columbus, Ohio 43218-2709
BLTSS@jfs.ohio.gov
(614) 466-6742

CATL-MRDD 10-01 (Home and Community Based Waiver Services - Reimbursement for Waiver Services Rule)

Community Access Transmittal Letter (CATL-MRDD) 10-01

June 21, 2010

TO: Ohio Association of County Boards
Ohio Developmental Disabilities Council
Ohio Provider Resource Association
Department of Developmental Disabilities (DODD)
Ohio Legal Rights Service
Advocacy and Protective Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Home and community based waiver services - reimbursement for waiver services rule

The Ohio Department of Job and Family Services (ODJFS) rule [5101:3-41-11](#) of the Administrative Code entitled home and community-based services (HCBS) waiver reimbursement for waiver services administered by the department of development disabilities is being rescinded and proposed new. This rule sets forth the payment standards governing reimbursement for home and community-based services provided by certified waiver providers to individuals enrolled in a HCBS program as a component of the Medicaid program and as administered by the department of developmental disabilities (DODD) in accordance with sections 5111.85 and 5111.873 of the Revised Code

OAC rule [5101:3-41-11](#): Home and community-based waiver services -reimbursement for waiver services administered by the department of development disabilities.

Instructions:

Remove and File as Obsolete	Insert /Replacement
5101:3-41-11 (effective 03/20/2008)	5101:3-41-11 (effective 07/01/2010)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

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At the "electronic manuals" web page, this CATL-MRDD and rules may be viewed as follows:

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- (2) Select "Community Access."
- (3) From the drop-down menu entitled "Table of Contents" at the top of the page, scroll to and select the desired CATL-MRDD 10-01.
- (4) Scroll through the CATL-MRDD to the desired rule number highlighted in blue and select the rule number.

Questions:

Questions about this CATL should be addressed to:

Ohio Department of Job and Family Services
Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTSS@jfs.ohio.gov

(614) 466-6742

CATL-MH 09-08 (Community Mental Health Medicaid Rule)

Community Access Transmittal Letter (CATL-MH) 09-08

February 16, 2010

TO: All Interested Parties
FROM: Douglas E. Lumpkin, Director
SUBJECT: Community Mental Health Medicaid Rule

The Ohio Administrative Code (OAC) rule 5101:3-27-05 dealing with the Community Mental Health Medicaid Services is being updated. This rule becomes effective on February 15, 2010.

Rule [5101:3-27-05](#), entitled reimbursement for community mental health medicaid services. This rule describes the payment methodology for Medicaid covered community mental health services.

Instructions:

Remove and File as Obsolete	Insert Replacement
5101:3-27-05 (effective 9/01/2005)	5101:3-27-05 (effective 2/15/2010)

Web Page: The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is as follows:
<http://emanuals.odjfs.state.oh.us/emanuals/>

This CATL-MH and rules may be viewed at the "electronic manuals" web page. To access them, do the following:

- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Community Access."
- (3) From the drop-down menu entitled "Table of Contents" at the top of the page, scroll to and select CATL-MH 09-08.
- (4) Scroll through the CAT-MH 09-08 to the desired rule number highlighted in blue and select the rule number.

If you have any question regarding this CATL-MH 09-08, please contact:

Questions:

Questions about this CATL should be addressed to:

Ohio Department of Job and Family Services
Bureau of Community Services Policy

P.O. Box 182709

Columbus, Ohio 43218-2709

<http://ifs.ohio.gov/OHP/consumer.stm>

(614) 466-6742

CATL-AGE 09-07 (Assisted Living Waiver Definition Rule)

Community Access Transmittal Letter (CATL-AGE) 09-07

December 29, 2009

TO: All Interested Parties
FROM: Douglas E. Lumpkin, Director
SUBJECT: ASSISTED LIVING WAIVER DEFINITION RULE

The Ohio Administrative Code (OAC) rule 5101:3-33-02 dealing with the Ohio Assisted Living home and community based services (HCBS) Medicaid waiver program is being updated. This rule is being proposed for amendment to clarify the assisted living waiver definition.

Rule [5101:3-33-02](#) entitled **Definitions for the Assisted Living HCBS Waiver Program**, sets forth terms used in the assisted living HCBS waiver program.

Instructions:

Remove and File as Obsolete	Insert Replacement
5101:3-33-02 (effective 7/01/2006)	5101:3-33-02 (effective 12/31/2009)

Web Page: The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This CATL-AGE and rules may be viewed at the "electronic manuals" web page. To access them, do the following:

- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Community Access."
- (3) From the drop-down menu entitled "Table of Contents" at the top of the page, scroll to and select CATL-AGE 09-07.
- (4) Scroll through the CATL-AGE to the desired rule number highlighted in blue and select the rule number.

If you have any question regarding this CATL-AGE 09-07, please contact:

Questions:

Questions about this CATL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Community Services Policy

P.O. Box 182709

Columbus, Ohio 43218-2709

<http://jfs.ohio.gov/OHP/consumer.stm>

(614) 466-6742

CATL-AGE 09-06 (OAC PASRR)

Community Access Transmittal Letter (CATL-AGE) 09-06

December 2, 2009

TO: Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD)
County Boards of Mental Retardation and Developmental Disabilities (CBMRDD)
Ohio Department of Mental Health (ODMH)
Ohio Department of Health (ODH)
Alcohol, Drug Addiction and Mental Health (ADAMH)
Community Mental Health Boards (CMH)
Ohio Department of Aging (ODA)
Office of Budget and Management (OBM)
Executive Medicaid Management Administration (EMMA)
The Ohio Academy of Nursing Homes (OANH)
Centers for Independent Living (CIL)
PASSPORT Administering Agencies (PAAs)
Ohio Legal Rights Services (OLRS)
Ohio Olmstead Task Force (OOTF)
Long-Term Care Ombudsman Program (LTCOP)
Ohio Home Care Association
Ohio Health Care Association (OHCA)
Ohio Hospital Association (OHA)
Ohio Association of County Behavioral Health Authorities (OACBHA)
Ohio Council of Behavioral Health and Family Services Providers
The Advocate of Not-for-Profit Services for Older Ohioans (AOPHA)
Pro Seniors Incorporated

FROM: Douglas E. Lumpkin, Director

SUBJECT: OHIO ADMINISTRATIVE CODE (OAC) Preadmission Screening Resident Review Rules (PASRR)

The Ohio Department of Job and Family Services (ODJFS) has adopted the following rule as new [5101:3-3-14](#), and amended rules [5101:3-3-15.1](#) and [5101:3-3-15.2](#) of the Ohio Administrative Code (OAC). These rules are designed to improve clarity to Preadmission Screening and Resident Review (PASRR) in order to improve the seamlessness of administrative processes and to ensure Ohioans receive the most appropriate placement setting for their needs. The amendment of these rules will become effective on December 1, 2009.

The PASRR rule revision is comprised of changes to the OAC rules and associated processes, policy and criteria review, form revisions JFS (07000) and JFS (03622), and Ohio Revised Code (ORC) language changes as well as staff/provider training and associated processes in order to meet the stakeholder approved Money Follows the Person (MFP) subcommittee's mission, vision and values via the "front door stakeholder group".

These rules are one component of the larger project of long-term services and supports system balancing. The revised rules are considered Phase 1 of this process which encompasses the updating and rewriting of

rules to provide short term system balance related specifically to PASRR. Additional changes are expected in later phases of the 'front door stakeholder group' project.

The following is a description of the rules:

Rule [5101:3-3-14](#) entitled Preadmission Screening (PAS) and resident review (RR) definitions sets forth terms used in Chapter 5101:3-3 of the Ohio Administrative Code.

Rule [5101:3-3-15.1](#) entitled Preadmission Screening (PAS) requirements for individuals seeking admission to nursing facilities (NFs) sets forth the preadmission screening requirements which must be met prior to any new admission. This rule prohibits nursing facilities (NFs) and the PASSPORT waiver program from accepting any new admission unless the individual has met the PAS exemption requirements specified in this rule.

Rule [5101:3-3-15.2](#) entitled Resident Review (RR) requirements for individuals residing in nursing facilities (NFs) sets forth the RR requirements which states that NFs are prohibited from retaining any individual who have serious mental illness (SMI) or mental retardation (MR) an/or other developmental disabilities (DD) unless the RR rules specified in this rule have been met.

Note: The above Ohio Department of Job and Family Services rules has been amended at the same time as related sister agency rules. This includes rule 5123:2-14-01 entitled Preadmission Screening and resident review for PASSPORT waiver applicants, and nursing facility applicants and residents with mental retardation or developmental disability (MRDD). This also includes rule 5122-21-03 Preadmission Screening and Resident Review (PASRR) for nursing facility and PASSPORT waiver applicants and residents with serious mental illness.

Instructions:

Remove and File as Obsolete	Insert /Replacement
	<p style="text-align: center;">5101:3-3-14 (effective 12/01/2009)</p>
5101:3-3-15.1 (effective 01/01/1998)	<p style="text-align: center;">5101:3-3-15.1 (effective 12/01/2009)</p>
5101:3-3-15.2 (effective 01/01/1998)	<p style="text-align: center;">5101:3-3-15.2 (effective 12/01/2009)</p>
JFS 03622 (effective 02/1993)	<p style="text-align: center;">JFS 03622 (effective 11/2009)</p>
	<p style="text-align: center;">JFS 07000 (effective 11/2009)</p>

Web Page: To locate copies of this CATL or these rules, the Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is as follows: <http://emanuals.odjfs.state.oh.us/emanuals/>

At the "electronic manuals" web page, this CATL-AGE and rules may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Community Access."
- (3) From the drop-down menu entitled "Table of Contents" at the top of the page, scroll to and select the desired CATL-AGE 09-06.
- (4) Scroll through the CATL-AGE to the desired rule number highlighted in blue and select the rule number.

If you have any questions regarding this CATL-AGE, please contact:

Ohio Department of Job and Family Services

Bureau of Community Services Policy

P.O. Box 182709

Columbus, OH 43218-2709

<http://ifs.ohio.gov/OHP/consumer.stm>

614-466-6742

CATL-EDU 09-05 (OAC Medicaid School Program Rules)

Community Access Transmittal Letter (CATL-EDU) 09-05

October 2, 2009

TO: Ohio Department of Education
Ohio Association of County Boards of MRDD
Ohio Occupational Therapy Association
Ohio Provider Resource Association
Ohio Department of MRDD

FROM: Douglas E. Lumpkin, Director

SUBJECT: OHIO ADMINISTRATIVE CODE (OAC) MEDICAID SCHOOL PROGRAM RULES

The Ohio Department of Job and Family Services (ODJFS) amending rules [5101:3-35-01](#), [5101:3-35-02](#), [5101:3-35-04](#) (with appendix), [5101:3-35-05](#), and [5101:3-35-06](#) of the Ohio Administrative Code (OAC). The Individuals with Disabilities Education Act (IDEA) mandates public schools to provide specific healthcare benefits to children with special needs. The amended rules provide an opportunity for schools to receive Medicaid reimbursement for the healthcare services they provide to Medicaid eligible children ages 3 to 21 who receive the services through an Individualized Education Program (IEP) developed in accordance with IDEA. The Ohio Medicaid School Program has received federal approval to implement this reimbursement program. The amendment of these rules will become effective on October 15, 2009.

The following is a description of the rules:

Rule [5101:3-35-01](#) entitled Definitions, defines terms used in Chapter 5101:3-35 of the Ohio Administrative Code.

Rule [5101:3-35-02](#) entitled Qualifications To Be A Medicaid School Program (MSP) Provider, sets forth the qualifications to become and the requirements for a MSP provider.

Rule [5101:3-35-04](#) entitled Reimbursement for Services Provided By Medicaid School Program (MSP) Providers, sets forth the requirements for claiming to receive Medicaid reimbursement for the provision of services by MSP providers.

Rule [5101:3-35-05](#) entitled Services Authorized for Medicaid Coverage That Can Be Provided By Medicaid School Program (MSP) Providers, sets forth the services authorized for Medicaid coverage that a MSP provider can provide and the conditions for providing the services.

Rule [5101:3-35-06](#) entitled Other Services, Medical Supplies And Equipment Authorized for Medicaid Coverage That Can Be Provided By Medicaid School Program (MSP) Providers, sets forth the services beyond those indicated in rule 5101:3-35-05 of the Administrative Code.

Fee-for-service rates will be used to reimburse for services on an interim basis, with final claim/ reimbursement based upon a cost report. The aggregate increase in expenditures for Ohio's Medicaid program as a result of implementing the Medicaid School Program is estimated to be approximately \$65.4 million in federal funds in state fiscal year 2010. The Medicaid School Program provider will be responsible for the non-federal share of costs. Therefore, there is no increase in expenditure of state funds anticipated as a result of implementing the Medicaid School Program.

Web Page: The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is as follows:
<http://emanuals.odjfs.state.oh.us/emanuals/>

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- (3) From the drop-down menu entitled "Table of Contents" at the top of the page, scroll to and select CATL-EDU **09-05**.
- (4) Scroll through the CATL-EDU to the desired rule number highlighted in blue and select the rule number.

If you have any question regarding this CATL-EDU, please contact:

Ohio Department of Job and Family Services
Bureau of Community Services Policy
P.O. Box 182709
Columbus, OH 43218-2709
BCA.INFO.TECH@odjfs.state.oh.us

CATL-AGE 09-04 (Amendment of Assisted Living Waiver Program Rules)

Community Access Transmittal Letter (CATL-AGE) 09-04

September 18, 2009

TO: All Interested Parties
FROM: Douglas E. Lumpkin, Director
SUBJECT: AMENDMENT OF ASSISTED LIVING WAIVER PROGRAM RULES

The Ohio Administrative Code (OAC) Chapter 5101:3-33 dealing with the Ohio Assisted Living home and community based services Medicaid waiver program (HCBS) is being updated to clarify Assisted Living waiver eligibility, enrollment, and provider reimbursement.

Rule 5101:3-33-03 entitled **Eligibility for the Assisted Living HCBS Waiver Program**, is being proposed for amendment and outlines the eligibility criteria for the Assisted Living waiver.

Rule 5101:3-33-04 entitled **Enrollment Process for Assisted Living HCBS Waiver Program**, is being proposed for amendment and describes the enrollment process for consumers entering the Assisted Living waiver.

Rule 5101:3-33-07 entitled **Assisted Living HCBS Waiver Rate Setting**, is being proposed for amendment and describes the methods used to determine waiver provider rates in the Assisted Living waiver.

Web Page: The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is as follows:
<http://emanuals.odjfs.state.oh.us/emanuals/>

This CATL-AGE and rules may be viewed at the "electronic manuals" web page. To access them, do the following:

- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Community Access."
- (3) From the drop-down menu entitled "Table of Contents" at the top of the page, scroll to and Select CATL-AGE 09-04.
- (4) Scroll through the CATL-AGE to the desired rule number highlighted in blue and select the rule number.

If you have any question regarding this CATL-AGE, please contact:

Questions:

Questions about this CATL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Community Services Policy

P.O. Box 182709

Columbus, Ohio 43218-2709

<http://jfs.ohio.gov/OHP/consumer.stm>

(614) 466-6742

CATL-AGE 09-03 (Changes to Odjfs Passport Waiver Covered Services)

Community Access Transmittal Letter (CATL-AGE) 09-03

June 12, 2009

TO: All Interested Parties
FROM: Douglas E. Lumpkin, Director
SUBJECT: CHANGES TO ODJFS PASSPORT WAIVER COVERED SERVICES.

The Ohio Administrative Code (OAC) rule 5101:3-31-05 dealing with the pre-admission screening system providing options today (PASSPORT) home and community based services (HCBS) Medicaid waiver program's covered services is being amended. The rule as amended will clarify that consumers participating in the Home Choice program who are enrolling in the PASSPORT HCBS waiver may obtain community transition service available through Home Choice in lieu of, but not in addition to, the community transition service available through the PASSPORT HCBS waiver.

5101:3-31-05: PASSPORT HCBS waiver covered services. This rule sets forth services covered by the pre-admission screening system providing options and resources today (PASSPORT) home and community based services (HCBS) wavier program.

Web Page: The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This CATL-AGE and rule may be viewed at the "electronic manuals" web page. To access them, do the following:

- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Community Access."
- (3) From the drop-down menu entitled "Table of Contents" at the top of the page, scroll to and select CATL-AGE 09-03.
- (4) Scroll through the CATL-AGE to the desired rule number highlighted in blue and select the rule number.

Questions:

Questions about this CATL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Community Services Policy

P.O. Box 182709

Columbus, Ohio 43218-2709

<http://jfs.ohio.gov/OHP/consumer.stm>

(614) 466-6742

CATL-AGE 09-02 (OAC PACE Rules)

Community Access Transmittal Letter (CATL-AGE) 09-02

March 24, 2009

TO: All Interested Parties
FROM: Douglas E. Lumpkin, Director
SUBJECT: OHIO ADMINISTRATIVE CODE (OAC) PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE) RULES

Ohio Administrative Code (OAC) Chapter 5101:3-36 is being proposed as new and will codify rules for the administration of the program of all inclusive care for the elderly (PACE).

- **5101:3-36-01: Program of all inclusive care for the elderly (PACE) definitions.** The purpose of this rule is to define the terms used in rules governing in the program of all-inclusive care for the elderly (PACE).
- **5101:3-36-02: Program of all inclusive care for the elderly (PACE) program administration.** This rule sets forth that the day to day administration of the PACE program shall be carried out by Ohio department of aging (ODA).
- **5101:3-36-03: Program of all inclusive care for the elderly (PACE) eligibility.** This rule sets forth methods used to determine the eligibility for the PACE program.
- **5101:3-36-04: Program of all inclusive care for the elderly (PACE) enrollment and disenrollment.** This rule sets forth the enrollment and disenrollment processes for the PACE program.
- **5101:3-36-05: Program of all inclusive care for the elderly (PACE) interdisciplinary team, participant plan of care and services.** The rule sets forth that each PACE organization shall establish and maintain an interdisciplinary team to assess the care and service needs of each PACE participant and develop a plan of care.
- **5101:3-36-06: Program of all inclusive care for the elderly (PACE) organization reimbursement.** This rule sets forth the reimbursement standards for the PACE program.

Web Page: The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This CATL-AGE and rules may be viewed at the "electronic manuals" web page. To access them, do the following:

- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Community Access."
- (3) From the drop-down menu entitled "Table of Contents" at the top of the page, scroll to and select CATL-AGE **09-02**.
- (4) Scroll through the CATL-AGE to the desired rule number highlighted in blue and select the rule number.

If you have any question regarding this CATL-AGE, please contact:

Questions:

Questions about this CATL should be addressed to:

Ohio Department of Job and Family Services
Bureau of Community Services Policy
P.O. Box 182709

Columbus, Ohio 43218-2709

<http://jfs.ohio.gov/OHP/consumer.stm>

(614) 466-6742

CATL-EDU 09-01 (OAC Medicaid School Program Rules)

Community Access Transmittal Letter (CATL-EDU) 09-01

February 12, 2009

TO: Ohio Association of County Boards of MRDD
Ohio Occupational Therapy Association
Ohio Provider Resource Association
Ohio Department of MRDD
Buckeye Association of School Administrators
Ohio Association of School Business Officials
Ohio Alliance for Public Charter Schools
Ohio Speech-Language-Hearing Association
Ohio School Psychologists Association

FROM: Douglas E. Lumpkin, Director

SUBJECT: OHIO ADMINISTRATIVE CODE (OAC) MEDICAID SCHOOL PROGRAM RULES

Ohio Administrative Code rules 5101:3-35-01, 5101:3-35-02, 5101:3-35-04, 5101:3-35-05, and 5101:3-35-06 were effective on an emergency basis 11/26/08. If no revisions are made to the proposed rules prior to the finalization by JCARR, the regular filing will become effective on a permanent basis on 3/2/09.

The Individuals with Disabilities Education Act (IDEA) mandates public schools to provide specific healthcare benefits to children with special needs. The rules provide an opportunity for schools to receive Medicaid reimbursement for the healthcare services they provide to Medicaid eligible children ages 3 to 21 who receive the services through an Individualized Education Program (IEP) developed in accordance with IDEA. The Ohio Medicaid program has received federal approval to implement this reimbursement program.

The following is a description of the rules:

Rule 5101:3-35-01 entitled Definitions, defines terms used in Chapter 5101:3-35 of the Ohio Administrative Code.

Rule 5101:3-35-02 entitled Qualifications To Be A Medicaid School Program (MSP) Provider, sets forth the qualifications to become and the requirements for a MSP provider.

Rule 5101:3-35-04 entitled Reimbursement for Services Provided By Medicaid School Program (MSP) Providers, sets forth the requirements for claiming to receive Medicaid reimbursement for the provision of services by MSP providers.

Rule 5101:3-35-05 entitled Services Authorized for Medicaid Coverage That Can Be Provided By Medicaid School Program (MSP) Providers, sets forth the services authorized for Medicaid coverage that a MSP provider can provide and the conditions for providing the services.

Rule 5101:3-35-06 entitled Other Services, Medical Supplies And Equipment Authorized for Medicaid Coverage That Can Be Provided By Medicaid School Program (MSP) Providers, sets forth the services, beyond those indicated in rule 5101:3-35-05 of the Administrative Code, authorized for Medicaid coverage that a MSP provider can provide the conditions for providing the services.

Fee-for-service rates will be used to reimburse for services on an interim basis, with final claim/reimbursement based upon a cost report. The aggregate increase in expenditures for Ohio's Medicaid program as a result of implementing the Medicaid School Program is estimated to be approximately \$40 million in federal funds in state fiscal year 2009. The Medicaid School Program provider will be responsible for the non-federal share of costs. Therefore, there is no increase in expenditure of state funds anticipated as a result of implementing the Medicaid School Program.

Web Page: The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This CATL-EDU and rules may be viewed at the "electronic manuals" web page. To access them, do the following:

- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Community Access."
- (3) From the drop-down menu entitled "Table of Contents" at the top of the page, scroll to and select CATL-EDU **09-01**.
- (4) Scroll through the CATL-EDU to the desired rule number highlighted in blue and select the rule number.

If you have any question regarding this CATL-EDU, please contact:

Questions:

Questions about this CATL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Community Services Policy

P.O. Box 182709

Columbus, Ohio 43218-2709

<http://jfs.ohio.gov/OHP/consumer.stm>

(614) 466-6742

CATL-ODMH 08-01 (Amendments to OAC Rule 5101:3-27-02 entitled 'Coverage and Limitations of Medicaid Community Mental Health Services')

Community Access Transmittal Letter MH (CATL-MH) 08-01

June 20, 2008

TO: All ODMH-Certified Community Mental Health Medicaid Providers
CC: Directors, County Departments of Job and Family Services
Sandra Stephenson, Director, Ohio Department of Mental Health
Executive Directors, ADAMH/CMH Boards
FROM: Helen E. Jones-Kelley, Director
SUBJECT: Amendments to Ohio Administrative Code Rule 5101:3-27-02 entitled 'Coverage and Limitations of Medicaid Community Mental Health Services'

Effective July 1, 2008, ODJFS has amended Ohio Administrative Code (OAC) rule 5101:3-27-02 entitled 'Coverage and Limitations of Medicaid Community Mental Health Services'. The purpose of the amendments to this rule is two-fold. The first is to allow for Medicaid reimbursement for mental health assessments and counseling and psychotherapy services that are rendered via interactive videoconferencing. The second is to provide additional clarity related to all community mental health services which are reimbursed under the federal Medicaid rehabilitation option. The rule is being clarified based on federal requirements and expectations; as well as federal findings that are occurring in other states under this option.

These amendments will assure the proper expenditure of Medicaid dollars by clarifying that community mental health services eligible for Medicaid reimbursement must be rehabilitation services that provide for the maximum reduction of mental illness and are intended to restore an individual to the best possible functional level. The rule is also being amended to clarify that the Medicaid program does not cover habilitation services as part of Medicaid community mental health services and to ensure services meet the principles set forth in rule 5101:3-1-02 of the Administrative Code.

Instructions:

Insert amended OAC rule 5101:3-27-02

Web Page:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.ODJFS.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (left column).
- (2) Select "Community Access" (left column).
- (3) Select "Community Access Transmittal Letters" and "CATL- MH XX-xx" (in the "Table of Contents" dropdown).

Questions:

Questions pertaining to this CATL should be addressed to:

Ohio Department of Job and Family Services
Bureau of Community Access
P.O. Box 182709
Columbus, Ohio 43218-2709
BCA_INFO_TECH@ODJFS.state.oh.us

CATL- MRDD 06- 02 (Rescission of Level Provider Payment)

Community Access Transmittal Letter MRDD (CATL- MRDD) 06 02

January 3, 2007

TO: Ohio Association of County Boards of MRDD
Ohio Developmental Disabilities Council
Ohio Provider Resource Association
Ohio Department of MRDD
Ohio Legal Rights Service
Advocacy and Protective Services

FROM: Barbara E. Riley, Director

SUBJECT: Rescission of Level Provider Payment

The Ohio Department of Job and Family Services (ODJFS) is rescinding rule 5101:3- 42-11 of the Ohio Administrative Code (OAC), which sets forth the standards governing the conditions which must exist in order to make payments to certified level one waiver providers and established the allowable payment standards for the provision of level one waiver services. The rescission of this rule will become effective January 1, 2007.

OAC 5101:3- 42-11, "Medicaid home and community- based services- level one waiver provider payment standards" will be rescinded on January 1, 2007. The rule set forth the standards governing the conditions which must exist in order to make payments to certified level one waiver providers and established the allowable payment standards for the provision of level one waiver services.

Web Page: To locate copies of this CATL- MRDD or these rules, the Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is as follows: <http://emanuals.odjfs.state.oh.us/emanuals/>

At the "electronic manuals" web page, this CATL- MRDD and rules may be viewed as follows:

- (1) Select "Ohio Health Plans Provider."
- (2) Select "Community Access."
- (3) From the drop- down menu entitled "Table of Contents" at the top of the page, scroll to and select the desired CATL- MRDD number.
- (4) Scroll through the CATL- MRDD to the desired rule number highlighted in blue and select the rule number.

If you have any question regarding this CATL- MRDD, please contact:

Ohio Department of Job and Family Services
Bureau of Community Access
30 E Broad St, 27th floor
Columbus, OH 43215
BCA.INFO.TECH@odjfs.state.oh.us

CATL- MRDD 06- 01 (Changes to Level One Waiver Program Rule, OAC 5101:3-42-01 and Level One Payment Standards Rule, OAC 5101:3-42-11)

Community Access Transmittal Letter - MRDD (CATL- MRDD) 06- 01

September 13, 2006

TO: Ohio Association of County Boards of MRDD
Ohio Developmental Disabilities Council
Ohio Provider Resource Association
Ohio Department of MRDD
Ohio Legal Rights Service
Advocacy and Protective Services

FROM: Barbara E. Riley, Director

SUBJECT: CHANGES TO LEVEL ONE WAIVER PROGRAM RULE, OAC 5101:3-42-01 AND LEVEL ONE PAYMENT STANDARDS RULE, OAC 5101:3-42-11.

The Ohio Department of Job and Family Services (ODJFS) recently modified rules 5101:3-42-01 and 5101:3-42-11 of the Ohio Administrative Code (OAC), which authorize and establish payment standards for the Level One waiver program. These rule changes became effective on July 1, 2006.

OAC 5101:3-42-01 "Medicaid home and community- based services program - level one waiver" was amended to assure consistency with the recently renewed waiver. The rule changes clarify service limitations allowable on the waiver program and adds monitoring requirements by county boards of mental retardation and developmental disabilities.

OAC 5101:3-42-11 "Medicaid home and community- based services - level one waiver payment standards" was amended to correct one rule cite and to correct two billing code errors listed in the appendix of this rule.

Web Page: To locate copies of this CATL- MRDD or these rules, the Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is as follows: <http://emanuals.odjfs.state.oh.us/emanuals/>

At the "electronic manuals" web page, this CATL- MRDD and rules may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Community Access."
- (3) From the drop- down menu entitled "Table of Contents" at the top of the page, scroll to and select the desired CATL- MRDD number.
- (4) Scroll through the CATL- MRDD to the desired rule number highlighted in blue and select the rule number.

If you have any question regarding this CATL- MRDD, please contact:

Ohio Department of Job and Family Services
Bureau of Community Access
30 E Broad St, 27th floor
Columbus, OH 43215
BCA.INFO.TECH@odjfs.state.oh.us

Chapter 1 Ohio Department of Aging

Rate Setting

5160-1-06 Home and Community-Based Service Waivers: General Description

***Formerly* 5101:3-1-06 Home and Community-Based Service Waivers: General Description**

[Click here to view OAC 5160-1-06, Home and community-based service waivers: general description](#)

This rule is maintained in the Ohio Home Care Manual, located in the Ohio Health Plans - Provider collection.

5160-1-06.4 Home and Community-Based Services (HCBS) Waivers: Choices

~~*Formerly*~~ 5101:3-1-06.4 Home and Community-Based Services (HCBS) Waivers: Choices

LTCSTL 13-07

Effective Date: September 27, 2013

Most Current Prior Effective Date: July 1, 2013

5101:3-1-06.4 Appendix A - Choices Waiver Rates

- (A) The Ohio department of aging (ODA) is responsible for the daily administration of the choices (HCBS) waiver. ODA will administer the waiver pursuant to an interagency agreement with the Ohio department of ~~job and family services (ODJFS)~~ medicaid (ODM), in accordance with section ~~5111.91~~ 5162.35 of the Revised Code.
- (B) The choices waiver provides HCBS to persons aged sixty and over ~~who~~ that reside in the service area defined in the approved 1915(c) waiver for the choices program and who require an intermediate ~~level of care as set forth in rule 5101:3-3-06 of the Administrative Code~~ or skilled care level of care as set forth in rule ~~5101:3-3-05~~ 5101:3-3-08 of the Administrative Code and are enrolled in the waiver.
- (1) The choices HCBS waiver services and program eligibility criteria are set forth in Chapter 5101:3-32 of the Administrative Code.
 - (2) The maximum allowable reimbursement rates for choices HCBS waiver program services are listed in appendix A to this rule and are effective on ~~July 1, 2014~~ September 27, 2013.
 - (3) Choices HCBS reimbursement must be provided in accordance with ~~paragraphs (A) to (C)~~ of rule 5101:3-1-60 of the Administrative Code.

Effective: 09/27/2013

R.C. 119.032 review dates: 09/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 09/16/2013

Promulgated Under: 119.03

Statutory Authority: 5111.85

Rule Amplifies: 5111.85, 173.403

Prior Effective Dates: 1/1/04, 7/1/05, 7/1/06, 7/1/07(Emer.), 10/1/07, 7/1/08(Emer.), 7/1/11(Emer.), 7/1/13 (Emer.)

5160-1-06.1 Home Community-Based Service Waivers: PASSPORT

***Formerly* 5101:3-1-06.1 Home and Community-Based Service Waivers: PASSPORT**

LTCSTL 14-09

Effective Date: July 1, 2014

Most Current Prior Effective Date: March 1, 2014

51601-06.1, Appendix A - PASSPORT Waiver Rates

- (A) The Ohio department of aging (ODA) is responsible for the daily administration of the preadmission screening system providing options and resources today (PASSPORT) medicaid waiver program. ODA will administer the waiver pursuant to an interagency agreement with the Ohio department of medicaid in accordance with section [5162.35](#) of the Revised Code.
- (B) The PASSPORT waiver provides home and community based services to persons aged sixty and over that require an intermediate or skilled care level of care as set forth in rule [5160-3-08](#) of the Administrative Code and are enrolled in the waiver.
- (C) The PASSPORT HCBS waiver services and program eligibility criteria are set forth in Chapter 5160-31 of the Administrative Code.
- (D) The maximum allowable reimbursement rates for PASSPORT HCBS waiver program services are listed in [appendix A](#) to this rule.
- (E) PASSPORT HCBS reimbursement must be provided in accordance with paragraphs (A) to (C) of rule [5160-1-60](#) of the Administrative Code.
- (F) A consumer may not receive community transition services with a cumulative or singular value in excess of one thousand four hundred seventy-seven dollars and fifty cents. The consumer may only access the goods and services available through the community transition service as set forth in rule [173-39-02.17](#) of the Administrative Code.

Effective: 07/01/2014

R.C. 119.032 review dates: 03/01/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 06/20/2014

Promulgated Under: 119.03

Statutory Authority: 5166.02

Rule Amplifies: 5166.02, 173.52

Prior Effective Dates: 1/1/04, 7/1/06, 7/2/07 (Emer.), 10/1/07, 7/1/08 (Emer.), 9/30/08, 7/1/11 (Emer.), 9/29/11, 7/1/13 (Emer.), 9/27/13, 3/1/14

5160-1-06.5 Home and Community Based Services (HCBS) Waivers: Assisted Living

~~*Formerly*~~ 5101:3-1-06.5 Home and Community Based Services (HCBS) Waivers: Assisted Living

LTCSTL 13-07

Effective Date: September 27, 2013

Most Current Prior Effective Date: July 1, 2013

5101:3-1-06.5 Appendix A - Assisted Living Waiver Rates

- (A) The Ohio department of aging (ODA) is responsible for the daily administration of the assisted living HCBS waiver. ODA will administer this waiver pursuant to an interagency agreement with the Ohio department of ~~job and family services (ODJFS)~~ medicaid (ODM), in accordance with section ~~5111.91~~ 5162.35 of the Revised Code.
- (B) The assisted living HCBS waiver is an alternative to nursing facility placement for persons age twenty-one and over who require an intermediate level of care ~~as set forth in rule 5101:3-3-06 of the Administrative Code~~ or a skilled level of care as set forth in rule ~~5101:3-3-05~~ 5101:3-3-08 of the Administrative Code and are enrolled in the waiver.
- (1) The assisted living HCBS waiver's services and program eligibility criteria are set forth in Chapter 5101:3-33 of the Administrative Code.
 - (2) The maximum allowable reimbursement rates for assisted living HCBS waiver program services are listed in appendix A to this rule and are effective on ~~July 1, 2011~~ September 27, 2013.
 - (3) Assisted living HCBS reimbursement shall be provided in accordance with ~~paragraphs (A) to (C) of~~ rule 5101:3-1-60 of the Administrative Code.
 - (4) The billing maximum for the community transition service listed in appendix A to this rule represents the cumulative maximum for the items purchased or deposits made through the community transition service as set forth in rule 173-39-02.17 of the Administrative Code.

Effective: 09/27/2013

R.C. 119.032 review dates: 09/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 09/16/2013

Promulgated Under: 119.03

Statutory Authority: 5111.85, 5111.89

Rule Amplifies: 5111.85, 5111.89

Prior Effective Dates: 7/1/06, 3/22/08, 7/1/11(Emer.), 7/1/13(Emer.)

Level of Care (LOC)/Pre-Admission Screening

5160-3-05 Level of Care Definitions

***Formerly* 5101:3-3-05 Level of Care Definitions**

[Click here to view OAC 5160-3-05, Level of Care Definitions](#)

This rule is maintained in the Long Term Care Manual, located in the Ohio Health Plans - Provider collection.

5160-3-06 **Criteria for the Protective Level of Care**

***Formerly* 5101:3-3-06** **Criteria for the Protective Level of Care**

[Click here to view OAC 5160-3-06, Criteria for the Protective Level of Care](#)

This rule is maintained in the Long Term Care Manual, located in the Ohio Health Plans - Provider collection.

5160-3-06.1 Institutions for Mental Diseases (IMDs)

***Formerly* 5101:3-3-06.1 Institutions for Mental Diseases (IMDs)**

[Click here to view OAC 5160-3-06.1, Institutions for Mental Diseases \(ILOC\)](#)

This rule is maintained in the Long Term Care Manual, located in the Ohio Health Plans - Provider collection.

Formerly 5101:3-3-07 Intermediate Care for Individuals with Mental Retardation and Developmental Disabilities

Effective Date: July 1, 2008

Most Current Prior Effective Date: [January 20, 2002](#)

- (A) This rule sets forth the criteria used to determine whether an individual who is seeking medicaid payment for long-term care services, as defined in rule 5101:3-3-15 of the Administrative Code, needs services at the level of intermediate care facility services for the mentally retarded, as defined in rule ~~5101:3-3-153~~ 5101:3-3-15.3 of the Administrative Code. The criteria set forth in this rule must be used when determining level of care for individuals seeking medicaid coverage of either home and community-based services (HCBS) waivers or facility-based institutional long term care services.
- (B) Definitions.
- (1) "Active Treatment"
- (a) "Active treatment" means the continuous, aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in ~~42 C.F.R. 483~~, 42 CFR 483, dated October 1, 2007 that is directed toward:
- (i) The acquisition of the behaviors necessary for the individual to function with as much self determination and independence as possible; and
- (ii) The prevention or deceleration of regression or loss of current optimal functional status.
- (b) Active treatment does not include services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous active treatment program.
- (2) "Developmental delay" means that an individual has not achieved developmental milestones as expected for the individual's chronological age as measured, documented, and determined by qualified professionals using generally accepted diagnostic instruments and/or procedures.
- (3) "Habilitation", as defined in section 5126.01 of the Revised Code, means the process by which the staff of a facility or agency assists an individual with mental retardation or other developmental disabilities in acquiring and maintaining those life skills that enable the individual to cope more effectively with the demands of the individual's own person and environment, and in raising the level of the individual's personal, physical, mental, social, and vocational efficiency.
- (4) "HCBS", as defined in section 5126.01 of the Revised Code means medicaid-funded home and community based services as an alternative to placement in an intermediate care facility for mental retardation provided under a medicaid component that the department of mental retardation and developmental disabilities administers pursuant to section 5111.871 of the Revised Code.
- (5) "Major life area" refers to categories that are related to the age appropriate performance of life activities and includes the following:
- (a) "Capacity for independent living" means:
- (i) For individuals age sixteen years and older, the ability to safely carry out all of the following tasks:
- (a) Purchase groceries, clothing and household items; and
- (b) Plan and prepare nutritious meals; and
- (c) Respond to emergencies; and

- (d) Clean house, make beds, sweep and mop floors, dust, wash dishes, pick up clutter, take out trash; and
 - (e) Wash and dry clothing; and
 - (f) Make and answer telephone calls; and
 - (g) Use public or private transportation to access the community; or
 - (ii) For individuals age nine through fifteen years, the ability to safely carry out all of the following tasks:
 - (a) Prepare a snack; and
 - (b) Respond to emergencies; and
 - (c) Participate in household chores; and
 - (d) Use neighborhood resources such as playground, corner store, neighbors' houses; or, for individuals age twelve years and older, use public transportation; and
 - (e) For ages nine through eleven years, stay alone for at least two hours with a responsible adult in another part of the house; and
 - (f) For ages twelve through fifteen years, stay alone for at least two hours; or
 - (iii) For individuals age six through eight years, the ability to safely carry out all of the following tasks:
 - (a) Prepare a simple snack; and
 - (b) Respond to emergencies; and
 - (c) Participate in household chores; and
 - (d) Use neighborhood resources, with supervision appropriate to age and as appropriate to community standards, such as playground, corner store, or neighbors' houses; and
 - (e) Stay alone for at least two hours with a responsible adult in another part of the house within visual or hearing distance.
- (b) "Communication" means the age appropriate ability to express needs and wants in a manner that is understandable to people who do not know the individual, using spoken, written, signed, electronic or mechanical means and to understand such communication as appropriate to age.
- (c) "Economic self-sufficiency" means the ability of individuals age sixteen years and older to do at least two of the following:
 - (i) Obtain and engage in community employment;
 - (ii) Pay bills;
 - (iii) Manage money;
 - (iv) Access insurance and/or public benefits.
- (d) "Learning" means the cognitive ability to acquire, retain and apply new information, skills and attitudes as appropriate to age.
- (e) "Mobility" means the ability to do all of the following with or without the use of one or more assistive devices:
 - (i) Transfer between surfaces (including but not limited to; to/from bed, chair, wheelchair, standing position, in and out of car, up and down steps or curbs etc); and

- (ii) Move between locations by ambulation or other means both at home and in the community.
- (f) "Personal care" means
 - (i) For individuals age sixteen years and older, the ability to do all of the following with or without the use of one or more assistive devices:
 - (a) Bathe, including cleansing one's body by showering, tub or sponge bath, or any other generally accepted method; and
 - (b) Perform the tasks associated with oral hygiene, hair and nail care; and
 - (c) Perform the tasks associated with toileting, which includes appropriate elimination, disposal of bodily waste, and adequate hygiene related to toileting.
 - (d) Dress self, including putting on and taking off all items of clothing, including any necessary prostheses; and
 - (e) Feed self, including the processes of getting food into one's mouth, chewing and swallowing, and/or the ability to use and manage a feeding tube; and
 - (f) Self-administer medications as defined in ~~chapter 47~~ Chapter 47. of the Revised Code.
 - (ii) For individuals age six through fifteen years, the ability to do all of the following with or without the use of one or more assistive devices:
 - (a) Bathe, including cleansing one's body by showering, tub or sponge bath, or any other generally accepted method; and
 - (b) Perform the tasks associated with oral hygiene and hair care; and
 - (c) Perform the tasks associated with toileting, which includes appropriate elimination, disposal of bodily wastes, and adequate and hygiene related to toileting.
 - (d) Dress self, including putting on and taking off all items of clothing, including any necessary prostheses; and
 - (e) Feed self, including the processes of getting food into one's mouth, chewing, and swallowing.
- (g) "Self-direction" means:
 - (i) For individuals age sixteen years and older, the ability to do all of the following:
 - (a) Foresee the outcome of one's actions; and
 - (b) Make informed choices that are unlikely to result in harm to self or others; and
 - (c) Initiate appropriate activities; and
 - (d) Exercise self-control in daily life; or,
 - (ii) For individuals age nine through fifteen years, the ability to do all of the following:
 - (a) Foresee the outcome of one's actions, understand cause and effect, and change future decisions based on past consequences; and
 - (b) Make informed choices that are unlikely to result in harm to self or others, demonstrate good judgement when asking for help when needed for physical, emotional and practical needs; and
 - (c) Initiate appropriate activities, show adequate social skills for establishing and maintaining relationships; and

- (d) Exercise self-control in daily life, occupy self without difficulty, follow basic rules; and
 - (iii) For individuals ages six through eight years, the ability to do all of the following:
 - (a) Foresee the outcome of one's actions, understand basic cause and effect, and change future decisions based on past consequences; and
 - (b) Make informed choices that are unlikely to result in harm to self or others, demonstrate judgement when asking for help when needed for physical, emotional and practical needs; and
 - (c) Initiate appropriate activities, show adequate social skills for relationships such as turn taking and sharing; and
 - (d) Exercise self-control in daily life, can occupy self for short periods of time without difficulty, and follow basic rules.
 - (6) "Manifested" means a condition was diagnosed and has interfered with the individual's ability to develop and/or maintain functioning in at least one major life area, as referenced in paragraph (B)(5) of this rule.
 - (7) "Substantial functional limitation" means the inability to independently, adequately, safely, and consistently perform age appropriate tasks as associated with the major life areas, as referenced in paragraph (B)(5) of this rule, without undue effort and within a reasonable period of time. An individual who has access to and is able to perform the tasks independently, adequately, safely, and consistently with the use of adaptive equipment or assistive devices is not considered to have a substantial functional limitation.
- (C) An individual that is age six years or older shall be determined to require an ICF-MR level of care if all of the following criteria are met:
 - (1) The individual meets the minimum criteria for a protective level of care set forth in paragraph (C)(2) of rule 5101:3-3-08 of the Administrative Code; and
 - (2) The individual has at least one diagnosed condition other than mental illness; and
 - (3) The condition(s) referenced in paragraph (C)(2) of this rule was manifested before the individual's twenty-second birthday; and
 - (4) The condition(s) referenced in paragraph (C)(2) of this rule is likely to continue indefinitely; and
 - (5) The condition(s) referenced in paragraph (C)(2) of this rule currently results in:
 - (a) Substantial functional limitations in three or more of the following major life areas for individuals age six through fifteen:
 - (i) Capacity for independent living;
 - (ii) Communication;
 - (iii) Learning;
 - (iv) Mobility;
 - (v) Personal care;
 - (vi) Self-direction; or
 - (b) Substantial functional limitations in three or more of the following major life areas for individuals age sixteen and older:
 - (i) Capacity for independent living;
 - (ii) Communication;
 - (iii) Economic self-sufficiency;
 - (iv) Learning;

- (v) Mobility;
- (vi) Personal care;
- (vii) Self-direction; and

(6) The individual would benefit from services and supports designed and coordinated specifically to promote the individual's acquisition of skills and to decrease or prevent regression in the performance of tasks related to the major life areas, as referenced in paragraph (B)(5) of this rule, where significant functional limitations were identified. These services and supports are to be provided in one of the following settings:

- (a) An intermediate care facility for the mentally retarded (ICF-MR) where active treatment is provided, as defined in paragraph (B)(1) of this rule; or
- (b) A home and community based services waiver where habilitation services are provided, as defined in paragraph (B)(3) of this rule.

(7) The individual, parent of a minor child, or legal guardian agrees to the individual's active participation in an individualized plan of services and supports.

(D) An individual birth through five years of age shall be determined to require an ICF-MR level of care if all of the following criteria are met:

- (1) The individual meets the minimum criteria for a protective level of care set forth in paragraph (C)(2) of rule 5101:3-3-08 of the Administrative Code; and
- (2) The individual has demonstrated at least three developmental delays, as defined in paragraph (B)(2) of this rule, in the following areas:

- (a) Adaptive behavior;
- (b) Physical development or maturation, fine and gross motor skills, growth;
- (c) Cognition;
- (d) Communication;
- (e) Social or emotional development;
- (f) Sensory development; and

(3) The individual would benefit from services and supports designed and coordinated specifically to promote the individual's acquisition of skills and to decrease or prevent regression in the performance of those areas where delays are indicated. These services and supports are to be provided in one of the following settings:

- (a) An intermediate care facility for the mentally retarded where active treatment is provided, as defined in paragraph (B)(1) of this rule; or
- (b) A home and community based services waiver where habilitation services are provided, as defined in paragraph (B)(3) of this rule.

(4) The parent or legal guardian agrees to the individual's active participation in an individualized plan of services and supports.

Effective: 07/01/2008

R.C. 119.032 review dates: 04/07/2008 and 07/01/2013

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.02

Prior Effective Dates: 4/7/77, 10/14/77, 7/1/80, 11/5/01 (Emer.), 1/20/02

5160-3-08 **Criteria for Nursing Facility-Based Level of Care**

***Formerly* 5101:3-3-08** **Criteria for Nursing Facility-Based Level of Care**

[Click here to view OAC 5160-3-08, Criteria for Nursing Facility-Based Level of Care](#)

This rule is maintained in the Long Term Care Manual, located in the Ohio Health Plans - Provider collection.

5160-3-14 Preadmission Screening (PAS) and Resident Review (RR) Definitions

***Formerly* 5101:3-3-14 Preadmission Screening (PAS) and Resident Review (RR) Definitions**

[Click here to view OAC 5160-3-14, Preadmission Screening \(PAS\) and Resident Review \(RR\) Definitions](#)

This rule is maintained in the Long Term Care Manual, located in the Ohio Health Plans - Provider collection.

5160-3-15 Process and Timeframes for a Level of Care Determination for Nursing Facility-Based Level of Care Programs

***Formerly* 5101:3-3-15 Process and Timeframes for a Level of Care Determination for Nursing Facility-Based Level of Care Programs**

[Click here to view OAC 5160-3-15, Process and Timeframes for a Level of Care Determination for Nursing Facility-Based Level of Care Programs](#)

This rule is maintained in the Long Term Care Manual, located in the Ohio Health Plans - Provider collection.

5160-3-15.1 Preadmission Screening (PAS) Requirements for Individuals Seeking Admission to Nursing Facilities (NFs)

***Formerly* 5101:3-3-15.1 Preadmission Screening (PAS) Requirements for Individuals Seeking Admission to Nursing Facilities (NFs)**

[Click here to view OAC 5160-3-15.1, Preadmission Screening \(PAS\) Requirements for Individuals Seeking Admission to Nursing Facilities \(NFs\)](#)

This rule is maintained in the Long Term Care Manual, located in the Ohio Health Plans - Provider collection.

5160-3-15.2 Resident Review (RR) Requirements for Individuals Residing in Nursing Facilities (NFs)

***Formerly* 5101:3-3-15.2 Resident Review (RR) Requirements for Individuals Residing in Nursing Facilities (NFs)**

[Click here to view OAC 5160-3-15.2, Resident Review \(RR\) Requirements for Individuals Residing in Nursing Facilities \(NFs\)](#)

This rule is maintained in the Long Term Care Manual, located in the Ohio Health Plans - Provider collection.

5160-3-15.3 Level of Care Review Process for Intermediate Care Facilities for the Mentally Retarded

***Formerly* 5101:3-3-15.3 Level of Care Review Process for Intermediate Care Facilities for the Mentally Retarded**

[Click here to view OAC 5160-3-15.3, Level of Care Review Process for Intermediate Care Facilities for the Mentally Retarded](#)

This rule is maintained in the Long Term Care Manual, located in the Ohio Health Plans - Provider collection.

5160-3-15.5 ICF-MR Level of Care Determination Process for Home and Based Medicaid Waivers Administered by the Ohio Department of Mental Retardation and Developmental Disabilities

***Formerly* 5101:3-3-15.5 ICF-MR Level of Care Determination Process for Home and Based Medicaid Waivers Administered by the Ohio Department of Mental Retardation and Developmental Disabilities**

Effective Date: January 20, 2002

- (A) The purpose of this rule is to describe the level of care review and determination process for all individuals applying for an ICF-MR home and community based medicaid waiver administered by the Ohio department of mental retardation and developmental disabilities and to describe the annual level of care redetermination process. An ICF-MR level of care determination is required for all individuals as a component of eligibility for ICF-MR home and community based services.
- (B) Definitions
- (1) "CBMRDD" means a county board of mental retardation and developmental disabilities that has local medicaid administrative authority under section 5126.055 of the Revised Code.
 - (2) "CDJFS" means a county department of job and family services.
 - (3) "ICF-MR" means intermediate care facility for the mentally retarded.
 - (4) "HCBS", as defined in section 5126.01 of the Revised Code means medicaid-funded home and community based services as an alternative to placement in an intermediate care facility for mental retardation provided under a medicaid component that the department of mental retardation and developmental disabilities administers pursuant to section 5111.871 of the Revised Code.
 - (5) "ICF-MR home and community based services" means the residential facility waiver, the individual options waiver and any new or amended hcbs waivers that are designed to provide services in lieu of an ICF-MR facility.
 - (6) "ICF-MR LOC determination" means a decision made by appropriately qualified personnel which establishes that an individual does or does not meet the criteria for an intermediate care facility for the mentally retarded level of care specified in rule 5101:3-3-07 of the Administrative Code.
 - (7) "Individual" means a medicaid recipient or person with pending medicaid eligibility who is making application for an ICF-MR home and community based waiver
 - (8) "ODJFS" means the Ohio department of job and family services
 - (9) "ODMRDD" means the Ohio department of mental retardation and developmental disabilities.
 - (10) "Significant change of condition" means that the individual has experienced a change in physical or mental condition, or functional abilities, or has reached the age of 6 or the age of 16, any of which may result in a change in the individual's level of care.
- (C) The CBMRDD, shall, in accordance with section 5126.055 of the Revised Code, coordinate and/or perform evaluations and assessments of the individual and make a recommendation to ODJFS or designee as to whether the individual meets the criteria for an ICF-MR level of care as set forth in rule 5101:3-3-07 of the Administrative Code
- (1) The assessment shall include:
 - (a) Medical, psychiatric and developmental diagnoses, and dates of onset if the date of onset is significant in determining whether the individual has a developmental disability; and
 - (b) Review of current functional capacity. This review should be documented on a standard functional assessment form that is approved by the Ohio department of job and family services.
 - (2) The assessment documentation shall be kept in the official waiver file and made available for state and federal quality assurance and audit purposes.

- (D) CBMRDD shall submit a recommendation and supporting documentation described in this section to ODJFS or designee for review and approval or denial of an ICF-MR LOC determination as set forth in rule 5101:3-3-07 of the Administrative Code.
- (1) For an initial ICF-MR LOC determination, the cbmrdd shall submit to ODJFS or designee the following documentation supporting the individual's need for an ICF-MR LOC:
 - (a) A medical evaluation which includes etiology of the condition leading to a developmental disability, diagnoses, and dates of onset, completed by a doctor of medicine or osteopathy who is licensed by the state of Ohio medical board.
 - (b) A psychological evaluation completed by a psychologist who has been licensed by the Ohio board of psychology to practice psychology in the state of Ohio, or a psychiatric evaluation completed by a psychiatrist licensed to practice psychiatry by the state of Ohio medical board, which includes the most current diagnoses as specified in the most current diagnostic statistical manual of mental disorders, axes I, II and III.
 - (c) ICF-MR LOC eligibility determination form as approved by ODJFS.
 - (2) The CBMRDD shall submit an ICF-MR LOC redetermination to ODJFS or designee within twelve months of the initial LOC determination, and every year thereafter, and upon a significant change of the individual's condition, as defined in paragraph (B) (10) of this rule, which will establish one of the following:
 - (a) The individual has not had a significant change in condition. The cbmrdd shall submit the appropriate ICF-MR LOC redetermination form verifying that the individual's condition has not changed significantly since the initial loc determination and shall recommend continuation of the ICF-MR LOC; or
 - (b) The individual has experienced a significant change of condition from the time of the initial ICF-MR LOC determination. The CBMRDD shall reassess the individual's needs and submit new evaluations which verify the change in condition with the appropriate ICF-MR LOC redetermination form. This redetermination should be completed as soon as a significant change in condition has occurred.
- (E) Following receipt by ODJFS or designee of the documentation specified in paragraph (D) (1) (c) of this rule, ODJFS or designee shall make a determination of whether the documentation is sufficiently complete for its personnel to perform the ICF-MR LOC review and make a determination based upon the criteria set forth in rule 5101:3-3-07 of the Administrative Code.
- (1) If the documentation is not complete, ODJFS or designee shall notify the individual and the CBMRDD regarding the need for additional documentation. This notice shall specify the additional documentation that is required and shall indicate that the individual, or someone on their behalf, has twenty days from the date ODJFS or designee mails the notice to submit additional documentation or the authorized form will be denied for incompleteness with no ICF-MR LOC authorized. In the event an individual, or someone on their behalf, is not able to complete an authorized form in the time specified, ODJFS or designee shall, upon good cause, grant an extension when an extension is requested by the individual or someone on their behalf.
 - (2) Within thirty days of receipt of all required documentation, ODJFS or designee shall issue an ICF-MR LOC determination. An ICF-MR LOC determination will be issued pursuant to the criteria as set forth in rule 5101:3-3-07 of the Administrative Code.
 - (3) A request for an ICF-MR LOC will not be denied by ODJFS or designee for the reason that the individual does not meet the ICF-MR LOC criteria, as set forth in rule 5101:3-3-07 of the Administrative Code, until a qualified professional, whose qualifications include being a registered nurse or a qualified mental retardation professional, as specified at 42 C.F.R 483.430, conducts a face-to-face assessment of the individual and reviews the medical records that accurately reflect the individual's condition. Authorized personnel other than the person who conducted the face-to-face assessment will review the face-to-face assessment and make the final ICF-MR LOC determination.

- (F) Once a final ICF-MR LOC determination is made, ODJFS or designee shall notify the individual. The notice shall establish the individual's hearing rights, as set forth in 5101:6-2-02 through 5101:6-2-04 of the Administrative Code, and the time frames within which they must be exercised.
- (1) If a hearing request is received in response to the notice specified in paragraph (F) of this rule and within the time frames specified in rule 5101:6-4-01 of the Administrative Code that require the continuation of benefits, authorization for payment will be continued pending the issuance of a state hearing decision.
- (2) If the individual does not submit a hearing request within the time frame specified in paragraph (F) of this rule, vendor payment will automatically terminate on the date specified in the notice advising the recipient of ODJFS' intent to terminate vendor payment.
- (G) Federal financial participation (FFP) shall not be claimed for ICF-MR home and community based waiver services delivered prior to the ICF-MR LOC determination date.

Rule promulgated under: Revised Code Chapter 119

Rule authorized by: Revised Code 5111.02

Rule amplifies: Revised Code 5111.01, 5111.02

Effective Date: 20 JAN 2002

Rule Review Date: 11/5/01, 11/5/06

Certification: Thomas J. Hayes

Date 10 JAN 2002

Prior effective dates: 11/1/01 (Emer.)

PASSPORT

LTCSSTL 14-02

Effective Date: March 6, 2014

Most Current Prior Effective Date: September 29, 2011

(A) The purpose of this rule is to define the terms used in Chapter ~~5101:3-31~~ 5160-31 of the Administrative Code governing the preadmission screening system providing options and resources today (PASSPORT) home and community based services (HCBS) waiver program.

As used in this chapter:

(B) "ADL" means activities of daily living including bathing; grooming; toileting; dressing; eating; and mobility which refers to bed mobility, transfer, and locomotion as defined in ~~rules 5101:3-3-06 and 5101:3-3-08~~ rule 5160-3-08 of the Administrative Code.

(C) "Assessment" means a face-to-face evaluation used to obtain information about an individual including his or her condition, personal goals and preferences, functional limitations, health status and other factors that are relevant to the authorization and provision of services. Assessment information supports the determination that an individual requires waiver services as well as the development of the service plan.

(D) "Authorized representative" means a person, eighteen years of age or older, who is chosen by and acts on behalf of an individual who is applying for, or receiving, medical assistance. In accordance with rule ~~5101:1-38-01.2~~ 5160:1-2-01.2 of the Administrative Code, the individual must provide a written statement naming the authorized representative and the duties that the named authorized representative may perform on the individual's behalf.

(E) "CDJFS" means a county department of job and family services.

(F) "C.F.R." means the code of federal regulations.

~~(E)~~(G) "Caregiver" means relatives, friend, and/or significant others who voluntarily provide assistance to the ~~consumer~~ individual enrolled in PASSPORT and are responsible for the ~~consumer's~~ individual's care on a continuing basis.

~~(F)~~(H) "Case management" means a set of person centered activities provided by the PASSPORT administrative agency (PAA) that are undertaken to ensure that the ~~waiver consumer~~ individual enrolled in PASSPORT receives appropriate and necessary services. Under a HCBS waiver, these activities may include, but are not necessarily limited to, assessment, service plan development, service plan implementation and service monitoring as well as assistance in accessing waiver, state plan, and other services and resources as needed.

~~(G)~~ ~~"CDJFS" means a county department of job and family services.~~

~~(H)~~(I) "Certification" means providers are certified by the Ohio department of aging (ODA) to provide services for PASSPORT as established in Chapter 173-39 of the Administrative Code.

~~(I)~~ ~~"Consumer" means an individual who has been accepted for enrollment and is receiving PASSPORT services. Consumer includes the consumer's legal representative and/or authorized representative, as applicable.~~

(J) "HCBS" or "home and community-based services" means services furnished under the provisions set forth in 42 C.F.R. 441 Subpart G (October 1, 2009) that permit individuals to live in a home setting rather than a nursing facility (NF) or hospital. HCBS waiver services are approved by CMS for specific populations and are not otherwise available under the medicaid state plan.

(K) "CMS" means the centers for medicare and medicaid services (CMS), a federal agency that is part of the U.S. department of health and human services, and administers the medicaid program and approves home and community-based services waivers.

- (L) "FMS" or "financial management service" is a support provided to waiver participants who direct some or all of their waiver services. In the PASSPORT waiver, this support is conducted as an administrative activity through an entity under contract with the ~~ODA~~ state of Ohio. When used in conjunction with the ~~employer authority~~ self-direction authorities available to ~~consumers~~ individuals enrolled in PASSPORT, this support includes operating a payroll service for participant-employed workers and making required payroll withholdings.
- (M) "Home first" means the component of the PASSPORT HCBS waiver program that offers priority enrollment in the waiver for certain individuals in accordance with section ~~173.401~~ 173.521 of the Revised Code.
- (N) "IADL" means an instrumental activity of daily living as defined in rule ~~5101:3-3-08~~ 5160-3-08 of the Administrative Code and includes shopping; meal preparation; laundry; community access activities including telephoning, transportation, legal or financial; and environmental activities including house cleaning, heavy chores, yard work or maintenance.
- (O) "Individual" means a medicaid recipient, a medicaid recipient enrolled in a HCBS program, or person with pending medicaid eligibility who is applying ~~to a NF or intermediate care facility for the mentally retarded (ICF-MR); or for is applying for~~ HCBS waiver enrollment; ~~or is applying for residential state supplement (RSS) funded placement; or is seeking~~ other long-term care services.
- (P) "Individual provider" means a person with a signed medicaid provider agreement with ODM to provide PASSPORT services in rule 5160-31-05 of the Administrative Code, and who meets the PASSPORT waiver program's conditions of participation set forth in rule 5160-31-06 of the Administrative Code and who is not the spouse, parent, stepparent, and/or legal guardian of the consumer.
- ~~(P)~~ (Q) "Keys amendment facility", as found in section 1616(e) of the Social Security Act (as in effect on January 1, 2014), means ~~includes, but is not limited to,~~ an institution, foster home or group living arrangement, including those licensed by the state, in which a significant number of recipients of supplemental security income benefits are residing or are likely to reside. ~~Keys amendment facilities include:~~
- ~~(1) Adult foster homes certified under section 5119.362 of the Revised Code;~~
 - ~~(2) Adult family homes or adult group homes as defined in section 3722.01 of the Revised Code, that is licensed as an adult care facility under section 3722.04 of the Revised Code;~~
 - ~~(3) Residential care facility as defined in section 3721.02 of the Revised Code;~~
 - ~~(4) Community alternative homes as defined in section 3724.01 of the Revised Code, that are licensed under section 3724.03 of the Revised Code;~~
 - ~~(5) Residential facilities of the type defined in division (A)(1)(d)(ii) of section 5119.22 of the Revised Code, that are licensed by the Ohio department of mental health (ODMH); or,~~
 - ~~(6) An apartment or room that is used to provide community mental health housing services, is certified by the ODMH under section 5119.611 of the Revised Code, and is approved by a board of alcohol, drug addiction, and mental health services in accordance with division (A)(14) of section 340.03 of the Revised Code.~~
- ~~(Q)~~ (R) "Level of care" or "LOC" ~~(LOC)~~ means the designation describing a person's functional levels and nursing needs pursuant to the criteria set forth in rules ~~5101:3-3-05~~ 5160-3-05, ~~5105:3-3-06~~ 5160-3-06, ~~5101:3-3-07 and 5101:3-3-08~~ 5160-3-07 and 5160-3-08 of the Administrative Code.
- ~~(R)~~ (S) "NF" means a nursing facility as defined in section ~~5111.20~~ 5165.01 of the Revised Code.
- ~~(S)~~ (T) "ODA" means the Ohio department of aging.
- ~~(T)~~ (U) "~~ODJFS~~ ODM" means the Ohio department of ~~job and family services~~ medicaid.
- ~~(U)~~ (V) "PAA" means PASSPORT administrative agency.
- ~~(V)~~ (W) "PASSPORT" or "PASSPORT HCBS waiver program" means an HCBS waiver program that serves individuals who are aged sixty and over who have a LOC required for placement in a NF if the waiver

program were not available, and meet the PASSPORT eligibility criteria and enrollment requirements in Chapter ~~5101:3-31~~5160-31 of the Administrative Code.

~~(W)~~(X) "Region" means the geographic area in which a PAA administers the PASSPORT program.

~~(X)~~(Y) "Service plan" means a written, person centered plan between the ~~consumer~~individual, the ~~consumer's~~individual's case manager at the PAA and, as applicable, the ~~consumer's~~individual's caregiver(s). The service plan specifies the services that are provided to the ~~consumer~~individual, regardless of funding source, to address the ~~consumer's-individual~~individual's care needs as identified in the ~~consumer's~~individual's assessment.

~~(Y)~~(Z) "Subregion" means a geographic area located within a PAA region for the purpose of establishing PASSPORT unit rates as set forth in rule ~~5101:3-31-07~~5160-31-07 of the Administrative Code.

~~(Z)~~(AA) "Waiver service provider" means an agency or person with a signed medicaid provider agreement with ~~ODJFS~~SODM to provide HCBS waiver services, and who meets the PASSPORT conditions of participation set forth in rule ~~5101:3-31-06~~5160-31-06 of the Administrative Code.

Effective:

R.C. 119.032 review dates: 11/29/2013

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 5166.02

Rule Amplifies: 5166.02, 173.52

Prior Effective Dates: 7/16/84, 12/22/86 (Emer.), 3/23/87, 7/1/90, 1/14/96, 9/1/98, 3/1/00, 3/3/01, 7/1/06, 3/17/11, 9/29/11

LTCSTL 15-19

Effective Date: April 1, 2015

Most Current Prior Effective Date: March 1, 2014

- (A) Before an individual can be eligible for enrollment in the pre-admission screening system providing options and resources today (PASSPORT) home and community based services (HCBS) waiver program, all of the following criteria must be met:
- (1) ~~A county department of job and family services (CDJFS) must have determined the individual to be~~The individual must have been determined eligible for medicaid in accordance with rules ~~5160:1-2-01.6 and 5160:1-2-01.8~~5160:1-2-03 and 5160:1-1-58 of the Administrative Code.
 - (2) The waiver service cost of the twelve-month service plan does not exceed the individual cost limit. The individual cost limit is ~~calculated by the Ohio department of aging (ODA) at least biennially. The cost limit is a dollar amount equal to sixty per cent of the total medicaid cost for nursing facility (NF) services. The total medicaid cost for NF services is obtained by multiplying the average annual medicaid NF per diem rate by the number of days in the most recent state fiscal year in which data is available~~equal to fourteen thousand and seven hundred dollars per month for waiver services.
 - (a) If the PASSPORT administrative agency (PAA) determines that the applicant's waiver service needs cannot be met within the individual cost limit, the individual shall not be enrolled. ~~However, if an individual who has been enrolled and is receiving PASSPORT services experiences a change in his or her condition that causes the cost of care to exceed the cost limit, the individual may remain on the waiver at a higher cost not to exceed one hundred per cent of the total medicaid cost for NF services to avoid service disruption to the individual if the PAA grants approval to do so.~~
 - (b) Once enrolled in PASSPORT, additional waiver services may not be authorized in excess of the fourteen thousand and seven hundred dollars per month individual cost limit. When a change in condition occurs that necessitates the provision of additional waiver services, referrals to other community services, including institutional services, will be explored.
 - ~~(b)(c)~~(c) If the individual's waiver service needs exceed ~~one hundred per cent of the total medicaid cost for NF services~~the individual cost limit of fourteen thousand and seven hundred dollars per month, the individual shall be disenrolled from the waiver.
 - (3) The needed services are not readily available through another source at the level required to allow the individual to live in the community.
 - (4) The individual agrees to participate in PASSPORT and shall not be simultaneously enrolled in another HCBS medicaid waiver, the residential state supplement (RSS) program, or the program of all inclusive care for the elderly (PACE) while enrolled in PASSPORT.
 - (5) The individual's health related needs can be safely met in a home setting as determined by the PAA.
 - (6) Prior to PASSPORT enrollment, the attending physician must approve that the services are appropriate to meet the individual's needs. The physician's approval may be either verbal or written. If the approval is verbal, written approval must be obtained within thirty days of the enrollment date. The PAA shall be responsible for obtaining the physician's approval.
 - (7) While receiving PASSPORT, the individual must not be a resident of either a Keys amendment facility, a hospital or a nursing facility (NF) as defined in rule 5160-31-02 of the Administrative Code. For purposes of this rule, a resident of a Keys amendment facility is an individual who receives services from the facility and is not a family member of the owner or operator of the facility.
 - (8) The individual is age sixty or older at the time of enrollment.

- (9) The individual must be determined to meet the criteria for an intermediate or skilled level of care in accordance with rule ~~5160-3-05 or 5160-3-06~~ 5160-3-08 of the Administrative Code and, in the absence of PASSPORT, would require NF services as defined in 42 C.F.R. 440.40 and 42 C.F.R. 440.150 (~~dated~~ as in effect on October 1, ~~2007~~2014).
- (10) PASSPORT has not reached the centers for medicare and medicaid services (CMS)-authorized limit on the number of individuals who may enroll on the waiver during the current year.
- ~~(11) An individual who has been enrolled in and is receiving PASSPORT services may subsequently be enrolled in and receive hospice services under medicaid or medicare. A person who is enrolled in hospice under medicaid or medicare is not eligible to enroll in PASSPORT if that hospice enrollment occurred prior to PASSPORT enrollment.~~
- ~~(12)~~(11) The individual must require the provision of at least one waiver service on a monthly basis as documented in the individual's approved service plan.
- (B) If, at any time, the individual fails or ceases to meet any of the eligibility criteria identified in this rule, the individual shall be denied or disenrolled from PASSPORT. In such instances, the individual shall be notified ~~by the CDJFS and entitled to~~ of his or her hearing rights in accordance with ~~Chapters 5101:6-1 to 5101:6-9~~ division 5101:6 of the Administrative Code.

Effective: 04/01/2015

Five Year Review (FYR) Dates: 12/08/2014 and 04/01/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 03/12/2015

Promulgated Under: 119.03

Statutory Authority: 5166.02

Rule Amplifies: 5166.02, 173.52

Prior Effective Dates: 12/22/86 (Emer.), 3/23/87, 1/14/96, 2/22/01, 1/31/05, 7/1/08, 3/17/11, 3/1/14

5160-31-04 Enrollment Process for the Pre-Admission Screening System Providing Options and Resources Today (PASSPORT) HCBS Waiver Program

***Formerly* 5101:3-31-04 Enrollment Process for the Pre-Admission Screening System Providing Options and Resources Today (PASSPORT) HCBS Waiver Program**

LTCSSSTL 14-02

Effective Date: March 6, 2014

Most Current Prior Effective Date: September 29, 2011

- (A) The Ohio department of aging (ODA) is responsible for the daily operation of the PASSPORT home and community based services (HCBS) waiver. ODA will operate this waiver pursuant to an interagency agreement with the Ohio department of ~~job and family services (ODJFS)~~ medicaid in accordance with sections ~~5111.94~~ 5162.35 and ~~5111.874~~ 5166.21 of the Revised Code. ODA will establish processes and procedures to enroll individuals on this waiver.
- (B) Individuals who wish to enroll in PASSPORT must have a medicaid eligibility determination made by the county department of job and family services (CDJFS) and an assessment of PASSPORT waiver eligibility made by the PASSPORT administering agency (PAA). The individual may contact either the CDJFS or the PAA to start the enrollment process and the two agencies shall coordinate processing the request for enrollment into the PASSPORT HCBS waiver program:
- (1) Individuals initially contacting the CDJFS will complete the JFS 07200 "Request for Cash, Food ~~Stamps~~, and Medical Assistance" (rev. ~~3/2010~~ 12/2012) and the JFS 02399 "Request for Medicaid Home and Community Based Services" (rev. ~~4/2006~~ 5/2013) in accordance with rules ~~5101:1-38-01.2~~ 5160:1-2-01.2 and ~~5101:1-38-01.6~~ 5160:1-2-01.6 of the Administrative Code. The CDJFS will notify the PAA of the individual's application for waiver services. The PAA will initiate contact with the individual to complete the enrollment process.
 - (2) Individuals initially contacting the PAA will receive an in-person assessment to determine eligibility for the PASSPORT HCBS waiver program. The PAA may assist the individual in applying for medicaid if not already initiated by completing the JFS 07200 and JFS 02399.
- (C) If the individual has been determined eligible and a waiver slot is available, the ~~consumer~~ individual shall be enrolled in accordance with the PASSPORT HCBS waiver program's home first component, if applicable, and rule 173-42-03 of the Administrative Code.
- (D) The PAA shall make the determination of PASSPORT eligibility using the criteria set forth in rule ~~5101:3-31-03~~ 5160-31-03 of the Administrative Code. The PAA shall notify the CDJFS of the results of the PASSPORT eligibility determination.
- (E) Any applicant for PASSPORT HCBS waiver program services is entitled to notice and hearing rights as set forth in section 5101.35 of the Revised Code and division 5101:6 of the Administrative Code.

Effective:

R.C. 119.032 review dates: 11/29/2013

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 5166.02

Rule Amplifies: 5166.02, 173.52

Prior Effective Dates: 7/16/84, 12/22/86 (Emer.), 3/23/87, 7/1/90, 1/14/96, 2/22/01, 10/03/05 (Emer.), 1/1/06, 3/17/11, 9/29/11

LTCSTL 14-09

Effective Date: July 1, 2014

Most Current Prior Effective Date: March 1, 2014

- (A) The purpose of this rule is to establish the services covered by the pre-admission screening system providing options and resources today (PASSPORT) home and community based services (HCBS) waiver program.
- (B) The PASSPORT HCBS waiver program benefit package is limited to the following services:
- (1) Adult day services as set forth in rule [173-39-02.1](#) of the Administrative Code;
 - (2) Alternative meal services as set forth in rule [173-39-02.2](#) of the Administrative Code;
 - (3) Choices home care attendant services as set forth in rule [173-39-02.4](#) of the Administrative Code;
 - (4) Chore services as set forth in rule [173-39-02.5](#) of the Administrative Code;
 - (5) Community transition services as set forth in rule [173-39-02.17](#) of the Administrative Code;
 - (6) Emergency response system services as set forth in rule [173-39-02.6](#) of the Administrative Code;
 - (7) Enhanced community living services as set forth in rule [173-39-02.20](#) of the Administrative Code;
 - (8) Homemaker services as set forth in rule [173-39-02.8](#) of the Administrative Code;
 - (9) Home care attendant services as set forth in rule [173-39-02.24](#) of the Administrative Code;
 - ~~(9)~~(10) Home delivered meal services as set forth in rule [173-39-02.14](#) of the Administrative Code;
 - ~~(10)~~(11) Home medical equipment and supplies services as set forth in rule [173-39-02.7](#) of the Administrative Code;
 - ~~(11)~~(12) Independent living assistance services as set forth in rule [173-39-02.15](#) of the Administrative Code;
 - ~~(12)~~(13) Minor home modification, maintenance and repair services as set forth in rule [173-39-02.9](#) of the Administrative Code;
 - ~~(13)~~(14) Non-medical transportation services as set forth in rule [173-39-02.18](#) of the Administrative Code; ~~and~~
 - ~~(14)~~(15) Nutrition consultation services as set forth in rule [173-39-02.10](#) of the Administrative Code;
 - (16) Out-of-home respite services as set forth in rule [173-39-02.23](#) of the Administrative Code;
 - ~~(15)~~(17) Personal care services as set forth in rule [173-39-02.11](#) of the Administrative Code;
 - ~~(16)~~(18) Pest control services as set forth in rule [173-39-02.3](#) of the Administrative Code;
 - ~~(17)~~(19) Social work counseling services as set forth in rule [173-39-02.12](#) of the Administrative Code; ~~and~~
 - ~~(18)~~(20) Transportation services as set forth in rule [173-39-02.13](#) of the Administrative Code; ~~and~~
 - (21) Waiver nursing services as set forth in rule [173-39-02.22](#) of the Administrative Code.

- (C) Services shall be delivered by providers in a manner that is consistent with the individual's service plan as documented in the PASSPORT information management system (PIMS).
- (D) If an individual enrolled on PASSPORT is also a participant in the helping ohioans move, expanding (HOME) choice demonstration program in accordance with Chapter 5160-51 of the Administrative Code, the individual may, at the individual's discretion, use the HOME choice community transitions service in lieu of, but not in addition to, the community transition service available through the PASSPORT waiver program.
- (E) If an individual receives enhanced community living services, per the federally approved waiver, the consumer may not receive either personal care or homemaker services available through the PASSPORT waiver program.
- (F) In accordance with the federally approved PASSPORT waiver the services identified in this paragraph are subject to employer and/or budget authority if elected by the individual. Services are to be furnished in accordance with the requirements in paragraph (B) of this rule:
 - (1) The following services are subject to employer authority, which includes but is not limited to, the ability to hire, fire, and train employees:
 - (a) Choices home care attendant service; and
 - (b) Personal care services.
 - (2) The following services are subject to budget authority, which includes but is not limited to, the ability to negotiate reimbursement rates paid to providers furnishing services:
 - (a) Alternative meals service;
 - (b) Choices home care attendant service
 - (c) Home medical equipment and supplies service;
 - (d) Minor home modification, maintenance and repair services; and
 - (e) Pest control service
- (G) An individual who elects to self-direct any of the services provided in paragraph (F) of this rule shall be assessed by their case manager to determine the individual's ability to self-direct their services as set forth in rule [173-42-06](#) of the Administrative Code.
 - (1) If an individual demonstrates the ability to self-direct their care the case manager may initiate the orientation process to familiarize the individual with the self-direction of services including the role of the financial management service (FMS).
 - (2) If the individual is unable to demonstrate the ability to self-direct his or her care and to assume the responsibilities associated with the self-direction authorities in paragraph (F) of this rule, the individual may choose an authorized representative to act on his or her behalf.
 - (3) If no authorized representative is available, the case manager will assist the individual with obtaining services through ODA-certified long-term care agency providers.
- (H) If an individual who is seeking to self-direct his or her care chooses an authorized representative to act on his or her behalf in accordance with paragraph (G)(2) of this rule, the authorized representative shall not simultaneously serve as the consumer's authorized representative and the consumer's provider.

Effective: 07/01/2014

R.C. 119.032 review dates: 03/01/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 06/20/2014

Promulgated Under: 119.03

Statutory Authority: 5166.02

Rule Amplifies: 5166.02, 173.52

Prior Effective Dates: 7/16/84, 12/22/86 (Emer.), 3/23/87, 7/1/90, 9/1/98, 7/1/06, 7/1/08, 6/28/09, 3/17/11, 3/1/14

LTCSTL 14-05

Effective Date: July 1, 2014

Most Current Prior Effective Date: March 17, 2011

- (A) The purpose of this rule is to establish the conditions under which providers are able to participate in the preadmission screening system providing options and resources today (PASSPORT) home and community based services (HCBS) waiver program.
- (B) In order to obtain a medicaid provider agreement to be a PASSPORT provider furnishing services in rule 5160-31-05 of the Administrative Code, the provider shall be certified by the Ohio department of aging (ODA) or its designee in accordance with the provisions of Chapter 173-39 of the Administrative Code.
- ~~(C) PASSPORT waiver providers may be certified as either:~~
- ~~(1) An ODA-certified long-term care agency provider in accordance with the provisions of rule 173-39-03 of the Administrative Code, or~~
 - ~~(2) An ODA-certified long-term care non-agency provider in accordance with the provisions of rule 173-39-03 of the Administrative Code, or~~
 - ~~(3) An ODA-certified long-term care consumer-directed personal care provider in accordance with the provisions of rule 173-39-03 of the Administrative Code.~~
- ~~(D)~~(C) Individuals enrolled in the PASSPORT HCBS waiver shall be given a free choice of qualified providers in accordance with rule 173-42-06 of the Administrative Code.

Effective: 07/01/2014

R.C. 119.032 review dates: 03/20/2014 and 07/01/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 06/10/2014

Promulgated Under: 119.03

Statutory Authority: 5166.02

Rule Amplifies: 5166.02, 173.39, 173.52

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LTCSTL 14-09

Effective Date: July 1, 2014

Most Current Prior Effective Date: March 1, 2014

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

- (A) Rates determined under this rule shall not exceed the maximum reimbursement rate for PASSPORT services in appendix A to rule 5160-1-06.1 of the Administrative Code. Payment for PASSPORT HCBS waiver services constitutes payment in full and may not be construed as a partial payment when the payment amount is less than the provider's usual and customary charge. The provider may not bill the individual for any difference between the medicaid payment and the provider's charge or request the individual to share in the cost through a co-payment or other similar charge.
- (B) PASSPORT reimbursement rates are established for the services in rule 5160-31-05 of the Administrative Code under the following categories:
 - (1) Per job bid rate;
 - (2) Per item rate; and
 - (3) Unit rate.
- (C) Rates set within the categories in paragraph (B) of this rule may be:
 - (1) Participant-directed, in which the individual or their designated authorized representative, who is acting on the ~~individual's~~individual's behalf, may negotiate the reimbursement rate for services furnished by providers as specified in paragraphs (D)(3), (E)(3), (G)(4), and (H) of this rule.
 - (2) Statewide, in which the state establishes a rate that is used on a statewide basis to reimburse for services specified in paragraph (F) of this rule.
 - (3) Regional, in which the state establishes a regional reimbursement rate for services specified in paragraph (G) of this rule. The regions in which applicable rates are calculated shall be designated by ODA.
 - (a) The regional rate for each service shall be the weighted average rate paid in the region using cost and unit data either from the most recently completed state fiscal year or the most recent twelve calendar months for which complete data is available, whichever is later.
 - (b) ODA or its designee shall enter into a contract with providers in each region. The contract shall do all of the following:
 - (i) Specify the time period for which the rates shall be in effect;
 - (ii) Specify the timelines for contracting;
 - (iii) Define the region/subregions for which the rates will be established;
 - (iv) Base rates on the units of service as set forth in appendix A to rule 5160-1-06.1 of the Administrative Code;
 - (v) Reflect the rate the provider is willing to accept ~~as set forth in paragraph (H)(5) of this rule~~; and
 - (vi) Adjust the regional rate up to the nearest number that is divisible by four, out to two decimal places.
 - (c) Regional contract rates shall be established as follows:

- (i) No provider shall have a contract rate that exceeds the rate for that service as established in rule [5160-1-06.1](#) of the Administrative Code.
 - (ii) If the state recalculates regional rates for the services in paragraph (G) of this rule, certified providers may either accept the new regional rate or continue to be reimbursed at the rate paid for services prior to the calculation of the regional rate.
 - (iii) Providers who are certified after the regional rate is established shall have a contract rate less than or equal to the regional rate.
 - (4) Group rates, in which a provider that is furnishing certain services to more than one individual enrolled on PASSPORT is reimbursed at a rate that is seventy-five per cent of the reimbursement rate the provider would be paid for furnishing PASSPORT services as specified in paragraphs (D)(2), (F)(2), (G)(2), and (G)(3) of this rule.
- (D) For the services listed in this paragraph, a per job bid rate shall be negotiated between the provider and the ~~individual's~~ individual's case manager.
 - (1) A per job bid rate shall be used for the following services:
 - (a) Chore services;
 - (b) Community transition services;
 - (c) Minor home modification services;
 - (d) Non-medical transportation services;
 - (e) Pest control services; and
 - (f) Transportation services.
 - (2) Transportation and non-medical transportation services rendered simultaneously by the same provider to more than one individual enrolled in PASSPORT residing in the same household and traveling in the same vehicle to the same destination shall be reimbursed using a group rate that is equal to seventy-five per cent of the provider's per job bid rate. This applies to any combination of transportation and/or non-medical transportation services.
 - (3) Minor home modification and pest control services may be participant directed services in which the individual enrolled on PASSPORT or their authorized representative, acting on the ~~individual's~~ individual's behalf, may negotiate reimbursement rates.
 - (a) The negotiated rate shall be reviewed by the ~~individual's~~ individual's case manager and reflected on the ~~individual's~~ individual's service plan prior to service delivery.
 - (b) Should the individual choose not to negotiate a rate of reimbursement the service shall be reimbursed at a rate proposed by the provider and accepted by the consumer and the consumer's case manager. The accepted rate shall be reflected on the consumer's service plan.
- (E) A per item rate shall be determined for home medical equipment and supplies service.
 - (1) The cost of the item shall not exceed the medicaid state plan rate.
 - (2) The cost of an item that does not have an established medicaid rate shall be reimbursed at a per item bid rate submitted and agreed to in writing by the PASSPORT administrative agency (PAA) prior to delivery of the item.
 - (3) Home medical equipment and supplies services may be participant directed in which the individual enrolled on PASSPORT or the authorized representative, acting on the ~~individual's~~ individual's behalf, may negotiate reimbursement rates.
 - (a) The negotiated rate shall be reviewed by the ~~individual's~~ individual's case manager and reflected on the ~~individual's~~ individual's service plan prior to service delivery.
 - (b) Should the individual choose not to negotiate a rate of reimbursement the service shall be reimbursed at a rate proposed by the provider and accepted by the consumer and the

consumer's case manager. The accepted rate shall be reflected on the consumer's service plan.

- (F) The Ohio department of aging (ODA) shall establish unit rates for the services listed in this paragraph. No service shall have both a regional and statewide rate set pursuant to this rule.
- (1) Statewide rates shall be established and used for the following services:
 - (a) Adult day services;
 - (b) Emergency response system services;
 - (c) Enhanced community living services;
 - (d) Home care attendant services;
 - (e) Out-of-home respite services;
 - ~~(f)~~(f) Personal care services provided by ODA-certified long-term care consumer-directed personal care provider; and
 - (g) Waiver nursing services.
 - (2) ~~Personal care services~~ Personal care services The services in paragraphs (F)(1)(d), (F)(1)(f), and (F)(1)(g) of this rule, when rendered during the same visit ~~by the same ODA-certified long-term care consumer-directed personal care provider~~ to more than one but less than four PASSPORT consumers in the same household, as identified in the consumers' service plans, shall be reimbursed using a group rate equal to one hundred per cent of the provider's per unit rate set in accordance with paragraph (C) of this rule for one PASSPORT consumer. The provider shall be reimbursed seventy-five per cent of the provider's per unit rate for each subsequent PASSPORT consumer in the household receiving services during the visit.
- (G) ODA shall establish regional unit rates for the services listed in this paragraph pursuant to the methodology in paragraph (C)(3) of this rule. No service, except personal care services provided under paragraph (F)(1)(f) of this rule, shall have both a regional and statewide rate set pursuant to this rule.
- (1) Regional unit rates shall be set for the following services:
 - (a) Adult day services transportation;
 - (b) Home delivered meals services;
 - (c) Homemaker services;
 - (d) Social work counseling services;
 - (e) Nutritional consultation services
 - (f) Personal care services; and
 - (g) Independent living assistance services.
 - (2) Adult day service transportation services rendered simultaneously by the same provider to more than one consumer residing in the same household and traveling in the same vehicle to the same destination shall be reimbursed using a group rate equal to seventy-five per cent of the provider's regional unit rate.
 - (3) Personal care services, except personal care services provided under paragraph (F) of this rule, that are rendered during the same visit by the same provider to more than one but less than four PASSPORT consumers in the same household, as identified in the consumers' service plans, shall be reimbursed using a group rate equal to one hundred per cent of the provider's regional per unit rate set in accordance with paragraph (C) of this rule for one PASSPORT consumer. The provider shall be reimbursed seventy-five per cent of their regional per unit rate for each subsequent PASSPORT consumer in the household receiving services during the visit.

- (4) Homemaker services may be participant directed services in which the individual enrolled on PASSPORT or their authorized representative, acting on the ~~individual's~~individual's behalf, may negotiate reimbursement rates.
 - (a) The negotiated rate shall be reviewed by the ~~individual's~~individual's case manager and reflected on the ~~individual's~~individual's service plan prior to service delivery.
 - (b) Should the individual choose not to negotiate a rate of reimbursement the service shall be reimbursed in accordance with paragraph (G) of this rule. The accepted rate shall be reflected on the consumer's service plan.
- (H) The services in this paragraph are participant directed and the individual may negotiate unit rates with providers.
 - (1) The participant directed services include:
 - (a) Alternative meals service; and
 - (b) Choices home care attendant services.
 - (2) The consumer shall have in effect, before choices home care attendant services are delivered, a signed agreement with each ODA-certified consumer-directed individual provider delivering services to the consumer. The agreement shall:
 - (a) Include the rate of reimbursement negotiated with the provider;
 - (b) Specify the time period the rates shall be in effect;
 - (c) Base rates on the units of service as set forth in Chapter 173-39 of the Administrative Code;
 - (d) Be signed by the choices HCBS waiver program participant and the ~~HCAS~~HCBS provider.
 - (3) The rates negotiated by the choices HCBS waiver consumer with providers of services in this paragraph shall not exceed the maximum allowed per unit of service as specified in appendix A to rule 5160-1-06.1 of the Administrative Code. The negotiated rate shall be reviewed by the consumer's case manager and reflected on the consumer's service plan prior to service delivery.
 - (4) Should the consumer choose not to negotiate a rate of reimbursement for any of the services in this paragraph, the service shall be reimbursed at a rate proposed by the provider and accepted by the consumer and the consumer's case manager. The accepted rate shall be reflected on the consumer's service plan.
- (I) The Ohio department of medicaid, or its designee, shall evaluate unit rates within two years of the effective date of this rule and every two years thereafter.

Replaces: 5160-31-07

Effective: 07/01/2014

R.C. 119.032 review dates: 03/01/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 06/20/2014

Promulgated Under: 119.03

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Prior Effective Dates: 9/1/98, 3/1/00, 7/1/06, 7/1/08, 7/1/11 (Emer.), 3/17/11, 9/29/11, 3/1/2014

CHOICES

LTCSSTL 11-13

Effective Date: September 29, 2011

Most Current Prior Effective Date: July 1, 2006

Definitions as used in this chapter:

- (A) "ADL" means activities of daily living including bathing; grooming; toileting; dressing; eating; and mobility that refers to bed mobility, transfer, and locomotion as these are defined in ~~Chapter 5101:3-3~~ rules 5101:3-3-06 and 5101:3-3-08 of the Administrative Code.
- (B) "Agency Provider" means an established business who employs staff to provide choices program services, has a signed medicaid provider agreement with the Ohio department of job and family services (ODJFS) to provide choices program services, and meets the choices conditions of participation set forth in rule 5101:3-32-04 of the Administrative Code.
- (C) "Assessment" ~~means a face-to-face evaluation and interview that is conducted to collect in-depth information about an individual's current situation and ability to function. It is comprehensive and identifies the individual's strengths, problems, and care needs in the major functional areas: physical health, medical care utilization, activities of daily living, instrumental activities of daily living, mental and social functioning, financial resources, physical environment, and utilization of services and support~~ means a face-to-face evaluation used to obtain information about an individual including his or her condition, personal goals and preferences, functional limitations, health status and other factors that are relevant to the authorization and provision of services. Assessment information supports the determination that an individual requires waiver services as well as the development of a service plan.
- (D) "Authorized representative" means a person, eighteen years of age or older, who is chosen by and acts acting on behalf of an individual who is applying for or receiving medical assistance. ~~An authorized representative may be a family member, attorney, hospital social worker, or any other person chosen to act on the individual's behalf.~~ In accordance with rule 5101:1-38-01.2 of the Administrative Code, the individual must provide a written statement naming the authorized representative and the duties that the named authorized representative may perform on the individual's behalf.
- (E) "C.F.R." means the code of federal regulations.
- ~~(E)~~(F) "Caregivers" mean relatives, friends, and/or significant others who voluntarily provide assistance to the consumer and are responsible for the consumer's care on a continuing basis.
- ~~(F)~~(G) "Case management" ~~is a consumer-centered activity provided by the PASSPORT administrative agency (PAA)~~ means a set of person centered activities provided by the PASSPORT administrative agency that are undertaken to ensure that the waiver consumer receives appropriate and necessary services. Under a HCBS waiver, these activities may include, but are not necessarily limited to, assessment, service plan development, service plan implementation and service monitoring as well as assistance in accessing waiver, state plan, and other non-medicaid services and resources.
- ~~(G)~~(H) "CDJFS" means a county department of job and family services.
- ~~(H)~~(I) "Choices" or "choices home and community based services (HCBS) waiver program" means ~~the Ohio~~ an HCBS waiver program which provides home and community-based services including and the opportunity to self-direct certain waiver services ~~direct their own care~~ to individuals age sixty and over; who have the level of care required for placement in a nursing facility if the waiver program were not available; and meet the choices program eligibility and enrollment criteria as described in Chapter 5101:3-32 of the Administrative Code.
- ~~(H)~~(J) "CMS" means the centers for medicare and medicaid services, a federal agency that is part of the United States department of health and human services, and which administers the medicaid program and approves home and community-based services (HCBS) waivers.

- ~~(J)~~(K) "Consumer" means the choices HCBS waiver program participant, and the representative that Consumer includes the individual's legal representative and/or authorized representative, as applicable, who assists in directing the consumer's care.
- ~~(K)~~ "~~Consumers who are at high-risk" means consumers who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time.~~
- ~~(M)~~(L) "Direct service worker" means the paid agency provider staff or individual provider who has in-person contact with the choices consumer while providing choices services.
- (M) "FMS" or "financial management service" is a support provided to waiver participants who direct some or all of their waiver services. In the choices waiver, this support is provided as an administrative activity. When used in conjunction with the self-direction authority available to consumer in choices, this support includes operating a payroll service for participant-employed workers and making required payroll withholdings.
- ~~(M)~~(N) "IADL" means instrumental activities of daily living including shopping; meal preparation; laundry; community access activities that include telephoning, transportation, legal or financial; and environmental maintenance activities that are house cleaning, heavy chores, and yard work or maintenance, as these are defined in rule 5101:3-3-08 of the Administrative Code.
- ~~(N)~~(O) "Individual provider" means a person with a signed medicaid provider agreement with ODJFS to provide choices services, and who meets the choices HCBS waiver program conditions of participation set forth in rule 5101:3-32-04 of the Administrative Code and who is not the spouse, parent, stepparent, and/or legal guardian of the consumer.
- ~~(O)~~(P) "ODA" means the Ohio department of aging.
- ~~(P)~~(Q) "ODJFS" means the Ohio department of job and family services.
- ~~(Q)~~ "~~Plan of care" means the written outline of the consumer's HCBS waiver services, other medicaid services and any other services necessary to prevent institutionalization as developed by the choices consumer and case manager according to the provisions of rule 5101:3-32-03 of the Administrative Code.~~
- (R) "PAA" means ~~the local~~ PASSPORT administrative agency.
- (S) "PASSPORT" means the preadmission screening system providing options and resources today HCBS waiver program authorized in Section [173.40](#) of the Revised Code.
- ~~(T)~~ "~~Payroll agent" means the entity operating under contract with the PAA to facilitate payment of individual providers on behalf of the consumer for the provision of choices services. The payroll agent shall withhold from claims payment, all required federal, state, and local payroll taxes, including workers' compensation, and shall forward payments to relevant entities in compliance with applicable federal, state and local laws and regulations. The payroll agent shall collect all necessary paperwork related to paying the individual provider, and shall provide billing information to the PAA.~~
- (T) "Service Plan" means a written, person centered plan between the consumer, the consumer's case manager at the PAA and, as applicable, the consumer's caregiver(s). The service plan specifies the services that are provided to the consumer, regardless of funding source, to address the consumer's individual care needs as identified in the consumer's assessment.

Effective: 09/29/2011

R.C. 119.032 review dates: 07/14/2011 and 09/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 09/19/2011

Promulgated Under: 119.03

Statutory Authority: 5111.85

Rule Amplifies: 5111.85

Prior Effective Dates: 8/30/01, 7/01/05, 7/01/06

5160-32-03 Eligibility for Enrollment for the Choices Home and Community-Based Services (HCBS) Waiver Program

Formerly 5101:3-32-03 Eligibility for Enrollment for the Choices Home and Community-Based Services (HCBS) Waiver Program

LTCSTL 11-13

Effective Date: September 29, 2011

Most Current Prior Effective Date: October 1, 2007

The following criteria must be met in order for a consumer to be eligible for enrollment:

- (A) The consumer must be age sixty or older at time of enrollment.
- (B) The consumer must have an intermediate or skilled level of care in accordance with rule [5101:3-3-05](#) or rule [5101:3-3-06](#) of the Administrative Code.
- (C) The consumer must be eligible for ~~meet~~ medicaid ~~financial eligibility~~ as determined by the county department of job and family services (CDJFS) in accordance with ~~Chapters 5101:1-37 and 5101:1-39~~ rules [5101:1-38-01.8](#) and [5101:1-38-01.6](#) of the Administrative Code.
- (D) Prior to enrollment in the choices program the consumer must be a current preadmission screening systems providing options and resources today (PASSPORT) program participant.
- (E) The needed services are not readily available through another source at the level required to allow the individual to live in the community.
- (F) The individual's health related needs can be safely met in a home setting as determined by the passport administrative agency (PAA).
- (G) The individual may agrees to participate in choices and shall not be simultaneously enrolled in another home and community based medicaid waiver, residential state supplement (RSS), or the program of all inclusive care for the elderly (PACE)_while enrolled in choices.
- (H) While receiving choices program services, the consumer must shall reside in the service area defined in the approved 1915(c) waiver for the choices program. ~~The consumer shall not reside in any of the following living arrangements while enrolled in the choices program:~~
 - ~~(1) Adult foster home certified under section 173.36 of the Revised Code;~~
 - ~~(2) Adult family homes or adult group homes as defined in section 3722.01 of the Revised Code that is licensed as an adult care facility under section 3722.04 of the Revised Code;~~
 - ~~(3) Residential care facility as defined in section 3721.02 of the Revised Code;~~
 - ~~(4) Community alternative home as defined in section 3724.01 of the Revised Code that is licensed under section 3724.03 of the Revised Code;~~
 - ~~(5) Residential facility of the type defined in division (A)(1)(d)(ii) of section 5119.22 of the Revised Code that is licensed by the Ohio department of mental health;~~
 - ~~(6) An apartment or room that is used to provide community mental health housing services, is certified by the Ohio department of mental health under division (M) of section 5119.61 of the Revised Code, and is approved by a board of alcohol, drug addiction, and mental health services in accordance with division (A)(13) of section 340.03 of the Revised Code;~~
 - ~~(7) Hospital or nursing facility (NF) as defined in rule 5101:3-31-02 of the Administrative Code;~~
 - ~~(8) "Keys amendment facility" as defined in section 1616(e) of the Social Security Act; or~~
 - ~~(9) Any other facility that is licensed and/or certified by any state or local government.~~
- (I) The consumer shall not reside in any of the following living arrangements while enrolled in the choices program:
 - (1) Adult foster home certified under section [5119.362](#) of the Revised Code;

- (2) Adult family homes or adult group homes as defined in section 3722.01 of the Revised Code that is licensed as an adult care facility under section 3722.04 of the Revised Code;
- (3) Residential care facility as defined in section 3721.02 of the Revised Code;
- (4) Community alternative home as defined in section 3724.01 of the Revised Code that is licensed under section 3724.03 of the Revised Code;
- (5) Residential facility of the type defined in division (A)(1)(d)(ii) of section 5119.22 of the Revised Code that is licensed by the Ohio department of mental health (ODMH);
- (6) An apartment or room that is used to provide community mental health housing services, is certified by the ODMH under division (M) of section 5119.611 of the Revised Code, and is approved by a board of alcohol, drug addiction, and mental health services in accordance with division (A)(14) of section 340.03 of the Revised Code;
- (7) Hospital or nursing facility (NF) as defined in rule 5101:3-31-02 of the Administrative Code;
- (8) "Keys amendment facility" as defined in section 1616(e) of the Social Security Act; or
- (9) Any other facility that is licensed and/or certified by any state or local government.

(H)(J) The consumer or the consumer's authorized representative must be willing and capable of directing provider activities. ~~Capability~~ The consumer's capability to self-direct their services is ~~must be~~ demonstrated through a consumer certification process conducted by the (PAA) PAA. To obtain certification, the consumer or his or her designee must meet all of the following:

- (1) Attend all required ~~training~~ trainings;
- (2) Demonstrate all skills necessary to supervise direct service workers, including but not limited to:
 - (a) An understanding of what service activities are covered that the consumer may self-direct and ~~the corresponding~~ provider requirements; including criminal records check requirements; and
 - (b) Methods for selecting and dismissing providers; and
 - (c) Methods for entering into written agreements with providers for specific activities and corresponding payment rates; and
 - (d) Methods for training providers to meet the consumer's specific needs; and
 - (e) Methods for supervising and monitoring providers' performance of specific activities, including written approval of provider time sheets and billing invoices; and
 - (f) Development of a reliable service delivery back-up plan for situations in which a provider is unable to deliver the agreed-upon service(s); and
 - (g) Methods for lodging complaints, including use of the regional and state long term care ombudsman, and familiarity with the state's Ohio department of aging (ODA) ombudsman long term care complaint line; and
 - (h) Familiarity with state appeal and fair hearing request procedures; and
 - (i) Record keeping and ability to manage service delivery.
- (3) Agree to actively participate with the case manager in the development, monitoring and revision of the service plan.
- (4) Agree to inform the case manager of negotiated rates prior to delivery of choices services. ODA and/or the PAA retains the authority to approve negotiated rates.
- (5) The consumer must use the financial management service (FMS) ~~a payroll agent under contract with the PAA~~ to process all consumer-directed individual ~~service~~ provider claims.

(J)(K) If, at any time, the individual or consumer fails or ceases to meet any of the eligibility criteria identified in this rule, ~~the individual or consumer~~ he or she shall be denied or disenrolled from choices. In such

instances, ~~the individual or consumer~~ he or she shall be notified by the CDJFS and entitled to hearing rights in accordance with rules contained in Chapters 5101:6-1 to 5101:6-9 of the Administrative Code.

~~(K)~~(L) The choices program has not reached the center for medicaid and medicare services (CMS) authorized limit of participants for the current year.

~~(L)~~(M) ~~The cost of the twelve-month service plan does not exceed the cost cap. The "cost cap" is a dollar amount adjusted for inflation equal to sixty per cent of the total medicaid cost including consumer copayment for nursing facility services for the most recent state fiscal year for which data is available as set forth in rule 5101:3-31-03 of the Administrative Code~~ The waiver service cost of the twelve-month service plan does not exceed the individual cost limit. The individual cost limit is calculated by ODA at least biennially. The cost limit is the dollar amount equal to sixty per cent of the total medicaid cost for NF services. The total medicaid cost for NF services is obtained by multiplying the average annual medicaid NF per diem rate by the number of days in the most recent state fiscal year in which data is available.

(1) If the PAA determines that the applicant's needs cannot be met within the cost limit the individual shall not be enrolled; however if a consumer who is enrolled on the waiver and receiving choices services experiences a change in his or her condition that causes the cost of care to exceed the cost limit, the consumer may remain on the waiver at a higher cost, not to exceed one hundred per cent of the total medicaid cost for NF services to avoid service disruption to the consumer if the PAA grants approval to do so.

(2) If the consumer's needs exceed one hundred per cent of the total medicaid cost of NF services, the consumer shall be disenrolled from the waiver.

~~(M)~~(N) Prior to choices enrollment the individual's attending physician must approve that the services contained in the individual's service plan are appropriate to meet the individual's needs. The approval may be ~~given~~ either verbal or written; however if the approval is verbal, written approval of the service plan must be obtained within this timeframe, the individual shall be deemed to have not met the eligibility criteria set forth in this rule and be disenrolled ~~in accordance with~~ from the choices waiver pursuant to paragraph ~~(J)~~ (K) of this rule.

Effective: 09/29/2011

R.C. 119.032 review dates: 07/14/2011 and 09/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 09/19/2011

Promulgated Under: 119.03

Statutory Authority: 5111.85

Rule Amplifies: 5111.85

Prior Effective Dates: 8/30/01, 7/01/05, 7/01/06, 10/01/07

5160-32-04 Provider Conditions of Participation for the Choices Home and Community Based Services (HCBS) Waiver Program

***Formerly* 5101:3-32-04 Provider Conditions of Participation for the Choices Home and Community Based Services (HCBS) Waiver Program**

LTCSSSTL 11-13

Effective Date: September 29, 2011

Most Current Prior Effective Date: July 1, 2007

- (A) The purpose of this rule is to establish the conditions of participation under which providers are able to participate in the choices ~~home and community based services (HCBS)~~ HCBS waiver program.
- (B) In order to obtain a medicaid provider agreement to be a choices provider, the provider must be certified by the Ohio department of aging (ODA) or its designee in accordance with the provisions of Chapter 173-39 of the Administrative Code.
- (1) The provider may be certified as either:
- (a) An ODA certified long-term care agency providers in accordance with the provisions of rule ~~173-39-02~~ 173-39-03 of the Administrative Code, or
- (b) An ODA certified long-term care non-agency provider in accordance with the provisions of rule ~~173-39-02~~ 173-39-03 of the Administrative Code, or
- (c) An ODA certified consumer-directed individual provider in accordance with the provisions of rule ~~173-39-02~~ 173-39-03 of the Administrative Code.
- (C) Individuals enrolled in the choices HCBS waiver shall be given a free choice of qualified providers ~~in accordance with Chapter 5101:3-41 of the Administrative Code~~ as set forth in 42 C.F.R. 431.51 (as in effect on October 1, 2010).

Effective: 09/29/2011

R.C. 119.032 review dates: 07/14/2011 and 09/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 09/19/2011

Promulgated Under: 119.03

Statutory Authority: 5111.85

Rule Amplifies: 5111.85

Prior Effective Dates: 8/30/01, 7/01/05, 7/01/06, 7/01/07

[LTCSTL 11-13](#)

Effective Date: September 29, 2011

Most Current Prior Effective Date: [July 1, 2006](#)

- (A) The purpose of this rule is to establish services covered by the choices ~~home and community based services (HCBS)~~ HCBS waiver program.
- (B) The Ohio department of aging (ODA) is responsible for the daily ~~administration~~ operation of the choices HCBS waiver. ODA will ~~administer~~ operate this waiver pursuant to an interagency agreement with the Ohio department of job and family services (ODJFS), in accordance with sections [5111.91](#) and [5111.851](#) of the Revised Code.
- (C) The choices HCBS waiver program benefit package is limited to the following services:
- (1) Home care attendant services as set forth in rule [173-39-02.4](#) of the Administrative Code;
 - (2) Minor home modification, maintenance and repair services as set forth in rule [173-39-02.9](#) of the Administrative Code;
 - (3) Alternative meal services as set forth in rule [173-39-02.2](#) of the Administrative Code;
 - (4) Home delivered meal services as set forth in rule [173-39-02.14](#) of the Administrative Code;
 - (5) Emergency response systems services as set forth in rule [173-39-02.6](#) of the Administrative Code;
 - (6) Home medical equipment and supplies services as set forth in rule [173-39-02.7](#) of the Administrative Code;
 - (7) Adult day services as set forth in rule [173-39-02.1](#) of the Administrative Code; and
 - (8) Pest control services as set forth in rule [173-39-02.3](#) of the Administrative Code.
- (D) Services will be delivered consistent with the consumer service plan ~~as documented in the PASSPORT information management system (PIMS)~~.

Effective: 09/29/2011

R.C. 119.032 review dates: 07/14/2011 and 09/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 09/19/2011

Promulgated Under: 119.03

Statutory Authority: 5111.85

Rule Amplifies: 5111.85

Prior Effective Dates: 8/30/01, 7/01/05, 07/01/06

5160-32-06 Enrollment Process for Choices Home and Community Based Services (HCBS) Waiver Program

***Formerly* 5101:3-32-06 Enrollment Process for Choices Home and Community Based Services (HCBS) Waiver Program**

LTCSTL 14-02

Effective Date: March 1, 2014

Most Current Prior Effective Date: September 29, 2011

The current effective choices waiver is set to expire on June 30, 2014. Therefore, in accordance with Section 173.53 of the Revised Code, enrollment in the Choices waiver is suspended effective March 1, 2014. This suspension shall remain in effect until the choices waiver is terminated.

- (A) The purpose of this rule is to establish the standards and procedures for an individual to enroll in the choices HCBS waiver program.
- (B) An individual must be currently enrolled in the PASSPORT HCBS waiver program as described in Chapter 5101:3-31 of the Administrative Code to begin the choices waiver program enrollment process. The individual, a family member or case manager may initiate the choices enrollment process by contacting choices HCBS waiver program staff to request enrollment.
- (C) An individual who is seeking enrollment in the choices HCBS waiver program must meet the program eligibility requirements as described in rule 5101:3-32-03 of the Administrative Code prior to enrollment.
- (D) Any applicant for choices HCBS waiver program services is entitled to notice and hearing rights as set forth in section 5101.35 of the Revised Code and division 5101:6 of the Administrative Code.
 - (1) The PASSPORT administrative agency (PAA) must notify the individual and authorized representative, if any, of the approval for enrollment for an individual determined to meet all choices HCBS waiver program eligibility criteria.
 - (2) If the PAA determines that the individual does not meet the criteria for enrollment in the choices HCBS waiver program, the PAA shall notify the county department of job and family services (CDJFS). The CDJFS shall send notice of the waiver application denial to the individual and his or her authorized representative, if any.
 - (3) If the CDJFS determines the individual is not eligible for medicaid, the CDJFS shall send notice of denial to the individual and his or her authorized representative, if any, and notify the PAA of its determination.
- (E) If an individual meets all of the eligibility criteria in rule 5101:3-32-03 of the Administrative Code, but a slot is not available for enrollment in the choices waiver program, the individual shall be placed on a waiting list and offered enrollment in accordance with Chapter 173-44 of the Administrative Code.

Effective: 03/01/2014

R.C. 119.032 review dates: 11/29/2013 and 03/01/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 02/07/2014

Promulgated Under: 119.03

Statutory Authority: 5166.02

Rule Amplifies: 5166.02, 173.53

Prior Effective Dates: 8/30/01, 7/01/05, 7/01/06, 9/29/11

LTCSSTL 11-12

Effective Date: September 29, 2011

Most Current Prior Effective Date: July 1, 2011

- (A) ~~Subject to the limits set forth in rule 5101:3-1-06.4 of the Administrative Code, consumers negotiate rates with providers whereby expenditures may not exceed the authorized amounts identified in the service plan.~~ The purpose of this rule is to establish how the rates of reimbursement are set for choices HCBS waiver program services.
- (B) Choices HCBS waiver program providers must be long-term care providers certified by the Ohio department of aging (ODA) with an effective medicaid provider agreement in place before service delivery is initiated.
- ~~(B)(C) Consumers shall enrolled in the choices HCBS waiver and may negotiate reimbursement rates with ODA-certified long-term care providers for certain choices HCBS waiver program covered services as specified in rule 5101:3-32-05 of the Administrative Code, except for the enhanced level and the intensive level of adult day services, as defined in rule 173-39-02.1 of the Administrative Code as these are set forth in appendix A to rule 5101:3-1-06.4 of the Administrative Code.~~
- (1) Consumers enrolled in the choices HCBS waiver may negotiate rates for the following services specified in rule **5101:3-32-05** of the Administrative Code:
- (a) Home care attendant service (HCAS);
 - (b) Alternative meals;
 - (c) Home medical equipment and supplies;
 - (d) Pest control; and
 - (e) Minor home modification, maintenance, and repair services.
- (2) The consumer shall have in effect, before HCAS services are delivered, a signed agreement with each ODA-certified consumer-directed individual provider delivering HCAS services to the consumer. The agreement shall:
- (a) Include the rate of reimbursement negotiated with the provider;
 - (b) Specify the time period the rates shall be in effect;
 - (c) Base rates on the units of service as set forth in Chapter 173-39 of the Administrative Code;
 - (d) Be signed by the choices HCBS waiver program participant and the HCAS provider.
- (3) The rates negotiated by the choices HCBS waiver consumer with providers of services in paragraph (C) of this rule shall not exceed the maximum allowed per unit of service as specified in **appendix A** to rule **5101:3-1-06.4** of the Administrative Code. The negotiated rate shall be reviewed by the consumer's case manager and reflected on the consumer's service plan prior to service delivery.
- (4) Should the consumer choose not to negotiate a rate of reimbursement for any of the services in paragraph (C) of this rule, the service shall be reimbursed at a rate proposed by the provider and accepted by the consumer and the consumer's case manager. The accepted rate shall be reflected on the consumer's service plan and shall not exceed the maximum allowed per unit of service as specified in appendix A to rule 5101:3-1-06.4 of the Administrative Code.
- ~~(C)(D) The consumer shall contract for the services specified in the service plan with providers who have a signed medicaid provider agreement with ODJFS to provide choices HCBS waiver program covered services, who meet the requirements set forth in rules 5101:3-32-02 and 501:3-32-04 of the~~

~~Administrative Code to provide the specified service in the region for which the rate will be negotiated.~~ ODA certified long-term care providers shall be reimbursed in accordance with an agreement signed between the provider and the PASSPORT administrative agency (PAA) for the following services:

- ~~(1) The consumer shall:~~
- ~~(a) Specify the time period for which the rates shall be in effect;~~
 - ~~(b) Base rates on the units of service as set forth in rule 173-39-02 of the Administrative Code.~~
- ~~(2) The rates shall not exceed the cost cap as specified in paragraph (H) of rule 5101:3-32-03 of the Administrative Code nor the maximum allowed per service as specified in appendix A to rule 5101:3-1-06.4 of the Administrative Code.~~

- (1) Adult day health;
- (2) Home delivered meals;
- (3) Personal emergency response system; and
- (4) Home medical equipment and supplies.

The reimbursement rates contained in the agreement shall be set in accordance with rule 5101:3-31-07 of the Administrative Code. The rate shall be reflected on the consumer's service plan and shall not exceed the maximum allowed per unit of service as specified in appendix A to rule 5101:3-1-06.4 of the Administrative Code.

~~(D)~~(E) Payment for choices HCBS wavier covered services constitutes payment in-full and may not be construed as a partial payment when the payment amount is less than the provider's usual and customary charge. The provider may not bill the consumer for any difference between the medicaid payment and the provider's charge or request the recipient to share in the cost through a co-payment or other similar charge. The provider shall accept medicaid payment as payment in full.

Effective: 09/29/2011

R.C. 119.032 review dates: 07/14/2011 and 09/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 09/19/2011

Promulgated Under: 119.03

Statutory Authority: 5111.85

Rule Amplifies: 5111.85, 173.403

Prior Effective Dates: 8/30/01, 7/1/05, 7/1/11 (Emer.)

Effective Date: July 1, 2005

- (A) Subject to the limits set forth in rule ~~5101:3-1-06~~ 5101:3-1-06.4 of the Administrative Code, consumers negotiate rates with providers whereby expenditures may not exceed the authorized amounts identified in the service plan.
- (B) Consumers shall negotiate rates for the following categories:
- (1) Home care attendant service as set forth in paragraph (A) of rule 5101:3-32-05 of the Administrative Code; and
 - (2) Environmental accessibility adaptations as set forth in paragraph (B) of rule 5101:3-32-05 of the Administrative Code; and
 - (3) Alternative meals service as set forth in paragraph (C) of rule 5101:3-32-05 of the Administrative Code; and
 - (4) Home delivered meal services as set forth in paragraph (D) of rule 5101:3-32-05 of the Administrative Code; and
 - (5) Personal emergency response systems as set forth in paragraph (E) of rule 5101:3-32-05 of the Administrative Code; and
 - (6) Specialized medical equipment and supplies as set forth in paragraph (F) of rule 5101:3-32-05 of the Administrative Code; and
 - (7) Center-based adult day service as set forth in paragraph (G) of rule 5101:3-32-05 of the Administrative Code; and
 - (8) Pest control services as set forth in paragraph (H) of rule 5101:3-32-05 of the Administrative Code.
- (C) The consumer shall contract for the services specified in paragraph (B) of this rule with providers who have a signed medicaid provider agreement with ODJFS to provide **Choices** choices services, and who meet the requirements set forth in rules 5101:3-32-02 and 5101:3-32-04 of the Administrative Code to provide the specified service in the region for which the rate will be negotiated.
- (1) The consumer shall:
 - (a) Specify the time period for which the rates shall be in effect;
 - (b) Base rates on the units of service as set forth in rule 5101:3-32-05 of the Administrative Code.
 - (2) The rates shall not exceed the cost cap as specified in paragraph (H) of rule 5101:3-32-03 of the Administrative Code nor the maximum allowed amount per service as specified in Appendix A of rule 5101:3-1-06.4 of the Administrative Code.
- (D) Choices service payment constitutes payment in-full and may not be construed as a partial payment when the payment amount is less than the provider's usual and customary charge. The provider may not bill the recipient for any difference between the medicaid payment and the provider's charge or request the recipient to share in the cost through a co-payment or other similar charge. The provider shall ~~consider~~ accept medicaid payment as payment in full.

Effective: July 1, 2005

R.C. 119.032 review dates: 04/15/2005

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 173.40, 5111.02

Rule Amplifies: 173.40, 5111.01, 5111.02

Prior Effective Dates: 5101:3-1-06.4 (Emer.), 1/1/04, 5101:3-32-02 (Emer.), 8/30/01, 5101:3-32-03 (Emer.), 8/30/01, 5101:3-32-04 (Emer.), 8/30/01, 5101:3-32-05 (Emer.), 8/30/01, 5101:3-32-06 (Emer.), 8/30/01, 5101:3-32-07 (Emer.), 8/30/01. 5101:3-32-08 (Emer.), 8/30/01

LTCSSTL 11-13

Effective Date: September 29, 2011

Most Current Prior Effective Date: December 31, 2009

- (A) The purpose of this rule is to define the terms used in Chapter 5101:3-33 of the Administrative Code governing the medicaid assisted living HCBS waiver program.
As used in this chapter:
- (B) "ADL" means activities of daily living including bathing; grooming; toileting; dressing; eating; and mobility, which refers to bed mobility, transfer, and locomotion as these are defined in Chapter 5101:3-3 of the Administrative Code.
- (C) ~~"Assessment" means a face-to-face evaluation and interview that is conducted by the preadmission screening system providing options and resources today (PASSPORT) administrative agency (PAA) to collect in-depth information about an individual's current situation and ability to function. It is comprehensive and identifies the individual's strengths, problems, and care needs in the major functional areas: physical health, medical care utilization, activities of daily living, instrumental activities of daily living, mental and social functioning, financial resources, physical environment, and utilization of services and support~~ means a face-to-face evaluation used to obtain information about an individual including his or her condition, personal goals and preferences, functional limitations, health status and other factors that are relevant to the authorization and provision of services. Assessment information supports the determination that an individual requires waiver services as well as the development of a service plan.
- (D) "Assisted living HCBS waiver" means the medicaid program that serves individuals residing in ~~certified~~ licensed residential care facilities that are certified by ODA and enrolled on the waiver who would otherwise receive services in a nursing facility if the waiver program were not available.
- (E) "Authorized representative" means a person, ~~eighteen years of age or older, who is chosen by and acts acting~~ on behalf of an individual who is applying for or receiving medical assistance. ~~An authorized representative may be a family member, attorney, hospital social worker, or any other person chosen to act on the individual's behalf.~~ In accordance with rule 5101:1-38-01.2 of the Administrative Code, the individual must provide a written statement naming the authorized representative and the duties that the named authorized representative may perform on the individual's behalf.
- (F) "CDJFS" means a county department of job and family services.
- (G) "C.F.R." means the code of federal regulations.
- ~~(G)~~(H) "CMS" means the centers for medicare and medicaid services, a federal agency that is part of the United States department of health and human services, and that administers the medicaid program and approves ~~home and community based services (HCBS)~~ HCBS waivers.
- (I) "Case management" means a set of person centered activities provided by the PASSPORT administrative agency that are undertaken to ensure that the waiver consumer receives appropriate and necessary services. Under a HCBS waiver, these activities may include, but are not necessarily limited to, assessment, service plan development, service plan implementation and service monitoring as well as assistance in accessing waiver, state plan, and other non-medicaid services and resources.
- (J) "Certified" or "certification" means providers certified by the Ohio department of aging (ODA) to provide services for assisted living HCBS waiver consumers pursuant to Chapter 173-39 of the Administrative Code.
- ~~(H)~~(K) "Consumer" means the program participant and the representative who assists in directing the consumer's care.

- ~~(H)~~(L) "HCBS" or "home and community-based services" means services furnished under the provisions set forth in 42 ~~C.F.R.~~ 441 Subpart G (~~October 1, 2005~~)(October 1, 2009) that permit individuals to live in a home setting rather than a nursing facility (NF) or hospital. HCBS waiver services are approved by CMS for specific populations and are not otherwise available under the medicaid state plan.
- (M) "Home first" means the component of the assisted living HCBS waiver program that offers priority enrollment in the waiver for certain individuals in accordance with section 5111.894 of the Revised Code.
- ~~(J)~~(N) "Level of care" (LOC) means the designation describing an individual's functional levels and nursing needs pursuant to the criteria set forth in rules [5101:3-3-05](#), [5101:3-3-06](#), [5101:3-3-07](#) and [5101:3-3-08](#) of the Administrative Code.
- ~~(K)~~(O) "NF" means a nursing facility as defined in section [5111.20](#) of the Revised Code.
- ~~(L)~~(P) "ODA" means the Ohio department of aging.
- ~~(M)~~(Q) "ODJFS" means the Ohio department of job and family services.
- ~~(N)~~(R) "PASSPORT" means preadmission screening system providing options and resources today.
- ~~(O)~~(S) "PAA" means PASSPORT administrative agency.
- ~~(P)~~ ~~"Plan of care" means the written outline of the consumer's HCBS waiver services, other medicaid services and any other services necessary to prevent institutionalization as developed by the consumer and case manager.~~
- ~~(Q)~~(T) "Residential care facility" means a residential care facility as defined in section [3721.01](#) of the Revised Code that is issued a license pursuant to section [3721.02](#) of the Revised Code.
- ~~(R)~~(U) "Room and board" means a payment made by a consumer enrolled in the assisted living waiver directly to the ODA certified assisted living waiver provider. When paying "room" the consumer shall not be charged for the same furnishings and other shelter expenses the residential care facility provides at no cost to private pay non-waiver residents pursuant to the facility's resident agreement. The term "board" means three meals a day or any other full nutritional regimen.
- Room and board does not include charges for ancillary items, services, and/or social activities purchased or paid for by the consumer including hygiene and supplies not provided through medicaid and reflected on the consumer's care plan, recreation and activities, and/or other items or services purchased by the consumer; however ODA certified assisted living providers may, at their own discretion, provide ancillary items, services and/or social activities as part of the room and board payment.
- (V) "Service Plan" means a written, person centered plan between the consumer, the consumer's case manager at the PAA and, as applicable, the consumer's caregiver(s). The service plan specifies the services that are provided to the consumer, regardless of funding source, to address the consumer's individual care needs as identified in the consumer's assessment.

Effective: 09/29/2011

R.C. 119.032 review dates: 07/14/2011 and 09/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 09/19/2011

Promulgated Under: 119.03

Statutory Authority: 5111.85, 5111.89

Rule Amplifies: 5111.85, 5111.89

Prior Effective Dates: 7/01/06/ 12/31/09

LTCSTL 11-13

Effective Date: September 29, 2011

Most Current Prior Effective Date: September 19, 2009

- (A) The purpose of this rule is to outline the criteria that must be met for an individual to be eligible to enroll in the assisted living ~~home and community based services (HCBS)~~ HCBS waiver.
- (B) To be eligible for the assisted living program, an individual must meet all of the following requirements:
- (1) The individual must have an intermediate or skilled level of care in accordance with rule 5101:3-3-05 or 5101:3-3-06 of the Administrative Code.
 - (2) If the individual requires skilled nursing care beyond supervision of special diets, application of dressings, or administration of medication, it must ~~only be required on a part-time, intermittent basis provided in accordance with rule 3701-17-59.1 of the Administrative Code for not more than a total of one hundred twenty days in any twelve month period. A part-time, intermittent basis means that skilled nursing care is needed for less than eight hours a day or less than forty hours a week.~~
 - ~~(3) At the time the individual applies for the assisted living program, be one of the following:~~
 - ~~(a) A nursing facility resident who is seeking to move to a residential care facility and would remain in the nursing facility for long term care if not for the assisted living HCBS waiver; or~~
 - ~~(b) A participant who is currently enrolled in any of the following medicaid waivers who would move to a nursing facility if not for the assisted living HCBS waiver:~~
 - ~~(i) The preadmission screening system providing options and resources today (PASSPORT) HCBS waiver as set forth in Chapter 5101:3-31 of the Administrative Code that the Ohio department of aging administers; or~~
 - ~~(ii) The choices HCBS waiver as set forth in Chapter 5101:3-32 of the Administrative Code that the Ohio department of aging administers; or~~
 - ~~(iii) The Ohio home care HCBS waiver as set forth in Chapter 5101:3-12 of the Administrative Code that the Ohio department of job and family services administers; or~~
 - ~~(iv) The transitions carve-out waiver as set forth in Chapter 5101:3-50 of the Administrative Code that the Ohio department of job and family services administers.~~
 - ~~(c) A resident of a residential care facility (RCF) who has resided in the RCF for at least six months immediately before the date the individual applies for the assisted living HCBS waiver.~~
 - ~~(4)~~(3) At the time of enrollment, and while receiving assisted living HCBS services, the individual must reside in a residential care facility (RCF) certified by the Ohio department of aging ODA ~~(ODA)~~, including:
 - (a) A residential care facility that is owned or operated by a metropolitan housing authority that has a contract with the United States department of housing and urban development to receive an operating subsidy or rental assistance for the residents of the facility;
 - (b) A county or district home licensed as a residential care facility.

- ~~(5)~~(4) The consumer must ~~meet~~ be eligible for medicaid ~~financial eligibility~~ as determined by the county department of job and family services (CDJFS) in accordance with ~~Chapters 5101:1-37 and 5101:1-39~~ rules 5101:1-38-01.8 and 5101:1-38-01.6 of the Administrative Code.
- ~~(6)~~(5) The cost of the twelve-month service plan does not exceed the cost ~~cap~~ limit in effect for the program that is based on the maximum per-diem rate for assisted living services plus the maximum amount authorized for community transition services.
- ~~(7)~~(6) The individual must have the ability to make room and board payments calculated at the current supplemental security income (SSI) federal benefit level minus fifty dollars.
- ~~(8)~~(7) The individual is age twenty-one or older at the time of enrollment.
- ~~(9)~~(8) The assisted living HCBS waiver has not reached the centers for medicare and medicaid services (CMS) authorized limit of participants for the current year.
- ~~(10)~~(9) The individual's health related needs, as determined by the PASSPORT administrative agency, can be safely met in ~~an~~ a RCF as described in paragraph ~~(B)(4)~~ (B)(3) of this rule.
- (C) Providers shall not charge or collect room and board payments from consumers ~~for room and board any amount~~ in excess of the room and board payment calculated in paragraph ~~(B)(7)~~ (B)(6) of this rule.
- (D) If, at any time, the individual or consumer fails or ceases to meet any of the eligibility criteria identified in this rule, the individual or consumer shall be denied or disenrolled from the assisted living HCBS waiver. In such instances, the individual or consumer shall be notified by the CDJFS and entitled to hearing rights in accordance with Chapters 5101:6-1 to 5101:6-9 of the Administrative Code.
- (E) An individual who has been enrolled in the assisted living HCBS waiver may subsequently be enrolled in hospice, however, an individual who is ~~first~~ enrolled in hospice and is not currently enrolled in a HCBS waiver ~~specified in paragraph (A)(2)(b) of this rule~~ is not subsequently eligible for assisted living HCBS enrollment.

Effective: 09/29/2011

R.C. 119.032 review dates: 07/14/2011 and 09/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 09/19/2011

Promulgated Under: 119.03

Statutory Authority: 5111.85, 5111.89

Rule Amplifies: 5111.85, 5111.89

Prior Effective Dates: 7/1/06, 3/22/08, 9/19/09

~~*Formerly*~~ 5101:3-33-04 Enrollment Process for Assisted Living Home and Community Based Services (HCBS) Waiver Program

LTCSSTL 11-13

Effective Date: September 29, 2011

Most Current Prior Effective Date: September 19, 2009

- ~~(A) In order to be enrolled in the assisted living HCBS waiver, individuals must be receiving medical assistance either in a nursing facility or be enrolled in the preadmission screening system providing options and resources today (PASSPORT) HCBS waiver or the choices HCBS waiver or the Ohio home care HCBS waiver or the "Transitions Carve Out" HCBS waiver or be a resident of a residential care facility (RCF), who has resided in an RCF for at least six months immediately before the date the individual applies for the assisted living HCBS waiver.~~
- ~~(B)~~(A) Individuals who wish to enroll in the assisted living HCBS waiver must have an eligibility determination made by the county department of job and family services (CDJFS) and an assessment of assisted living HCBS waiver eligibility made by the PASSPORT ~~administering~~ administrative agency (PAA). The individual may contact either the CDJFS or the PAA to start the enrollment process, and the two agencies shall coordinate processing the request for enrollment into the assisted living ~~services~~ HCBS waiver program:
- (1) Individuals initially contacting the CDJFS will complete the JFS 07200 "Request for Cash, Food Stamps, and Medical Assistance" ~~(rev. 10/06)~~(rev. 03/10) and the JFS 02399 "Request for Medicaid Home and Community Based Services" ~~(rev. 6/04)~~(rev. 01/06) in accordance with ~~rule~~rules 5101:1-38-01.2 and 5101:1-38-01.6 of the Administrative Code. The CDJFS ~~will~~shall notify the PAA of the individual's application for waiver services. The PAA ~~will~~shall initiate contact with the individual to complete the enrollment process.
 - (2) Individuals initially contacting the PAA will receive an in-person assessment to determine eligibility for the assisted living HCBS waiver program. If the individual has not already initiated an application for medicaid or waiver eligibility as described in paragraph ~~(C)(1)~~ (A)(1) of this rule, the PAA may assist the individual.
- (B) If the individual has been determined eligible and a waiver slot is available, the consumer shall be enrolled in accordance with the assisted living HCBS waiver's home first component, if applicable, and rule 173-38-03 of the Administrative Code.
- ~~(C) Using the procedures outlined in rule 173-38-03 of the Administrative Code, the PAA shall offer enrollment to the individual if the individual has been determined eligible and a waiver slot is available. If a waiting list is employed, waiver slots shall be made available in accordance with rule 173-38-03 of the Administrative Code.~~
- ~~(D) The PAA shall make the determination of assisted living HCBS waiver eligibility for the individual using the criteria set forth in rule 5101:3-33-03 of the Administrative Code. The PAA shall notify the CDJFS of the results of the assisted living HCBS waiver eligibility determination.~~
- ~~(E)~~(C) Pursuant to rule 5101:1-38-01.6 of the Administrative Code, if a consumer is determined eligible for medicaid by the CDJFS, the consumer shall not enroll in the assisted living HCBS waiver program until the PAA establishes a waiver program enrollment date and authorizes the provision of waiver services by an ODA certified RCF. ~~The assisted living services HCBS waiver program enrollment date cannot be made retroactive, nor can the enrollment date be established to authorize assisted living waiver program services retroactively.~~ The waiver program enrollment date shall in no way restrict retroactive eligibility for non-assisted living waiver services available to consumers through the medicaid state plan.
- ~~(F)~~(D) Any applicant for assisted living services HCBS waiver program services is entitled to notice and hearing rights as set forth in section 5101.35 of the Revised Code and division 5101:6 of the Administrative Code.

Effective: 09/29/2011

R.C. 119.032 review dates: 07/14/2011 and 09/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 09/19/2011

Promulgated Under: 119.03

Statutory Authority: 5111.85, 5111.89

Rule Amplifies: 5111.85, 5111.89

Prior Effective Dates: 7/01/06, 3/22/08, 9/19/09

5160-33-05 Provider Conditions of Participation for the Assisted Living Home and Community Based Services (HCBS) Waiver Program

***Formerly* 5101:3-33-05 Provider Conditions of Participation for the Assisted Living Home and Community Based Services (HCBS) Waiver Program**

LTCSTL 11-13

Effective Date: September 29, 2011

Most Current Prior Effective Date: July 1, 2006

- (A) The purpose of this ~~rules~~ rule is to establish the conditions under which providers are able to participate in the assisted living ~~home and community based services (HCBS)~~ HCBS waiver program.
- (B) In order to obtain a medicaid provider agreement to be an assisted living services provider, the provider must be certified by the Ohio department of aging (ODA) or its designee in accordance with the provisions of rule ~~173-39-02~~ 173-39-03 of the Administrative Code.
- (C) Individuals enrolled in the assisted living HCBS waiver shall be given a free choice of qualified providers in accordance with ~~Chapter 5101:3-41~~ rule 173-42-06 of the Administrative Code and 42 C.F.R. 431.51 (as in effect on October 1, 2010).

Effective: 09/29/2011

R.C. 119.032 review dates: 07/14/2011 and 09/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 09/19/2011

Promulgated Under: 119.03

Statutory Authority: 5111.85, 5111.89

Rule Amplifies: 5111.85, 5111.89

Prior Effective Dates: 7/1/06

~~*Formerly*~~ 5101:3-33-06 Covered Services for the Assisted Living Home and Community Based Services (HCBS) Waiver Program

LTCSTL 11-13

Effective Date: September 29, 2011

Most Current Prior Effective Date: July 1, 2006

- (A) The purpose of this rule is to establish the services covered by the assisted living ~~home and community based services (HCBS)~~ HCBS waiver program.
- (B) The assisted living HCBS waiver benefit package is limited to the following services:
 - (1) Assisted living services as defined in rule 173-39-02.16 of the Administrative Code, and
 - (2) Community transition services as defined in rule 173-39-02.17 of the Administrative Code.
- (C) Services will be delivered consistent with the ~~consumer plan of care~~ consumer's service plan ~~as documented in the preadmission screening system providing options and resources today (PASSPORT) information management system (PIMS).~~

Effective: 09/29/2011

R.C. 119.032 review dates: 07/14/2011 and 09/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 09/19/2011

Promulgated Under: 119.03

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Rule Amplifies: 5111.85, 5111.89

Prior Effective Dates: 7/1/06

LTCSTL 11-13

Effective Date: September 29, 2011

Most Current Prior Effective Date: September 19, 2009

- (A) The purpose of this rule is to describe the methods used to determine provider rates for the assisted living ~~home and community based services (HCBS)~~ HCBS waiver as set forth in ~~rule 5101:3-1-06~~ appendix A to rule 5101:3-1-06.5 of the Administrative Code. ~~for the following categories:~~
- ~~(1) Per job bid rate or deposit made.~~
 - ~~(2)(1) Unit rate.~~
- (B) Provider rates will be determined for the following categories:
- (1) Per job bid rate or deposit made.
 - (2) Unit rate.
- ~~(B)~~(C) A per job bid rate or deposit made shall be determined on a per job basis for the community transition service as set forth in rule 173-39-02.17 of the Administrative Code. The cost per job shall be reimbursed at a per job bid rate that is negotiated and approved by Ohio department of aging's (ODA) designee and accepted by the consumer. The per job bid rate includes the cost of the purchase, delivery, and set-up of items. Deposits made include set-up fees or deposits for utility service access.
- ~~(1) The cost per job shall be reimbursed at a per job bid rate that is negotiated and approved by Ohio department of aging's (ODA) designee and accepted by the consumer. The per job bid rate includes the cost of the purchase, delivery, and set-up of items. Deposits made include set-up fees or deposits for utility on service access.~~
- ~~(C)~~(D) A unit rate shall be based on a three-tiered model, and shall not exceed the amounts as expressed in appendix A to rule 5101:3-1-06.5 of the Administrative Code. These rates will be used for assisted living services as set forth in rule 173-39-02.16 of the Administrative Code.
- (1) ~~Each consumer's~~ The rate for assisted living services for each consumer shall be determined by the preadmission screening system providing options and resources today (PASSPORT) administrative agency through an assessment of the consumer's service needs in four areas:
 - (a) Cognitive impairments,
 - (b) Medication administration,
 - (c) Nursing services, and
 - (d) Functional impairments.
 - (2) The assisted living HCBS waiver provider must agree to provide the services in the consumer's plan of care at the rate determined by the assessment.
- ~~(D)~~(E) ODA certified assisted living providers shall only be reimbursed for assisted living services authorized by the PASSPORT administrative agency (PAA) and reflected on the consumer's ~~care~~ service plan.
- ~~(E)~~(F) Assisted living service payment constitutes payment in full and may not be construed as a partial payment when the payment amount is less than the provider's charge. The provider may not bill the consumer of assisted living HCBS waiver program services for any difference between the medicaid payment and the provider's charge or request that the consumer share in the cost through a co-payment or other similar charge.
- ~~(F)~~(G) The assisted living service payment is for assisted living services as defined in rule 173-39-02.16 of the Administrative Code and does not include payment for room and board as calculated pursuant to rule 5101:3-33-03 of the Administrative Code, which is the responsibility of the consumer.

Effective: 09/29/2011

R.C. 119.032 review dates: 07/14/2011 and 09/01/2016

Certification: CERTIFIED ELECTRONICALLY

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Rule Amplifies: 5111.85, 5111.89

Prior Effective Dates: 7/1/06, 3/22/08, 9/19/09

LTCSTL 15-01

Effective Date: January 1, 2015

Most Current Prior Effective Date: September 29, 2011

The purpose of this rule is to define the terms used in Chapter ~~5101:3-36~~5160-36 of the Administrative Code governing the medicaid funded portion of the program of all-inclusive care for the elderly (PACE).

(A) As used in this chapter:

- (1) "Authorized representative" means a person, eighteen years of age or older, who stands in place of an individual who is applying for or receiving medical assistance including PACE enrollment and participation. The authorized representative may include a legal entity assisting in the application process, a family member, attorney, licensed social worker, or any other person chosen to act on the individual's behalf. In accordance with Chapter ~~5101:1-38~~5160:1-2 of the Administrative Code, the individual shall provide a written statement naming the authorized representative and the duties that the authorized representative may perform on the individual's behalf.
- (2) "CMS" means the centers for medicare and medicaid services, a federal agency that is part of the U.S. department of health and human services and administers the medicaid program.
- (3) "C.F.R." means the code of federal regulations.
- (4) "CDJFS" means county department of job and family services.
- (5) "Capitated payment" means the monthly payment paid to the PACE organization by ~~ODJFS~~ODM for medical care and services provided to medicaid recipients enrolled in the PACE program.
- (6) "Individual" is the applicant for or recipient of a medical assistance program such as medicaid.
- (7) "Involuntary disenrollment" means the disenrollment of a participant from the PACE program at the request of the PACE organization or a CDJFS.
- (8) "ODA" means the Ohio department of aging.
- (9) ~~"ODJFS" means the Ohio department of job and family services.~~ "ODM" means the Ohio department of medicaid.
- (10) "PACE" means the 'program of all-inclusive care for the elderly' provided for in 42 U.S.C. 1396u-4 and 42 C.F.R. Part 460 as in effect on October 1, ~~2007~~2013.
- (11) "PACE center" means a facility operated by a PACE organization where primary care or other related services offered by the PACE program are furnished to participants.
- (12) "PACE organization" means an entity that has a medicaid provider agreement and also has in effect a PACE program agreement with CMS and ODA.
- (13) "PACE program agreement" means an agreement between a PACE organization, CMS, and ODA.
- (14) "Participant" means a person enrolled in PACE and receiving services through the PACE program.
- (15) "Private pay participant" means an individual who does not meet the medicaid eligibility criteria but chooses to participate in PACE and is responsible for payment of the PACE organization's private pay premium.
- (16) "Service area" means the geographic area in which a PACE organization is approved by CMS and ODA to furnish services to PACE participants.

- (17) "State administering agency" means the state agency responsible for administering the PACE program agreement. Pursuant to section [173.50](#) of the Revised Code ODA shall serve as the state administering agency for PACE in Ohio.
- (18) "Voluntary disenrollment" means the disenrollment of a participant from the PACE program at the request of the participant or the participant's authorized representative.

Effective: 01/01/2015

Five Year Review (FYR) Dates: 09/30/2014 and 01/01/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 12/08/2014

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5164.02, 173.50 and 5162.35

Prior Effective Dates: 3/28/09, 7/1/11 (Emer.), and 9/29/11

LTCSSTL 15-01

Effective Date: January 1, 2015

Most Current Prior Effective Date: September 29, 2011

- (A) In accordance with section 173.50 of the Revised Code, the Ohio department of aging (ODA) shall serve as the designated state administering agency for the PACE program and shall adhere to and monitor the implementation of all applicable requirements for the program's administration as contained in 42 C.F.R Part 460 as in effect on October 1, ~~2007~~2013.
- (B) In this capacity ODA shall:
- (1) Facilitate the process in which prospective PACE organizations apply to the centers for medicare and medicaid services (CMS) for approval to provide PACE services;
 - (2) Enter into an agreement called the PACE program agreement with CMS and each PACE organization approved by CMS to provide PACE services to participants in Ohio who reside in the PACE organization's designated service area. The content and duration of that agreement shall conform to standards contained in 42 C.F.R. Part 460 as in effect on October 1, ~~2007~~2013.
 - (3) ~~Ensure~~Verify that PACE organizations providing PACE services have signed medicaid provider agreements as required by rule 5160-1-17 of the Administrative Code.
 - (4) Work with PACE organizations to assist individuals seeking enrollment in the PACE program.
 - (5) Manage PACE enrollment.
 - (6) Allocate and as appropriate reallocate slots to PACE organizations for use by individuals who are enrolled in the Ohio medicaid consumers program. The allocation and reallocation of slots does not apply to medicare only or private pay patients.
 - (7) Adopt rules including, but not limited to, PACE participant eligibility, PACE participant enrollment, PACE participant voluntary disenrollment and PACE participant involuntary disenrollment.
 - (8) Confer as necessary and appropriate with the Ohio ~~department of job and family services (ODJFS)~~department of medicaid (ODM) on matters including but not limited to:
 - (a) PACE participant eligibility;
 - (b) PACE participant enrollment, disenrollment, and PACE program waiting list trends;
 - (c) Establishing the rates of reimbursement for PACE organizations operating in Ohio;
 - (d) Designating each PACE organization's service area;
 - (e) The enrollment and disenrollment of PACE organizations as providers of services through the PACE program; and
 - (f) The termination of PACE program agreements.
- (C) ~~Effective July 1, 2011, ODJFS~~ODM shall be responsible for the capitated payments made to PACE organizations for medicaid services rendered to PACE program participants.

Effective: 01/01/2015

Five Year Review (FYR) Dates: 09/30/2014 and 01/01/2020

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Statutory Authority: 5164.02

Rule Amplifies: 5164.02, 173.50 and 5162.35

Prior Effective Dates: 3/28/09, 7/1/11 (Emer.) and 9/29/11

LTCSSTL 15-01

Effective Date: January 1, 2015

Most Current Prior Effective Date: March 28, 2009

- (A) To be eligible and maintain eligibility for the PACE program an individual shall meet the criteria for PACE participant eligibility in rule 173-50-02 of the Administrative Code.
- (B) Individuals seeking enrollment in the PACE program through medicaid shall be determined by their county department of job and family services (CDJFS) to be eligible for Ohio medicaid in accordance with Chapters ~~5101:1-37 to 5101:1-42~~5160:1-1 to 5160:1-6 of the Administrative Code.
- (C) If a PACE participant who is also enrolled in medicaid is institutionalized for a period of continuous institutionalization as defined in rule ~~5101:1-39-22~~5160:1-3-22 of the Administrative Code then that ~~consumer's~~individual's patient liability amount is to be recalculated by the appropriate CDJFS as directed in rule ~~5101:1-39-24~~5160:1-3-24 of the Administrative Code.
- (D) Participants who fail or cease to meet the eligibility criteria contained in paragraph (A) of this rule shall be denied enrollment in PACE or involuntarily disenrolled pursuant to rule ~~5101:3-36-04~~5160-36-04 of the Administrative Code.
- (E) If at any time an individual enrolled in the medicaid program fails or ceases to meet the medicaid eligibility criteria in paragraph (B) of this rule, the participant shall be denied entry in or disenrolled from the medicaid program. In such instances, the participant shall be notified by the appropriate CDJFS and granted all applicable hearing rights in accordance with Chapters 5101:6-1 to 5101:6-9 of the Administrative Code.
- (F) PACE participants who no longer meet the medicaid eligibility criteria shall be given the opportunity to remain enrolled in the PACE program as a medicare only or as a private pay participant.
- (G) Participants who no longer meet the medicaid financial eligibility criteria but choose to remain enrolled in the PACE program through private resources shall be charged no less than the medicaid rate for services by the PACE organization.
- (H) PACE participants who are no longer medicaid eligible and choose not to remain enrolled in PACE as a medicare only or private pay enrollee shall be disenrolled from the PACE program in accordance with rules adopted by the Ohio department of aging.

Effective: 01/01/2015

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Rule Amplifies: 5164.02, 173.50 and 5162.35

Prior Effective Dates: 3/28/09

LTCSTL 15-01

Effective Date: January 1, 2015

Most Current Prior Effective Date: March 28, 2009

- (A) Individuals eligible and seeking to enroll in the PACE program shall enroll in the manner established in rule [173-50-03](#) of the Administrative Code unless paragraph (B) of this rule applies.
- (B) If the number of eligible individuals seeking enrollment in the PACE program exceeds the number of slots allocated by the Ohio department of aging (ODA), ODA may establish and maintain a waiting list for PACE enrollment.
- (C) Should a waiting list for PACE enrollment be maintained by ODA, ODA shall, on a semiannual basis, provide the ~~Ohio department of job and family services (ODJFS)~~ Ohio department of medicaid (ODM) with the number of individuals on the waiting list for PACE services, the service area in which they reside, and the average length of time ~~consumers~~ individuals on the waiting list shall wait before enrolling in PACE.
- (D) A PACE participant may choose to voluntarily disenroll from the PACE program 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 PACE participant choose to voluntarily disenroll from PACE, ODA shall, prior to the participant's disenrollment, verify that the voluntary disenrollment was initiated by the ~~consumer~~ individual or the ~~consumer's~~ individual's authorized representative.
- (2) The voluntary disenrollment of a PACE participant shall occur in the manner prescribed in rule [173-50-04](#) of the Administrative Code.
- (E) A PACE organization may initiate the involuntary disenrollment of a PACE participant if any of the following applies:
- (1) The PACE participant no longer meets the eligibility criteria for the PACE program contained in rule [173-50-02](#) of the Administrative Code.
- (2) The PACE participant meets the criteria for involuntary disenrollment in paragraph (A) of 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.

Effective: 01/01/2015

Five Year Review (FYR) Dates: 09/30/2014 and 01/01/2020

Certification: CERTIFIED ELECTRONICALLY

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Statutory Authority: 5164.02

Rule Amplifies: 5164.02, 173.50 and 5162.35

Prior Effective Dates: 3/28/09

LTCSTL 15-01

Effective Date: January 1, 2015

Most Current Prior Effective Date: March 28, 2009

- (A) Each PACE organization shall establish and maintain at each PACE center an interdisciplinary team to assess the care and service needs of PACE participants. The composition of the interdisciplinary team shall be consistent with 42 C.F.R. Part 460 as in effect on October 1, ~~2007~~2013.
- (B) The interdisciplinary team shall conduct a comprehensive assessment and develop a plan of care for each PACE participant.
 - (1) The plan of care developed for each PACE participant shall specify which services are needed to meet the participant's medical, physical, emotional, and social needs as identified in the comprehensive assessment, and will identify measurable outcomes to be achieved for the PACE participant.
 - (2) The interdisciplinary team shall implement, coordinate, and monitor the PACE participant's plan of care and modify the plan of care as appropriate.
 - (3) The interdisciplinary team shall at least semiannually, or more often if the participant's condition dictates or if requested by the participant or the participant's authorized representative, reassess each PACE participant and make changes as necessary to the plan of care.
 - (4) The PACE interdisciplinary team shall collaborate with the participant in the development of the participant's plan of care as well as with changes made to the plan of care.
- (C) PACE organizations shall ensure that all PACE participants have access to all medically necessary services including, but not limited to, services covered by Ohio's medicaid program, in addition to those prescribed in 42 C.F.R. Part 460.92 as in effect on October 1, ~~2007~~2013 to 42 C.F.R. Part 460.96 as in effect on October 1, ~~2007~~2013.
 - (1) Services provided shall be sufficient in their amount, duration and scope to meet the participant's medical, physical, emotional, and social needs as identified in the comprehensive assessment to achieve the measurable outcomes identified in the participant's plan of care.
 - (2) Services provided shall be reflected in the participant's plan of care unless the services are an emergency service.

Effective: 01/01/2015

Five Year Review (FYR) Dates: 09/30/2014 and 01/01/2020

Certification: CERTIFIED ELECTRONICALLY

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Rule Amplifies: 5164.02, 173.50 and 5162.35

Prior Effective Dates: 3/28/09

LTCSTL 15-01

Effective Date: January 1, 2015

Most Current Prior Effective Date: September 29, 2011

- (A) PACE is a full-risk program in which the PACE organization assumes all financial risk for the cost of the medical care and services provided to PACE participants.
- (B) PACE organizations shall receive a monthly capitated payment from the Ohio ~~department of job and family services (ODJFS)~~ department of medicaid (ODM) for each PACE participant enrolled in the medicaid program including individuals enrolled in both medicaid and medicare.
- (C) The amount of the capitated payment shall be established in the PACE program agreement in rule ~~5101:3-36-02~~ 5160-36-02 of the Administrative Code.
- (D) The amount paid in accordance with paragraph (B) of this rule represents the total maximum payment obligation of the state administering agency to the PACE organization for the cost of medical care and services provided to PACE participants enrolled in medicaid including those participants enrolled in both medicaid and medicare.
- (E) The PACE organization shall accept the capitation payment amount as payment in full for medicaid participants and shall not bill, charge, collect, or receive any other form of payment from ~~ODJFS~~ ODM or from, or on behalf of, the participant, except as permitted under 42 C.F.R. Part 460.182(c) as in effect on October 1, ~~2007~~ 2013.

Effective: 01/01/2015

Five Year Review (FYR) Dates: 09/30/2014 and 01/01/2020

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Prior Effective Dates: 3/28/09, 7/1/11 (Emer.) and 9/29/11

Chapter 2 Department of Developmental Disabilities

Community Alternative Funding System (CAFS)

5160-38-02 Habilitation Center Eligibility Standards for Habilitation Center Services Delivered to Individuals Under Twenty-One Years of Age

***Formerly* 5101:3-38-02 Habilitation Center Eligibility Standards for Habilitation Center Services Delivered to Individuals Under Twenty-One Years of Age**

Effective Date: January 1, 2004

OAC 5101:3-38-02 [Appendix A](#)

- (A) The purpose of this rule is to specify the eligibility requirements for a habilitation center to be certified to provide services under the habilitation center program. This rule sets forth the criteria habilitation centers must meet in order to obtain certification under section 5123.041 of the Revised Code and the method for making habilitation center services available to eligible individuals with a medical need for these services.
- (B) Eligible habilitation center providers are habilitation centers with a valid provider agreement with the Ohio department of job and family services (ODJFS) and are certified by the Ohio department of mental retardation and developmental disabilities (ODMRDD) under section 5123.041 of the Revised Code. Habilitation centers must demonstrate compliance with all certification requirements through an on site visit from the ODMRDD.
- (C) Habilitation centers participating in this program must operate in accordance with the rules set forth in Chapter 5101:3-38 of the Administrative Code.
 - (1) All habilitation center services must be delivered in accordance with the eligible individual's plan.
 - (2) All professional services included in an eligible individual's plan shall meet the requirements established under this Chapter.
 - (3) Habilitation centers may provide active treatment for persons residing in ICFs/MR in accordance with rule 5101-3-38-13 of the Administrative Code. The habilitation center must have a written contract with the ICF/MR for the provision of active treatment.
 - (4) Habilitation centers may provide skills development and supports in accordance with rule 5101:3-38-14 of the Administrative Code.
 - (5) Habilitation centers may provide transportation in accordance with rule 5101:3-38-40 of the Administrative Code.
- (D) Habilitation centers must have the following written policies and/or procedures in place:
 - (1) Personnel records and other documentation to verify that personnel delivering habilitation center services have the qualifications to deliver the services.
 - (2) Individual record mechanisms which address confidentiality, access, duplication, dissemination, and destruction, including assurances that copies of the policies and procedures can be accessed upon request.
 - (3) Due process procedures for individuals that are consistent with division-level designation 5101:6 of the Administrative Code, including the method by which individuals, parents and/or legal guardians are informed of due process and confidentiality policies.
 - (4) Plan development procedures in accordance with applicable state and federal regulations and maintenance of a file copy of the current plan that substantiates the necessity for and provision of habilitation center services.
 - (5) Individual record and fiscal information that includes the method for collection, maintenance and retention of records and information that support billing and cost reporting information. Providers are required to maintain all records necessary and in such form as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any initiated audit is completed, whichever is longer.

- (E) Certified habilitation centers shall submit claims to the ODMRDD in a format prescribed by ODMRDD. The ODMRDD shall provide claim information to the ODJFS.
- (F) Certified habilitation centers shall receive reimbursement pursuant to the provisions in rule 5101:3-38-10 of the Administrative Code.
- (G) Certified habilitation centers shall cooperate fully with any program or fiscal audit or oversight review conducted by either the ODJFS or the ODMRDD. A medicaid local administrative authority (MLAA) shall participate in a program or oversight review as deemed appropriate by the ODJFS or the ODMRDD. Either department may request a plan of correction from any agency found to be out of compliance with any applicable rule contained in Chapter 5101:3-38 or 5123:2-15 of the Administrative Code.

Effective: 01/01/2004

R.C. 119.032 review dates: 01/01/2009

Certification: CERTIFIED ELECTRONICALLY

Date: 12/16/2003

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Rule Amplifies: 5111.01, 5111.02, 5111.041

LTCSSTL 15-18

Effective Date: April 1, 2015

Most Current Prior Effective Date: July 1, 2011

5101:3-48-01 Appendix A

(A) Purpose.

- (1) This rule specifies the conditions for medicaid payment of targeted case management (TCM), which is comprised of those activities described in section 5126.15 of the Revised Code and in rule 5123:2-1-11 of the Administrative Code, but only to the extent that they are listed in paragraph (D) of this rule as reimbursable activities for medicaid eligible individuals with ~~mental retardation and/or a developmental disability~~ intellectual disabilities.
- (2) The department of developmental disabilities (DODD), through an interagency agreement with the department of ~~job and family services (ODJFS)~~ medicaid (ODM), administers the TCM program on a daily basis in accordance with section ~~5111.91~~ 5126.35 of the Revised Code.

(B) Definitions.

- (1) "IEP" means an individualized education program and has the same meaning as described in rule 3301-51-07 of the Administrative Code.
- (2) "Institution" means a nursing facility, an intermediate care facility for ~~the mentally retarded (ICF/MR)~~ individuals with intellectual disabilities (ICF/IID), a state-operated intermediate care facility for ~~the mentally retarded (ICF/MR)~~ individuals with intellectual disabilities (ICF/IID) or a medical institution.
- (3) "ISP" means an individualized service plan as defined in rule 5123:2-1-11 of the Administrative Code.
- (4) "Major unusual incident" (MUI) has the same meaning as defined in rule 5123:2-17-02 of the Administrative Code.
- (5) ~~"Medically necessary"~~ "Medical necessity" for the purposes of this rule medically necessary has the same meaning as medical necessity as defined in rule 5160-1-01 of the Administrative Code ~~means services and activities that are of an appropriate type, amount, duration, scope and intensity which are also appropriate to the individual's health and welfare needs, living arrangement, circumstances or expected outcomes.~~
- (6) "Service and support administration" has the same meaning as described in section 5126.15 of the Revised Code.
- (7) "Targeted case management" means services which will assist individuals in gaining access to needed medical, social, educational and other services as described in this rule in accordance with section 1915(g) of the Social Security Act (42 U.S.C. 1396n(g)(2)) as effective ~~January 1, 2006~~ October 1, 2014. Targeted case management is also referred to as medicaid case management.
- (8) "Unusual incident" has the same meaning as defined in rule 5123:2-17-02 of the Administrative Code.

(C) Eligible individuals.

- (1) Individuals eligible for medicaid coverage of TCM services are:
 - (a) Medicaid eligible individuals, regardless of age, who are enrolled on home and community-based service (HCBS) waivers administered by the DODD, and

- (b) All other medicaid eligible individuals, age three or above, who are determined to have mental retardation or other developmental disability according to section [5126.01](#) of the Revised Code.

(D) Reimbursable activities.

- (1) Medicaid services listed in paragraph (D) of this rule are reimbursable only if provided to or on behalf of a medicaid eligible individual as defined in paragraph (C) of this rule and by qualified providers as defined in paragraph (E) of this rule. Payment for targeted case management services may not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Medicaid reimbursable TCM services are:
 - (a) Assessment. Activities reimbursable under the assessment category are limited to the following:
 - (i) Activities performed to make arrangements to obtain from therapists and appropriately qualified persons the initial and on-going assessments of an eligible individual's need for any medical, educational, social, and other services.
 - (ii) Eligibility assessment activities that provide the basis for the recommendation of an eligible individual's need for HCBS waiver services administered by DODD.
 - (iii) Activities related to recommending an eligible individual's initial and on-going need for services and associated costs for those individuals eligible for HCBS waiver services administered by DODD.
 - (b) Care planning. Activities reimbursable under the care planning category are limited to the following:
 - (i) Activities related to ensuring the active participation of the eligible individual and working with the eligible individual and others to develop goals and identify a course of action to respond to the assessed needs of the eligible individual. These activities result in the development, monitoring, and on-going revision of an individualized service plan (ISP).
 - (c) Referral and linkage. Activities reimbursable under the referral and linkage category are limited to the following:
 - (i) Activities that help link eligible individuals with medical, social, educational providers and/or other programs and services that are capable of providing needed services.
 - (d) Monitoring and follow-up. Activities reimbursable under the monitoring and follow-up category are limited to the following:
 - (i) Activities and contacts that are necessary to ensure that the ISP is effectively implemented and adequately addresses the needs of the eligible individual.
 - (ii) Conducting quality assurance reviews on behalf of a specific eligible individual and incorporating the results of quality assurance reviews into amendments of an ISP.
 - (iii) Reviewing the individual trends and patterns resulting from reports of investigations of unusual incidents and MUIs and integrating prevention plans into amendments of an ISP.
 - (iv) Ensuring that services are provided in accordance with the ISP and ISP services are effectively coordinated through communication with service providers.
 - (v) Activities and contacts that are necessary to ensure that guardians and eligible individuals receive appropriate notification and communication related to unusual incidents and MUIs.
 - (e) State hearings: Activities reimbursable under the state hearing category are limited to the following:

- (i) Activities performed to assist an eligible individual in preparing for a state hearing related to the reduction, termination or denial of a service on an ISP.

(2) Coverage exclusions.

- (a) Activities performed on behalf of an eligible individual residing in an institution are not billable for medicaid TCM reimbursement except for the last one hundred eighty consecutive days of residence when the activities are related to moving the eligible individual from an institution to a non-institutional community setting.
- (b) Emergency intervention services as described in paragraph (Q) of rule 5123:2-1-11 of the Administrative Code. This does not preclude those activities covered in paragraph (D)(1) of this rule when responding to an emergency and provided by a certified or registered service and support administrator.
- (c) Conducting investigations of abuse, neglect, unusual incidents, or major unusual incidents.
- (d) The provision of direct services (medical, educational, vocational, transportation, or social services) to which the eligible individual has been referred and with respect to the direct delivery of foster care services, including but not limited to those described in paragraph (A)(iii) of section 1915(g) of the Social Security Act (42 U.S.C. 1396n(g)(2)) as effective January 1, 2006.
- (e) Services provided to individuals who have been determined to not have mental retardation or another developmental disability according to section 5126.01 of the Revised Code, except for individuals eligible for coverage of TCM services pursuant to paragraph (C)(1)(a) of this rule.
- (f) Conducting quality assurance systems reviews.
- (g) Conducting quality assurance reviews for an eligible individual for whom the service and support administrator serves as the single point of accountability.
- (h) Payment or coverage for establishing budgets for services outside of the scope of individual assessment and care planning.
- (i) Activities related to the development, monitoring or implementation of an individualized education program (IEP).
- (j) Services provided to groups of individuals.
- (k) Habilitation management as defined in rule 5123:2-1-11 of the Administrative Code.
- (l) Eligibility determinations for county board of developmental disabilities (CBDD) services.

(E) Qualified providers.

Qualified providers of medicaid TCM services are CBDDCBsDD as established under Chapter 5126. of the Revised Code. Only those eligible activities as defined in this rule performed by CBDDCBsDD employees or CBDDCBsDD sub-contractors meeting the registration or certification standards contained in rule 5123:2-5-02 of the Administrative Code are eligible for payment.

(F) Documentation requirements.

To receive medicaid reimbursement for TCM activities provided under this rule, documentation must include, but is not limited to, the following elements:

- (1) The date that the activity was provided, including the year;
- (2) The name of the person for whom the activity was provided;
- (3) A description of the activity provided and location of the activity delivery (may be in case notes or a coded system with a corresponding key);
- (4) The duration in minutes or time in/time out of the activity provided. Duration in minutes is acceptable if the provider's schedule is maintained on file;

- (5) The identification of the activity provider by signature or initials on each entry of service delivery. Each documentation recording sheet must contain a legend that indicates the service provider's name (typed or printed), title, signature, and initials to correspond with each entry's identifying signature or initials.
- (G) Reimbursement and claims submission.
- (1) Each CBDD shall maintain a current fee schedule of usual and customary charges. Records of fee schedules must be maintained for a period of six years. The CBDD shall bill DODD its usual and customary charge for a TCM covered service. TCM services will be reimbursed the lesser of the CBDD's usual and customary charge or the rate found in appendix A to this rule. Without regard to the rate of reimbursement that may be identified in appendix A to this rule, no provider of TCM shall receive reimbursement at a rate in excess of the rate in the federally approved state plan amendment.
 - (2) Each CBDD is responsible for instituting collection efforts against third parties liable for the payment of TCM services as required by rule ~~5101:3-1-08~~5160-1-08 of the Administrative Code. The CBDD must maintain sufficient documentation to substantiate collection activities and any payments received. Sufficient documentation includes a written confirmation every twelve months from any known possible third party, if applicable, which states that the TCM service is not covered under that program or policy.
 - (3) If any of the TCM services provided by a CBDD are paid or attributable to another federal program, the costs of such services should be allocated in accordance with OMB Circular A-87.
 - (4) A CBDD shall not alter or adjust usual and customary rates charged to the medicaid program if such adjustments will result in a direct or indirect charge for costs of uncompensated care being charged to the medicaid program.
 - (5) A CBDD is required to submit claims to DODD within three hundred thirty days from the date of service in accordance with the format specified by DODD. Failure to submit claims within the specified three hundred thirty days may result in the CBDD not being reimbursed for such claims. The CBDD shall have no recourse to recover such non-reimbursed claims.
 - (6) Medicaid reimbursement for TCM services shall constitute payment in full. Medicaid recipients may not be billed for medicaid covered services.
 - (7) Payment for TCM services must not duplicate payments made to CBDD under other programs.
 - (8) To support the provision of providing TCM through fee for service, utilization review procedures will be incorporated to assure compliance with "42 C.F.R. Part 456" as in effect on ~~January 1, 2006~~October 1, 2014.
 - (9) Records relating to TCM services shall be made available to DODD, ~~ODJFS~~, ODM, centers for medicare and medicaid services (CMS) or any of their representatives to verify actual units of service provided are in compliance with federal requirements and are adequately supported.
 - (10) For the purpose of this rule, a unit of service is equivalent to fifteen minutes. Minutes of service provided to a specific eligible individual can be accrued over one calendar day. The number of units that may be billed during a day is equivalent to the total number of minutes of TCM provided during the day for a specific individual divided by fifteen plus one additional unit if the remaining number of minutes is eight or greater minutes.
 - (11) Billable units of service are those tasks/contacts made with the eligible individual or on behalf of the eligible individual. Activities which are not performed on behalf of or are not specific to an eligible individual are not billable.
 - (12) A CBDD shall not submit claims in excess of twenty-six units per day per service and support administrator (SSA) unless the service(s) associated with such claims is considered medically necessary as defined in paragraph (B)(5) of this rule. A CBDD is required to maintain sufficient documentation to track the units per day per SSA This requirement shall not be applicable for claims submitted on or after January 1, 2015.

(13) Where a CBDD submits claims in excess of the established limit as described in paragraph (G)(12) of this rule, the CBDD must also submit an attestation that the service(s) associated with such claims is considered medically necessary as defined in paragraph (B)(5) of this rule. Such claims for the specific SSA are to be submitted separately from all other TCM claims according to DODD specifications. This requirement shall not be applicable for claims submitted on or after January 1, 2015.

(H) Reimbursement on and after January 1, 2015.

- (1) A CBDD shall receive an interim rate as defined in the appendix to this rule for each fifteen minute unit of providing TCM services to medicaid eligible individuals as defined in paragraph (C) of this rule.
- (2) A CBDD shall be reimbursed for the actual incurred costs of providing TCM to eligible medicaid beneficiaries. Each CBDD must certify its expenditures as eligible for federal financial participation in order to settle to actual incurred costs for medicaid TCM.
- (3) Each CBDD shall submit their actual incurred costs as described in paragraph (G) (1) of this rule on an annual cost report as established in section [5126.131](#) of the Revised Code.
- (4) Each CBDD shall receive an interim rate in the amount of fifteen dollars and forty-eight cents per fifteen minute unit for providing TCM services to medicaid eligible individuals as defined in paragraph (C) of this rule.
- (5) DODD shall conduct a final settlement once all cost reports are received audited. Payments shall be paid to each provider in an amount based on the provider's reconciled costs for providing TCM services to medicaid eligible recipients less any amounts previously paid to the provider for proving TCM services under the state plan.
- (6) Reconciled costs shall be calculated by using a methodology approved by the centers for medicare and medicaid.

~~(H)~~(I) Record requests and retention.

- (1) CBDD shall make available all records including but not limited to work papers, supporting reports, medical reports, progress notes, charges, journals, ledgers, computer tapes, computer disks, and fiscal reports for review by representatives from ~~ODJFS~~ODM, ~~ODJFS'~~ODM's designee, CMS, or DODD at the discretion and request of these representatives.
- (2) Documentation will be retained for a period of six years from the date of receipt of final payment or until such time as a lawsuit or audit finding has been resolved, whichever is longer. The records shall be provided to ~~ODJFS~~ODM or its designee upon request in a timely manner. Records produced electronically must be produced at the provider's expense, in the format specific by state or federal authorities. A retrospective program review shall not be required on or after January 1, 2015.

~~(H)~~(J) Monitoring, compliance and sanctions.

- (1) DODD shall conduct periodic monitoring and compliance reviews related to TCM as authorized by the Revised Code. Reviews may consist of, but are not limited to, physical inspections of records and sites where services are provided, interviews of providers, recipients, and administrators. Qualified providers as defined in paragraph (E) of this rule, in accordance with the medicaid provider agreement and DODD, shall furnish to DODD, ~~ODJFS~~ODM, CMS, and the medicaid fraud control unit or their designees any records related to the administration and/or provision of TCM services.
- (2) DODD will conduct a retrospective program review for units that exceed the established limit as defined in paragraph (G)(12) of this rule to determine if the service(s) associated with such claims is considered medically necessary as defined in paragraph (B)(5) of this rule.
- (3) ~~ODJFS~~ODM will monitor the activities of DODD, as necessary, to ensure that funding applicable to the TCM program is used for authorized purposes in compliance with laws, regulations, and the provisions of the interagency agreement.

- (4) In the event a fiscal review reveals that an overpayment has been made, and/or there is a disallowance of medicaid payments, the amount of the overpayment and/or disallowance shall be recovered from the CBDD.

~~(J)~~(K) Due process.

- (1) Medicaid eligible individuals whose TCM services either affect the provision of services or whose TCM services are affected by any decision may appeal that decision at a ~~medicaid~~ state ~~fair~~ hearing pursuant to Chapter 5101:6 of the Administrative Code.. CBDDs must provide notice to the individual of their right to request a state ~~fair~~ hearing pursuant to Chapter 5101:6-2 of the Administrative Code.
- (2) If an eligible individual requests a hearing, as specified in Chapters 5101:6-1 to 5101:6-9 of the Administrative Code, the participation of DODD, and/or ~~ODJFS, ODM~~ and the CBDD is required during the hearing proceedings to justify the decision under appeal.
- (3) All rules related to ~~medicaid~~ due process shall be interpreted in a manner consistent with section 1.11 of the Revised Code, which requires that they be liberally construed in order to promote their objective and assist the individual in obtaining justice. All rules relating to the right to a hearing and limitations on that right shall be interpreted in favor of the right to a hearing.

~~(K)~~(L) Nonfederal share.

- (1) A CBDD is responsible for payment of the nonfederal share of medicaid expenditures in accordance with section 5126.057 of the Revised Code. A CBDD shall provide this nonfederal share prior to the CBDD receiving payment.

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Five Year Review (FYR) Dates: 07/01/2016

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Waivers

LTCSTL 11-04

Effective Date: July 15, 2011

Most Current Prior Effective Date: March 20, 2008

5101:3-40-01 Appendix A

(A) Purpose

- (1) The purpose of this rule is to establish the individual options waiver as a component of the medicaid home and community-based services program pursuant to sections [5111.85](#) and [5111.87](#) of the Revised Code.
- (2) The individual options waiver program provides necessary waiver services to individuals who meet the level of care criteria for an intermediate care facility for individuals with mental retardation and other developmental disabilities (ICF/MR) as set forth in rule [5101:3-3-07](#) of the Administrative Code, as well as other eligibility requirements established in this rule.
- (3) The Ohio department of ~~mental retardation and~~ developmental disabilities (~~ODMRDD~~) (DODD), through an interagency agreement with the Ohio department of job and family services (ODJFS), administers the individual options waiver program on a daily basis in accordance with section [5111.91](#) of the Revised Code.

(B) Definitions

- (1) "County board of ~~mental retardation and~~ developmental disabilities" (~~CBMRDD~~) (CBDD) means a board established under Chapter 5126. of the Revised Code.
- (2) "Funding range" means the dollar range to which an individual has been assigned for the purpose of funding waiver services. The funding range applicable to an individual is determined by the score derived from an assessment using the Ohio developmental disability profile "ODDP" that has been completed by a county board employee qualified to administer the tool.
- (3) "Home and community-based services" (HCBS) means any federally approved medicaid waiver service provided to a waiver enrollee as an alternative to institutional care under Section 1915(c) of the Social Security Act, 49 Stat. 620 (1935), 42 U.S.C.A. 1396n, ~~(as in effect on March 31, 2006)~~ as amended, under which federal reimbursement is provided for designated home and community-based services to eligible individuals.
- (4) "Individual" means a person with mental retardation or other developmental disability who is eligible to receive HCBS as an alternative to placement in an intermediate care facility for the mentally retarded under the applicable HCBS waiver. A guardian or authorized representative may take any action on behalf of the individual, may make choices for an individual or may receive notice on behalf of an individual to the extent permitted by applicable law.
- (5) "Individual funding level" means the total funds, calculated on a twelve month basis, that are necessary for payment for waiver services that have been determined through the individual service plan (ISP) development process to be sufficient in amount, duration and scope to meet the health and welfare needs of an individual.
- (6) "Individual Service Plan" (ISP) means a written description of the services, supports, and activities to be provided to an individual in accordance with paragraph (H) of this rule.
- (7) "Provider" means a person or agency certified or licensed by ~~ODMRDD~~ DODD that has met the provider qualification requirements to provide the specific individual options waiver service as specified in paragraph (I)(1) of this rule and holds a valid medicaid provider agreement in accordance with paragraph (I)(2) of this rule.

- (8) "SSA" means a service and support administrator who is certified in accordance with rules adopted by the ~~ODMRDD~~ DODD under Chapter 5123:2-5 of the Administrative Code and who provides the functions of service and support administration.
- (C) Application for the individual options waiver
- (1) Individuals seeking to enroll in the individual options waiver program must complete the JFS 02399 "Request for Medicaid Home and Community-Based Services (HCBS)." (rev. 1/2006) Forms shall be available at all ~~CBMRDD~~ CBDD. Forms are also available at the county department of job and family services (CDJFS). Forms are to be used in accordance with rule [5101:1-38-01.2](#) of the Administrative Code.
- (2) The ~~CBMRDD~~ CBDD is responsible for explaining to individuals requesting HCBS the services available through the individual options waiver benefit package including the amount, scope and duration of services and any applicable benefit package limitations.
- (D) Eligibility criteria for the individual options waiver
- (1) The individual applying for the individual options waiver program must be determined to require the level of care provided in an ICF/MR and be eligible for ICF/MR services upon initial enrollment and no later than every twelve months thereafter, as specified in rules 5101:3-3-07 and [5123:2-9-01](#) of the Administrative Code and in accordance with the process set forth in rule [5101:3-3-15.5](#) of the Administrative Code; and
- (2) The individual's medicaid eligibility has been established in accordance with Chapters 5101:1-37 to 5101:1-42 of the Administrative Code; and
- (3) The individual's health and welfare needs can be met through the utilization of individual options waiver services at or below the federally approved cost limitation, and, other formal and informal supports regardless of funding source.
- (4) The individual must require, at a minimum, one waiver service, as described in paragraph (F) of this rule, to be considered eligible for this waiver.
- (E) Individual options waiver enrollment, continued enrollment, and disenrollment
- (1) Individuals who meet the eligibility criteria in paragraph (D) of this rule, or their legal representative, shall be informed of the following:
- (a) All services available on this individual options waiver, as delineated in paragraph (F) of this rule, and any choices that the individual may make regarding those services;
- (b) Any feasible alternative to the waiver; and
- (c) The right to choose either institutional or home and community-based services.
- (2) An individual determined eligible for and seeking to enroll, but not yet enrolled on the individual options waiver or an individual whose continued enrollment in the individual options waiver program is being redetermined shall be assessed using the Ohio developmental disabilities profile as pursuant to Chapter 5123:2-9 of the Administrative Code. This instrument shall assess the relative needs and circumstances of an individual compared to others, which is then used to assign the individual to a funding range.
- (3) ~~ODMRDD~~ DODD shall allocate waiver ~~slots~~ capacity to the county board in accordance with rule 5123:2-9-03 of the Administrative Code as outlined in the approved individual options waiver.
- (4) The ~~CBMRDD~~ CBDD shall offer available individual options waiver slots to eligible individuals in accordance with applicable waiting list category requirements set forth in rules [5101:3-41-05](#) and [5123:2-1-08](#) of the Administrative Code.
- (5) An individual's continued enrollment in the individual options waiver program shall be redetermined no less frequently than every twelve months beginning with the individual's initial enrollment date or subsequent redetermination date. Individuals must continue to meet the

eligibility criteria specified in paragraph (D) of this rule to continue enrollment in the waiver program.

- (6) The maximum number of individuals that can be enrolled in the individual options waiver program statewide shall not exceed the allowable number specified in the federally approved waiver document. ~~The approved waiver document is available at <http://jfs.ohio.gov/OHP/bca/individualOptionsWaiver.pdf>.~~
- (7) The individual must require at least one waiver service monthly, or, if less than monthly, require monthly monitoring of the individual's health and welfare. If no services are planned to be delivered in a month, monthly monitoring of the individual's health and welfare must be required in the ISP, as designated in paragraph (G) of this rule, and must include at least periodic face-to-face monitoring.
- (8) While enrolled in the individual options waiver program, if the enrollee does not receive any waiver services as listed in paragraph (F) of this rule for one month, the county board shall, within fifteen days after the end of the calendar month, assess the enrollee's current need for waiver services, and discuss these needs with the enrollee and their representative. As a result of the assessment and discussion, if no waiver services are needed, the enrollee shall be recommended for disenrollment from the waiver program and shall be given notification of hearing rights as established in paragraph (L) of this rule.
- (9) Individuals enrolled in the individual options waiver program who are recommended for disenrollment from the waiver program shall be given notification of hearing rights as established in paragraph ~~(L)~~ (M) of this rule.

(F) Individual options waiver program benefit package, as included in the federally approved waiver document:

The individual options waiver program benefit package is limited to the following services:

- (1) Homemaker / personal care;
- (2) Social work;
- (3) Interpreter;
- (4) Nutrition;
- (5) Home-delivered meals;
- ~~(6) Day habilitation, available until December 31, 2007;~~
- ~~(7) Supported employment, available until December 31, 2007;~~
- ~~(8)~~(6) Environmental accessibility ~~modifications~~ adaptations;
- ~~(9)~~(7) Transportation;
- ~~(10)~~(8) Adaptive and assistive equipment;
- ~~(11)~~(9) Respite; available until July 14, 2011;
- ~~(12)~~(10) Supported employment - community;
- ~~(13)~~(11) Supported employment - enclave;
- ~~(14)~~(12) Adult day supports;
- ~~(15)~~(13) Vocational habilitation;
- ~~(16)~~(14) Supported employment - adapted equipment;
- ~~(17)~~(15) Non-medical transportation to access ~~the services listed in paragraphs (F)(12) to (F)(15) of this rule~~ an approved adult day service;
- ~~(18)~~(16) Adult foster care;
- ~~(19)~~(17) Homemaker/personal care-daily billing unit;

- (18) Adult family living;
- (19) Community respite;
- (20) Remote monitoring equipment;
- (21) Remote monitoring;
- (22) Residential respite.

(G) Limits on sets of individual options waiver services

- (1) The following benefits are subject to specific benefit limitations ~~that, when combined cannot exceed the maximum amount as specified in appendix B to rule 5101:3-41-15 of the Administrative Code, effective in twelve month periods beginning with the individual's enrollment or redetermination date:~~
 - (a) Supported employment - enclave;
 - (b) Supported employment - community;
 - (c) Supported employment - adapted equipment;
 - (d) Adult day supports;
 - (e) Vocational habilitation;
 - (f) Remote monitoring equipment.
- (2) Non-medical transportation services are subject to a benefit limitation not to exceed the amount specified in appendix B to rule 5101:3-41-15 of the Administrative Code.

(H) Individual options service plan requirements

- (1) All services shall be provided to an individual enrolled in the individual options waiver program pursuant to a written ISP.
- (2) The ISP shall be developed by qualified persons with input from the individual options waiver enrollee and the SSA in accordance with section 5126.15 of the Revised Code. Providers shall participate in the ISP meetings when a request for their participation is made by the individual enrollee.
 - (a) The ISP shall list the individual options waiver services and the non-waiver services, regardless of funding source, that are necessary to ensure the enrollee's health and welfare; and
 - (b) The ISP shall include an individual funding level as defined in paragraph ~~B(5)~~(B)(5) of this rule. If the county board, with the involvement of the individual enrolled on the individual options waiver program, is unable to recommend an ISP that includes a funding level that is within or below the funding range, the county board shall inform the individual of the right to request prior authorization as specified in division 5101:3 of the Administrative Code and shall provide the individual notification of hearing rights as established in paragraph ~~(L)~~ (M) of this rule; and
 - (c) The ISP shall contain the following medicaid required elements:
 - (i) Type of service to be provided; and
 - (ii) Amount of service to be provided; and
 - (iii) Frequency and duration of each service to be provided; and
 - (iv) Type of provider to furnish each service; and
 - (d) The ISP shall be developed on at least an annual basis consistent with the individual's redetermination as indicated in paragraph (E)(5) of this rule or as the individual's needs change and in accordance with division 5123:2 of the Administrative Code; and

- (e) The ISP shall be developed to include only waiver services which are consistent with efficiency, economy and quality of care. When reasonable, waiver services are not provided entirely at a one to one ratio. When combined with other non-waiver services, waiver services must ensure the health and welfare for the individual for whom the ISP is developed; and
- (f) The ISP is subject to approval by ODJFS and ~~ODMRDD~~DODD pursuant to section 5111.871 of the Revised Code. Notwithstanding the procedures set forth in this rule, ODJFS may in its sole discretion, and in accordance with section 5111.852 of the Revised Code direct the ~~CBMRDD~~CBDD or ~~ODMRDD~~ DODD to amend ISPs for individuals if ODJFS determines that such services are medically necessary and the procedures set forth in division 5101:3 of the Administrative Code would not accommodate a request for such medically necessary services.

(I) Free choice of provider

Individuals enrolled in the individual options waiver program shall be given a free choice of qualified individual options waiver providers in accordance with Chapters 5101:3-41 and 5123:2-9 of the Administrative Code. A provider is qualified if they meet the standards established in paragraph (I) of this rule. ~~ODMRDD~~DODD shall create and maintain an internet-based list of those providers who are qualified to provide individual options waiver services in accordance with section 5126.046 of the Revised Code. This list will be accessible to county boards and individuals applying for or receiving services. The ~~CBMRDD~~CBDD shall provide information about the internet-based provider list to applicants and enrollees and shall assist an individual to access this list to assure the individual's free choice of qualified providers.

(J) Provision of individual options waiver services

- (1) Individual options waiver services shall be provided by persons or agencies who have certification or licensure in accordance with section 5123.045 of the Revised Code and division 5123:2 of the Administrative Code; and
- (2) Individual options waiver services shall be provided by persons or agencies who have a valid medicaid provider agreement in accordance with rule 5101:3-1-17.2 of the Administrative Code; and
- (3) Individual options waiver services shall be provided only to individuals who have met the eligibility requirements in paragraph (D) of this rule and are enrolled in the individual options waiver program at the time of service delivery; and
- (4) Individual options waiver services shall be provided in accordance with each enrollee's ISP as specified in paragraph (G) of this rule; and
- (5) No provider of individual options waiver services shall enter into or maintain any contract for the provision of waiver services except as noted in paragraph (J)(2) of this rule. ~~Only those subcontracts specified in Chapter 5123:2-9 of the Administrative Code are permissible.~~

(K) Provider payment standards

~~Individuals enrolled in the individual options waiver program shall be subject to the payment standards set forth in rules 5123:1-2-08, 5123:1-2-11, and paragraphs (A) to (C) of rule 5101:3-1-60 of the Administrative Code. At such time as reimbursement standards in rules 5101:3-41-11 and 5123:2-9-06 of the Administrative Code are in effect those payment standards shall apply.~~ Provider payment standards for the individual options waiver are established in Chapters 5101:3-41 and 5123:2-9 of the Administrative Code.

(L) Monitoring, compliance, and sanctions

ODJFS shall conduct periodic monitoring and compliance reviews related to the individual options waiver program in accordance with Chapter 5111. of the Revised Code. Reviews may consist of, but are not limited to, physical inspections of records and sites where services are provided, interviews of providers, recipients, and administrators of waiver services. Certified or licensed individual options

waiver providers, in accordance with the medicaid provider agreement, ~~ODMRDD~~DODD, and ~~CBMRDD~~CBDD shall furnish to ODJFS, the center for medicare and medicaid services (CMS), and the medicaid fraud control unit or their designees any records related to the administration and/or provision of individual options waiver services. Individuals enrolled in the individual options waiver program shall cooperate with all monitoring, compliance, and quality assurance reviews conducted by ODJFS, CMS, and the medicaid fraud control unit or their designee.

(M) Due process

- (1) Whenever an applicant for or enrollee of the individual options waiver program is affected by any action proposed or taken by ~~ODMRDD~~DODD and/or ODJFS, or when action is recommended by the ~~CBMRDD~~CBDD, the entity recommending or taking the action will provide medicaid due process in accordance with section 5101.35 of the Revised Code through the state fair hearing process, and as specified in Chapters 5101:6-1 to 5101:6-9 of the Administrative Code. Such actions may include, but are not limited to, the approval, denial, or termination of enrollment or a denial or change in the level, and/or type of waiver services delivered to an individual options waiver enrollee.
- (2) If an applicant or enrollee requests a hearing, as specified in Chapters 5101:6-1 to 5101:6-9 of the Administrative Code, the participation of ~~ODMRDD~~DODD and the ~~CBMRDD~~CBDD is required during the hearing proceedings to justify the decision under appeal.

Effective:

R.C. 119.032 review dates: 04/29/2011

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 5111.85

Rule Amplifies: 5111.042, 5111.85, 5111.851, 5111.852, 5111.87,5111.871, 5111.91

Prior Effective Dates: 7/1/05, 1/1/07, 7/1/07, 10/1/07, 12/21/07(Emer),3/20/08

5160-41-05 Waiting Lists for Home and Community-Based Services Administered by the Ohio Department of Developmental Disabilities

Formerly 5101:3-41-05 Waiting Lists for Home and Community-Based Services Administered by the Ohio Department of Developmental Disabilities

LTCSSSTL 11-09

Effective Date: September 15, 2011

Most Current Prior Effective Date: May 9, 2002

(A) Purpose

This rule sets forth the requirements of a county board of developmental disabilities to establish and maintain a waiting list for home and community-based services.

(B) Definitions

- (1) "County board" means a county board of developmental disabilities established under Chapter 5126. of the Revised Code with local administrative authority.
- (2) "DODD" means the Ohio department of developmental disabilities established under section 121.02 of the Revised Code.
- (3) "Home and community-based services" means services provided under a medicaid-funded waiver pursuant to section **5111.871** of the Revised Code.
- (4) "ODJFS" means the Ohio department of job and family services as established under section **121.02** of the Revised Code.
- (5) "Waiting lists" means a list established and maintained in accordance with rule **5123:2-1-08** of the Administrative Code.

(C) Requirements

- (1) County boards shall establish and maintain waiting lists for home and community-based services in accordance with rule 5123:2-1-08 of the Administrative Code.
- (2) There shall be no waiting list for the following services:
 - (a) Medicaid state plan services.
 - (b) Home and community-based services for individuals already enrolled in a home and community-based services waiver administered by DODD who are assessed and determined to have a need for the services covered by the waiver in which the individual is enrolled.
 - (c) Home and community-based services to children who are subject to a determination under section **121.38** of the Revised Code and require the services.

(D) Due process shall be available to an individual aggrieved by an action of a county board related to the establishment or maintenance of, placement on, the failure to offer services in accordance with, or removal from a waiting list.

(E) DODD shall monitor compliance with this rule by the county boards and their contract agencies.

Replaces: 5101:3-41-05

Effective:

R.C. 119.032 review dates:

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 5111.85, 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.85, 5111.871, 5123.046, 5126.042

Prior Effective Dates: 2/15/02 (Emer.), 5/09/02

5160-41-08 Free Choice of Provider Requirements for Medicaid Home and Community-Based Services Programs Administered by the Ohio Department of Developmental Disabilities

***Formerly* 5101:3-41-08 Free Choice of Provider Requirements for Medicaid Home and Community-Based Services Programs Administered by the Ohio Department of Developmental Disabilities**

LTCSSSTL 11-09

Effective Date: September 15, 2011

Most Current Prior Effective Date: July 1, 2005

- (A) The purpose of this rule is to set forth the requirements the Ohio department of developmental disabilities (DODD) must meet to assure free choice of provider.
- (B) The ~~Ohio department of mental retardation and developmental disabilities (ODMRDD)~~ (DODD), through an interagency agreement with the Ohio department of job and family services (ODJFS), acts as the administrative agency for components of the medicaid home and community-based services programs in accordance with section 5111.91 of the Revised Code. In accordance with section 5111.871 of the Revised Code, the ~~ODMRDD~~ DODD, as the designated administrator, shall promulgate rule(s) to require that recipients of home and community-based services are provided choice of medicaid home and community-based providers consistent with federal free choice of provider requirements set forth in 42 C.F.R. 431.51 (as amended ~~June 14, 2002~~ December 4, 2007). Any rule(s) authorized by this rule and promulgated by the ~~ODMRDD~~ DODD are valid only to the extent they are consistent with 42 C.F.R. 431.51 (~~as amended June 14, 2002~~). If the rules promulgated by ~~ODMRDD~~ DODD are capable of more than one interpretation, they shall be applied in a manner most consistent with the letter and intent of 42 C.F.R. 431.51 (~~as amended June 14, 2002~~).
- (C) Rules promulgated by ~~ODMRDD~~ DODD shall establish policies related to the provision of free choice of medicaid home and community-based service providers for each service specified in a recipient's individual service plan and shall include the following:
- (1) The general roles and responsibilities of the county board of mental retardation and developmental disabilities as specified in rule 5123: 2-9-11 of the Administrative Code.
 - (2) The roles and responsibilities of the county board of ~~MRDD~~ developmental disabilities for the assurance of due process and fair hearing rights regarding recipients' free choice of medicaid home and community-based service providers.
 - (3) The roles and responsibilities of ~~ODMRDD~~ DODD for monitoring and assuring compliance with recipients' free choice of medicaid home and community-based service provider requirements.
 - (D) ODJFS shall conduct periodic monitoring and compliance reviews related to free choice of medicaid home and community-based service providers.

Effective:

R.C. 119.032 review dates: 06/28/2011

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 5111.85, 5111.871

Rule Amplifies: 5111.85, 5111.871

Prior Effective Dates: 7/1/05

5160-41-11 Home and Community-Based Waiver Services -Payment for Waiver Services Administered by the Department of Developmental Disabilities

Formerly 5101:3-41-11 Home and Community-Based Waiver Services -Payment for Waiver Services Administered by the Department of Developmental Disabilities

LTCSSTL 12-01

Effective Date: March 19, 2012

Most Current Prior Effective Date: July 15, 2011

5101:3-41-11 Appendix A

(A) Purpose.

The purpose of this rule is to establish the payment standards governing reimbursement for home and community-based services (HCBS) provided by certified or licensed waiver providers to individuals enrolled in a HCBS program as a component of the medicaid program and as administered by the department of developmental disabilities (DODD) in accordance with sections **5111.85** and **5111.873** of the Revised Code.

(B) The DODD is responsible for the daily administration of certain components of the medicaid program, to include HCBS, pursuant to an interagency agreement with the Ohio department of job and family services (ODJFS) in accordance with sections **5111.91 and **5111.871** of the Revised Code.**

(C) Individuals enrolled in the individual options or level one HCBS programs administered by DODD shall be subject to the payment standards set forth in rules **5101:3-41-18 and **5101:3-41-19** of the Administrative Code.**

(D) The standards and procedures set for prior authorization as defined in rule **5101:3-41-12 of the Administrative Code shall apply for individuals enrolled on the individual options waiver.**

(E) For purposes of payment, HCBS services provided to individuals enrolled on the level one or individual options waivers must meet the definition of the waiver service as defined in the federally approved waiver document.

(F) Projection of costs for HCBS services.

(1) Beginning on and after December 31, 2010, the county boards of developmental disabilities shall project waiver service costs in accordance with the individual service plan for individuals initially enrolled on the individual options or level one waivers or at an enrollee's annual re-determination date for waiver services by using the authorized cost projection tool as referenced in rule **5123:2-9-06 of the Administrative Code.**

(2) HCBS service cost projections made in accordance with paragraph (F)(1) of this rule shall be completed no later than December 31, 2011.

(3) DODD providers of HCBS waiver services shall have access to the cost projection tool upon request to the department. Providers may prepare draft versions of the cost projection tool and forward to the county board for consideration.

(G) Homemaker personal care rate modification for former residents of developmental centers.

(1) DODD shall pay an add-on rate modification for routine homemaker personal care services to providers serving individuals that are former residents of developmental centers in accordance with section 263.20.70 Amended Substitute House Bill No. 153 of the 129th General Assembly. The add-on will apply if the following conditions are met:

(a) The individual was a resident of a developmental center prior to enrollment in the individual options waiver; and

(b) The homemaker personal care service is identified in the individual service plan and the individual began receiving the service on or after July 1, 2011; and

(c) The director of DODD determines that the homemaker personal care add-on is warranted by the individual's special circumstances, including the individual's diagnosis, service needs, or length of stay at the developmental center, and that serving the individual through the individual options waiver is fiscally prudent for the medicaid program.

(2) The homemaker personal care rate add-on modification referenced in paragraph (G) of this rule shall be limited to fifty-two cents for each fifteen minute unit of routine homemaker personal care service provided to the individual.

(3) The homemaker personal care rate add-on modification amount shall be limited to former developmental center residents during the first year of their waiver enrollment and shall apply for enrollments beginning on or after July 1, 2011 and ending June 30, 2013.

(4) DODD shall provide ODJFS with supporting documentation of the homemaker personal care rate add-on for former developmental center residents upon request.

(H) ODJFS authority.

ODJFS retains the final authority to establish payment rates for waiver services approved under the level one and individual options waivers and has final approval of any policies and rules that govern any component of the medicaid program.

(I) Due process.

(1) Applicants for waiver enrollment or individuals enrolled on any waiver administered by DODD shall be afforded due process in accordance with section 5101.35 of the Revised Code through the state fair hearing process, and as specified in Chapters 5101:6-1 to 5101:6-9 of the Administrative Code.

(2) If an applicant or enrollee requests a hearing, as specified in Chapters 5101:6-1 to 5101:6-9 of the Administrative Code, the participation of DODD, and/or the county board of developmental disabilities is required during the hearing proceedings to justify the decision under appeal, in accordance with section [5126.055](#) of the Revised Code.

Replaces: 5101:3-41-11

Effective: 03/19/2012

R.C. 119.032 review dates: 01/01/2017

Certification: CERTIFIED ELECTRONICALLY

Date: 01/27/2012

Promulgated Under: 119.03

Statutory Authority: 5111.85, 5111.873, 5111.91, 5111.871

Rule Amplifies: 5111.85, 5111.873

Prior Effective Dates: 7/1/05, 10/1/07, 12/21/07 (Emer.), 3/20/08, 7/1/10, 7/15/11

5160-41-12 Home and Community-Based Services Waivers - Request for Prior Authorization for Individuals Enrolled in the Individual Options Waiver

***Formerly* 5101:3-41-12 Home and Community-Based Services Waivers - Request for Prior Authorization for Individuals Enrolled in the Individual Options Waiver**

LTCSTL 13-03

Effective Date: January 17, 2013

Most Current Prior Effective Date: July 1, 2005

(A) Purpose.

The purpose of this rule is to authorize the process for prior authorization of waiver services when an individual funding level exceeds the funding range determined by the Ohio developmental disabilities profile (ODDP) for individuals enrolled in the individual options waiver.

(B) Standards and procedures.

(1) The prior authorization process shall be followed in accordance with rule **5123:2-9-07** of the Administrative Code.

(2) The Ohio department of developmental disabilities (DODD) shall inform the office of medical assistance (OMA) of all approvals and denials. OMA may review all approvals and denials and may take corrective action in accordance with 42 C.F.R. 431.246.

(3) DODD and the county board shall maintain all records related to the review of prior authorizations for a period of six years following receipt of the request.

(C) Provider payment standards.

Provider payment standards for the individual options waiver are established in rule **5101:3-41-18** and Chapter 5123:2-9 of the Administrative Code.

(D) Monitoring, compliance, and sanctions.

(1) DODD shall submit to OMA, on a quarterly basis, a summary of requests for prior authorization received. DODD shall also systematically evaluate compliance with prior authorization requirements by verifying that each individual's funding level is maintained within the prior authorized amount. Results of this evaluation shall be provided in writing to OMA no less than quarterly.

(2) OMA shall periodically analyze the frequency and distribution of all requests for prior authorization to identify statistically significant patterns or trends.

(E) Due process.

Applicants for waiver enrollment or individuals enrolled on any waiver administered by DODD shall be afforded due process in accordance with section **5101.35** of the Revised Code through the state fair hearing process, and as specified in Chapters 5101:6-1 to 5101:6-9 of the Administrative Code.

(F) OMA authority.

OMA retains the final authority to establish payment rates for waiver services approved under the individual options waiver, and to approve individual service plans, and has final approval of any policies and rules that govern any component of the medicaid program.

Replaces: Part of 5101:3-41-12

Effective: 01/17/2013

R.C. 119.032 review dates: 01/01/2018

Certification: CERTIFIED ELECTRONICALLY

Date: 12/21/2012

Promulgated Under: 119.03

Statutory Authority: 5111.871, 5123.04

Rule Amplifies: 5111.871, 5123.04

Prior Effective Dates: 7/1/05

5160-41-15 Home and Community Based Waiver Services-Reimbursement for Adult Day Services as Administered by the Department of Developmental Disabilities

***Formerly* 5101:3-41-15 Home and Community Based Waiver Services-Reimbursement for Adult Day Services as Administered by the Department of Developmental Disabilities**

LTCSTL 12-07

Effective Date: September 15, 2012

Most Current Prior Effective Date: October 1, 2007

5101:3-41-15 Appendix A - Billing Codes

- (A) Individuals receiving an adult day service through a medicaid waiver program administered by the Ohio department of developmental disabilities (DODD) in accordance with sections **5111.85** and **5111.873** of the Revised Code shall be subject to payment standards set forth in this rule and in the following rules of the Administrative Code as specified:
- (1) Vocational habilitation shall be in accordance with rules **5123:2-9-14** and **5123:2-9-19** of the Administrative Code.
 - (2) Supported employment- community shall be in accordance with rules **5123:2-9-15** and 5123:2-9-19 of the Administrative Code.
 - (3) Supported employment- enclave shall be in accordance with rules **5123:2-9-16** and 5123:2-9-19 of the Administrative Code.
 - (4) Adult day support shall be in accordance with rules **5123:2-9-17** and 5123:2-9-19 of the Administrative Code.
 - (5) Non medical transportation shall be in accordance with rules **5123:2-9-18** and 5123:2-9-19 of the Administrative Code.
- (B) County boards of developmental disabilities shall submit cost reports to the DODD for the purpose of allocating adult day services costs. The format of the cost report shall be designed by DODD and accepted by ODJFS.
- (C) Due process.
- (1) Applicants for waiver enrollment or individuals enrolled on a waiver administered by DODD shall be afforded due process in accordance with section **5101.35** of the Revised Code through the state fair hearing process and as specified in Chapters 5101:6-1 to 5101:6-9 of the Administrative Code.
 - (2) If an applicant or enrollee requests a hearing, as specified in Chapters 5101:6-1 to 5101:6-9 of the Administrative Code, the participation of DODD and/or the county board of developmental disabilities is required during the hearing proceedings to justify the decision under appeal in accordance with section **5126.055** of the Revised Code.
- (D) Monitoring.
- ODJFS shall monitor reimbursement made under authority of this rule as necessary to ensure that the funding applicable to home and community-based services (HCBS) is used for authorized purposes in compliance with laws, regulations and provisions governing the medicaid program.

Replaces: 5101:3-41-15

Effective: 09/15/2012

R.C. 119.032 review dates: 09/01/2017

Certification: CERTIFIED ELECTRONICALLY

Date: 08/27/2012

Promulgated Under: 119.03

Statutory Authority: 5111.873, 5111.85

Rule Amplifies: 5111.873, 5111.85

Prior Effective Dates: 1/01/07, 07/01/07, 10/01/07

5160-41-16 Assistance to Enable a County Board of Developmental Disabilities to Pay Non-Federal Share of Medicaid Expenditures for Home and Community-Based Services

***Formerly* 5101:3-41-16 Assistance to Enable a County Board of Developmental Disabilities to Pay Non-Federal Share of Medicaid Expenditures for Home and Community-Based Services**

CATL-MRDD 10-02

Effective Date: September 1, 2010

(A) Purpose.

This rule authorizes the provisions set forth in rule 5123:1-5-02 of the Administrative Code which sets forth the process a county board of developmental disabilities must follow to request assistance from the department of developmental disabilities (DODD) in the event of failure of a county property tax levy for home and community-based services (HCBS) to individuals with developmental disabilities in that county.

(B) Definitions.

- (1) "County board" means a county board of developmental disabilities established under Chapter 5126. of the Revised Code.
- (2) "Home and community-based services" means medicaid-funded home and community-based services provided pursuant to section 5111.871 of the Revised Code.
- (3) "OBM" means the office of budget and management as established by section 121.02 of the Revised Code.
- (4) "ODJFS" means the Ohio department of job and family services as established under section 121.02 of the Revised Code.
- (5) "DODD" means the Ohio department of developmental disabilities established under section 121.02 of the Revised Code.

(C) Requirements.

- (1) A county board of developmental disabilities may request assistance from the DODD to pay the non-federal share of medicaid expenditures for HCBS services when a local county board operating levy fails in accordance with rule 5123:1-5-02 of the Administrative Code.
- (2) Prior to a county board of developmental disabilities receiving assistance, the DODD shall notify and consult with both OBM and the ODJFS, office of Ohio health plans.
- (3) Documentation submitted by a county board to make a request for assistance and/or any documentation used by the department to determine a decision of approval or denial shall be made available to OBM or ODJFS upon request.

Effective: 09/01/2010

R.C. 119.032 review dates: 09/01/2015

Certification: CERTIFIED ELECTRONICALLY

Date: 08/17/2010

Promulgated Under: 119.03

Statutory Authority: 5111.01, 5111.02, 5111.85

Rule Amplifies: 5111.01, 5111.02, 5111.85

LTCSTL 12-04

Effective Date: July 1, 2012

(A) Purpose.

- (1) The purpose of this rule is to establish the self-empowered life funding waiver as a component of the medicaid home and community-based services program pursuant to sections [5111.85](#) and [5111.87](#) of the Revised Code.**
- (2) The self-empowered life funding waiver program provides necessary waiver services to individuals who meet the level of care criteria for an intermediate care facility for individuals with mental retardation and other developmental disabilities as set forth in rule [5101:3-3-07](#) of the Administrative Code, as well as other eligibility requirements established in this rule.**
- (3) The Ohio department of developmental disabilities (DODD), through an interagency agreement with the Ohio department of job and family services (ODJFS), administers the self-empowered life funding waiver program on a daily basis in accordance with section [5111.91](#) of the Revised Code.**
- (4) This waiver will provide services under a participant-directed model to individuals with developmental disabilities in order to avoid or delay institutionalization.**

(B) Definitions.

- (1) "Adult" means an individual who is at least twenty-two years old or an individual who is eligible for adult day support, vocational habilitation, supported employment-enclave, or integrated employment.**
- (2) "Agency with choice" has the same meaning as defined in rule [5123:2-9-40](#) of the Administrative Code.**
- (3) "Budget authority" has the same meaning as defined in rule [5123:2-9-40](#) of the Administrative Code.**
- (4) "Child" means an individual twenty-one years of age or younger who is not eligible for adult day support, vocational habilitation, supported employment-enclave, or integrated employment.**
- (5) "Co-employer" has the same meaning as defined in rule [5123:2-9-40](#) of the Administrative Code.**
- (6) "Common law employer" has the same meaning as defined in rule [5123:2-9-40](#) of the Administrative Code.**
- (7) "County board of developmental disabilities (CBDD)" means a board established under Chapter [5126](#). of the Revised Code.**
- (8) "Employer authority" has the same meaning as defined in rule [5123:2-9-40](#) of the Administrative Code.**
- (9) "Financial management services" has the same meaning as defined in rule [5123:2-9-40](#) of the Administrative Code.**
- (10) "Home and community-based services (HCBS)" means any federally approved medicaid waiver service provided to a waiver enrollee as an alternative to institutional care under Section 1915(c) of the Social Security Act, 49 Stat. 620 (1935), 42 U.S.C.1396n, as amended, under which federal reimbursement is provided for designated home and community-based services to eligible individuals.**

- (11) "Individual" means a person with mental retardation or other developmental disability who is eligible to receive HCBS as an alternative to placement in an intermediate care facility for the mentally retarded under the applicable HCBS waiver. A guardian or authorized representative may take any action on behalf of the individual, may make choices for an individual or may receive notice on behalf of an individual to the extent permitted by applicable law.
- (12) "Individual Service Plan (ISP)" means a written description of the services, supports, and activities to be provided to an individual in accordance with paragraph (H) of this rule.
- (13) "Participant direction" has the same meaning as defined in rule 5123:2-9-40 of the Administrative Code.
- (14) "Provider" means a person or agency certified or licensed by DODD that has met the provider qualification requirements to provide the specific self-empowered life funding waiver service as specified in paragraph (J)(1) of this rule and holds a valid medicaid provider agreement in accordance with paragraph (J)(2) of this rule.
- (15) "SSA" means a service and support administrator who is certified in accordance with rules adopted by the DODD under Chapter 5123:2-5 of the Administrative Code and who provides the functions of service and support administration.
- (16) "Waiver eligibility span" means the twelve-month period following either an individual's initial enrollment date or a subsequent eligibility re-determination date.

(C) Application for the self-empowered life funding waiver.

- (1) Individuals seeking to enroll in the self-empowered life funding waiver program must complete the JFS 02399 "Request for Medicaid Home and Community-Based Services (HCBS) " (rev. 1/2012). Forms shall be available at all CBDD. Forms are also available at the county department of job and family services (CDJFS). Forms are to be used in accordance with rule [5101:1-38-01.2](#) of the Administrative Code.
- (2) The CBDD is responsible for explaining to individuals requesting HCBS the services available through the self-empowered life funding waiver benefit package including the amount, scope and duration of services and any applicable benefit package limitations.

(D) Eligibility criteria for the self-empowered life funding waiver.

- (1) The individual applying for the self-empowered life funding waiver program must be determined to require the level of care provided in an ICF/MR and be eligible for ICF/MR services upon initial enrollment and no later than every twelve months thereafter, as specified in rules 5101:3-3-07 and [5123:2-9-01](#) of the Administrative Code and in accordance with the process set forth in rule [5101:3-3-15.5](#) of the Administrative Code; and
- (2) The individual's medicaid eligibility has been established in accordance with Chapters 5101:1-37 to 5101:1-42 of the Administrative Code; and
- (3) The individual's health and welfare needs can be met through the utilization of self-empowered life funding waiver services at or below the federally approved cost limitation and other formal and informal supports regardless of funding source.
- (4) The individual must require, at a minimum, one waiver service as described in paragraph (F) of this rule, to be considered eligible for this waiver.

(E) Self-empowered life funding waiver enrollment, continued enrollment, and disenrollment.

- (1) Individuals who meet the eligibility criteria in paragraph (D) of this rule, or their legal representative, shall be informed of the following:
 - (a) All services available on this self-empowered life funding waiver, as delineated in paragraph (F) of this rule, and any choices that the individual may make regarding those services;
 - (b) Any feasible alternative to the waiver; and

(c) The right to choose either institutional or home and community-based services.

- (2) DODD shall allocate waiver slots to the county board in accordance with section 5111.872 of the Revised Code.
- (3) DODD shall reserve capacity under the self-empowered life funding waiver for children with intensive behavioral needs as federally approved.
- (4) The CBDD shall offer available self-empowered life funding waiver slots to eligible individuals in accordance with applicable waiting list category requirements set forth in rules 5101:3-41-05 and 5123:2-1-08 of the Administrative Code.
- (5) An individual's continued enrollment in the self-empowered life funding waiver program shall be redetermined no less frequently than every twelve months beginning with the individual's initial enrollment date or subsequent redetermination date. Individuals must continue to meet the eligibility criteria specified in paragraph (D) of this rule to continue enrollment in the waiver program.
- (6) The maximum number of individuals that can be enrolled in the self-empowered life funding waiver program statewide shall not exceed the allowable number specified as federally approved.
- (7) The individual must require at least one waiver service monthly, or, if less than monthly, require monthly monitoring of the individual's health and welfare. If no services are planned to be delivered in a month, monthly monitoring of the individual's health and welfare must be required in the ISP, as designated in paragraph (H) of this rule, and must include at least periodic face-to-face monitoring.
- (8) While enrolled in the self-empowered life funding waiver program, if the enrollee does not receive any waiver services as listed in paragraph (F) of this rule for one month, the county board shall, within fifteen days after the end of the calendar month, assess the enrollee's current need for waiver services, and discuss these needs with the enrollee and their representative. As a result of the assessment and discussion, if no waiver services are needed, the enrollee shall be recommended for disenrollment from the waiver program and shall be given notification of hearing rights as established in paragraph (M) of this rule.

(F) Self-empowered life funding waiver program benefit package, as included in the federally approved waiver document:

The self-empowered life funding waiver program benefit package is limited to the following services:

- (1) Support broker;
- (2) Community inclusion- personal assistance;
- (3) Community inclusion- transportation;
- (4) Participant-directed goods and services;
- (5) Participant family stability assistance;
- (6) Functional behavioral assessment;
- (7) Clinical therapeutic intervention;
- (8) Community respite;
- (9) Residential respite;
- (10) Remote monitoring;
- (11) Remote monitoring equipment;
- (12) Integrated employment;
- (13) Adult day supports;
- (14) Vocational habilitation;

(15) Supported employment-enclave;

(16) Non-medical transportation.

(G) Limits on self-empowered life funding waiver services.

(1) Self-empowered life funding waiver benefit limitations shall be in accordance with the benefit limitations as established in rule [5123:2-9-40](#) of the Administrative Code.

(2) Adults receiving services under the self-empowered life funding waiver are subject to a benefit limitation not to exceed forty thousand dollars per waiver eligibility span.

(3) Children receiving services under the self-empowered life funding waiver are subject to a benefit limitation not to exceed twenty-five thousand dollars per waiver eligibility span.

(H) Self-empowered life funding service plan requirements.

(1) All services shall be provided to an individual enrolled in the self-empowered life funding waiver program pursuant to a written ISP.

(2) The ISP shall be developed by qualified persons with input from the self-empowered life funding waiver enrollee and the SSA in accordance with section 5126.15 of the Revised Code. Providers shall participate in the ISP meetings when a request for their participation is made by the individual enrollee.

(a) The ISP shall list the self-empowered life funding waiver services and the non-waiver services, regardless of funding source, that are necessary to ensure the enrollee's health and welfare; and

(b) The ISP shall contain the following medicaid required elements:

(i) Type of service to be provided; and

(ii) Amount of service to be provided; and

(iii) Frequency and duration of each service to be provided; and

(iv) Type of provider to furnish each service.

(c) The ISP shall be developed on at least an annual basis consistent with the individual's redetermination as indicated in paragraph (E) of this rule or as the individual's needs change and in accordance with division 5123:2 of the Administrative Code; and

(d) The ISP shall be developed to include only waiver services which are consistent with efficiency, economy and quality of care; and

(e) The ISP is subject to approval by ODJFS and DODD pursuant to section [5111.871](#) of the Revised Code. Notwithstanding the procedures set forth in this rule, ODJFS may in its sole discretion, and in accordance with section [5111.852](#) of the Revised Code direct the CBDD or DODD to amend ISPs for individuals if ODJFS determines that such services are medically necessary and the procedures set forth in division 5101:3 of the Administrative Code would not accommodate a request for such medically necessary services.

(I) Free choice of provider.

Individuals enrolled in the self-empowered life funding waiver program shall be given a free choice of qualified self-empowered life funding waiver providers in accordance with Chapters 5101:3-41 and 5123:2-9 of the Administrative Code. A provider is qualified if they meet the standards established in paragraph (J)(2) of this rule. DODD shall create and maintain an internet-based list of those providers who are qualified to provide self-empowered life funding waiver services in accordance with section 5126.046 of the Revised Code. This list will be accessible to county boards and individuals applying for or receiving services. The CBDD shall provide information about the internet-based provider list to applicants and enrollees and shall assist an individual to access this list to assure the individual's free choice of qualified providers.

(J) Provision of self-empowered life funding waiver services.

- (1) Self-empowered life funding waiver services shall be provided by persons or agencies who have certification or licensure in accordance with section 5123.045 of the Revised Code and division 5123:2 of the Administrative Code; and
- (2) Self-empowered life funding waiver services shall be provided by persons or agencies who have a valid medicaid provider agreement in accordance with rule [5101:3-1-17.2](#) of the Administrative Code; and
- (3) Self-empowered life funding services shall be provided only to individuals who have met the eligibility requirements in paragraph (D) of this rule and are enrolled in the self-empowered life funding waiver program at the time of service delivery; and
- (4) Self-empowered life funding waiver services shall be provided in accordance with each enrollee's ISP as specified in paragraph (G) of this rule; and
- (5) No provider of self-empowered life funding waiver services shall enter into or maintain any contract for the provision of waiver services except as noted in paragraph (J)(2) of this rule.

(K) Provider payment standards.

Provider payment standards for the self-empowered life funding waiver are established in rule [5101:3-41-20](#) and Chapter 5123:2-9 of the Administrative Code.

(L) Monitoring, compliance, and sanctions.

ODJFS shall conduct periodic monitoring and compliance reviews related to the self-empowered life funding waiver program in accordance with Chapter 5111. of the Revised Code. Reviews may consist of, but are not limited to, physical inspections of records and sites where services are provided, interviews of providers, recipients, and administrators of waiver services. Certified self-empowered life funding waiver providers, in accordance with the medicaid provider agreement, DODD, and CBDD shall furnish to ODJFS, the center for medicare and medicaid services (CMS), and the medicaid fraud control unit or their designees any records related to the administration and/or provision of self-empowered life funding waiver services. Individuals enrolled in the self-empowered life funding waiver program shall cooperate with all monitoring, compliance, and quality assurance reviews conducted by ODJFS, CMS, and the medicaid fraud control unit or their designee.

(M) Due process.

- (1) Whenever an applicant for or enrollee of the self-empowered life funding waiver program is affected by any action proposed or taken by DODD and/or ODJFS, or when action is recommended by the CBDD, the entity recommending or taking the action will provide medicaid due process in accordance with section 5101.35 of the Revised Code through the state fair hearing process, and as specified in Chapters 5101:6-1 to 5101:6-9 of the Administrative Code. Such actions may include, but are not limited to, the approval, denial, or termination of enrollment or a denial or change in the level, and/or type of waiver services delivered to a self-empowered life funding waiver enrollee.
- (2) If an applicant or enrollee requests a hearing, as specified in Chapters 5101:6-1 to 5101:6-9 of the Administrative Code, the participation of DODD and the CBDD is required during the hearing proceedings to justify the decision under appeal.

Effective:

R.C. 119.032 review dates:

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 5111.85, 5111.87, 5111.872, 5111.91, 5111.871, 5111.852

Rule Amplifies: 5111.85, 5111.87

LTCSSTL 14-06

Effective Date: July 1, 2014

Most Current Prior Effective Date: March 19, 2012

5101:3-41-18 Appendix A

(A) Purpose.

The purpose of this rule is to establish the payment standards for the individual options home and community-based services (HCBS) waiver for services provided to individuals enrolled in a HCBS program, as a component of the medicaid program and as administered by the department of developmental disabilities (DODD) in accordance with sections **5166.02** and **5166.23** of the Revised Code.

(B) The DODD is responsible for the daily administration of certain components of the medicaid program, to include HCBS, pursuant to an interagency agreement with the Ohio department of medicaid (ODM) in accordance with sections **5162.35 and **5166.21** of the Revised Code.**

(C) Individuals enrolled in the individual options HCBS program administered by DODD shall be subject to payment standards set forth in this rule and the rules associated with the individual options waiver program as established in Chapter **5123:2-9 of the Administrative Code.**

(D) Payment for individual options waiver services shall not exceed the maximum rates established in Chapter 5123:2-9 of the Administrative Code.

(E) Claims for the provision of HCBS shall be submitted in accordance with the process specified in rule **5123:2-9-06 of the Administrative Code.**

(F) Claims for the provision of HCBS shall be paid as indicated in this rule when the following conditions exist:

(1) The waiver service is provided to an individual who is enrolled in a waiver program at the time of service; and

(2) The waiver service is provided within the limitations specified by the waiver program in which the individual is enrolled; and

(3) The waiver service is provided to an enrollee who is not an inpatient of a hospital and is not residing in a nursing facility or an intermediate care facility for individuals with intellectual disabilities (ICF/IID).

(a) An individual enrolled in a DODD administered waiver program which offers institutional respite as one of the waiver services shall not be considered a resident of an intermediate care facility (ICF) if an ICF is providing the institutional respite service.

(b) An ICF providing respite services for any DODD administered waiver program that offers such services shall not bill medicaid through the ICF program. Payments for respite services shall be made through the waiver program in which the individual is enrolled.

(G) Payments made under authority of this rule constitute payment-in-full and shall not be construed as a partial payment.

(H) ODM authority.

ODM retains the final authority to establish payment rates for waiver services approved under the individual options waiver and has final approval of any policies and rules that govern any component of the medicaid program.

Replaces: 5160-41-18

Effective: 07/01/2014

R.C. 119.032 review dates: 07/01/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 06/10/2014

Promulgated Under: 119.03

Statutory Authority: 5166.02, 5166.23

Rule Amplifies: 5166.02, 5166.23, 5162.35, 5166.21

Prior Effective Dates: 3/19/12

LTCSTL 14-06

Effective Date: July 1, 2014

Most Current Prior Effective Date: September 1, 2013

5101:3-41-19 Appendix A

(A) Purpose.

The purpose of this rule is to establish the payment standards for the level one home and community-based services (HCBS) waiver for services provided to individuals enrolled in a HCBS program, as a component of the medicaid program and as administered by the department of developmental disabilities (DODD) in accordance with sections **5166.02** and **5166.23** of the Revised Code.

(B) The DODD is responsible for the daily administration of certain components of the medicaid program, to include HCBS, pursuant to an interagency agreement with the Ohio department of medicaid (ODM) in accordance with sections **5162.35 and **5166.21** of the Revised Code.**

(C) Individuals enrolled in the level one HCBS program administered by DODD shall be subject to payment standards set forth in this rule and the rules associated with the level one waiver program as established in Chapter **5123:2-9 of the Administrative Code.**

(D) Payment for level one waiver services shall not exceed the maximum rates established in Chapter 5123:2-9 of the Administrative Code.

(E) Claims for the provision of HCBS shall be submitted in accordance with the process specified in rule **5123:2-9-06 of the Administrative Code.**

(F) Claims for the provision of HCBS shall be paid as indicated in this rule when the following conditions exist:

(1) The waiver service is provided to an individual who is enrolled in a waiver program at the time of service; and

(2) The waiver service is provided within the limitations specified by the waiver program in which the individual is enrolled; and

(3) The waiver service is provided to an enrollee who is not an inpatient of a hospital and is not residing in a nursing facility or an intermediate care facility for individuals with intellectual disabilities (ICF/IID).

(a) An individual enrolled in a DODD administered waiver program which offers residential respite as one of the waiver services shall not be considered a resident of an intermediate care facility (ICF) if an ICF is providing the residential respite service.

(b) An ICF providing residential respite services for any DODD administered waiver program that offers such services shall not bill medicaid through the ICF program. Payments for residential respite services shall be made through the waiver program in which the individual is enrolled.

(G) Payments made under authority of this rule constitute payment-in-full and shall not be construed as a partial payment.

(H) ODM authority.

ODM retains the final authority to establish payment rates for waiver services approved under the level one waiver and has final approval of any policies and rules that govern any component of the medicaid program.

Replaces: 5160-41-19

Effective: 07/01/2014

R.C. 119.032 review dates: 07/01/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 06/10/2014

Promulgated Under: 119.03

Statutory Authority: 5166.02, 5166.23

Rule Amplifies: 5166.02, 5166.23, 5162.35, 5166.21

Prior Effective Dates: 9/1/2013, 3/19/12

LTCSSSTL 12-04

Effective Date: July 1, 2012

OAC 5101:3-41-20 Appendix A, Fee Schedule Maximums for Home and Community Based Services - Self-Empowered Life Funding

(A) Purpose.

The purpose of this rule is to establish the payment standards governing reimbursement for home and community-based services (HCBS) provided by certified or licensed waiver providers to individuals enrolled in the self-empowered life funding waiver program as a component of the medicaid program and as administered by the Ohio department of developmental disabilities (DODD) in accordance with sections [5111.85](#) and [5111.873](#) of the Revised Code.

(B) The DODD is responsible for the daily administration of certain components of the medicaid program, to include HCBS, pursuant to an interagency agreement with the Ohio department of job and family services (ODJFS) in accordance with sections [5111.91](#) and [5111.871](#) of the Revised Code.

(C) Individuals enrolled in the self-empowered life funding waiver administered by the DODD shall be subject to the payment standards set forth in this rule.

(D) The standards and procedures set for prior authorization as defined in rule [5101:3-41-12](#) of the Administrative Code shall not apply to individuals enrolled on the self-empowered life funding waiver.

(E) For purposes of payment, HCBS services provided to individuals enrolled on the self-empowered life funding waiver must meet the definition of the waiver service as federally approved.

(F) Budget limitations.

(1) Children receiving services under the self-empowered life funding waiver shall be subject to a budget limitation of twenty-five thousand dollars for the individual's waiver eligibility span.

(2) Adults receiving services under the self-empowered life funding waiver shall be subject to a budget limitation of forty-thousand dollars for the individual's waiver eligibility span.

(G) Individuals enrolled in the self-empowered life funding HCBS program administered by DODD shall be subject to the payment standards set forth in this rule and in the following rules of the Administrative Code as specified:

(1) Community inclusion shall be in accordance with rule [5123:2-9-42](#) of the Administrative Code.

(2) Residential respite shall be in accordance with rule [5123:2-9-34](#) of the Administrative Code.

(3) Supported employment- enclave shall be in accordance with rules [5123:2-9-16](#) and [5123:2-9-19](#) of the Administrative Code.

(4) Participant-directed goods and services shall be in accordance with rule [5123:2-9-45](#) of the Administrative Code.

(5) Participant/family stability assistance shall be in accordance with rule [5123:2-9-46](#) of the Administrative Code.

(6) Support brokerage shall be in accordance with rule [5123:2-9-47](#) of the Administrative Code.

(7) Clinical/therapeutic intervention shall be in accordance with rule [5123:2-9-41](#) of the Administrative Code.

(8) Residential and community respite shall be in accordance with rule [5123:2-9-34](#) of the Administrative Code.

- (9) Functional behavioral assessment shall be in accordance with rule [5123:2-9-43](#) of the Administrative Code.
- (10) Adult day support shall be in accordance with rules [5123:2-9-17](#) and [5123:2-9-19](#) of the Administrative Code.
- (11) Vocational habilitation shall be in accordance with rules [5123:2-9-14](#) and [5123:2-9-19](#) of the Administrative Code.
- (12) Integrated employment shall be in accordance with rule [5123:2-9-44](#) of the Administrative Code.
- (13) Non medical transportation shall be in accordance with rules [5123:2-9-18](#) and [5123:2-9-19](#) of the Administrative Code.
- (14) Remote monitoring shall be in accordance with rule [5123:2-9-35](#) of the Administrative Code.
- (15) Remote monitoring equipment shall be in accordance with rule [5123:2-9-35](#) of the Administrative Code.
- (H) For purposes of payment, HCBS services provided to individuals enrolled on the self-empowered life funding waiver must meet the definition of the waiver service as federally approved.
- (I) Payment for self-empowered life funding waiver services shall not exceed the rates established in [appendix A](#) to this rule.
- (J) The provider shall bill DODD its usual and customary charge or a rate that does not exceed the maximum rate established in appendix A to this rule.
- (K) Payments made to certified or licensed waiver providers by the DODD are subject to the provision, conditions, and payment standards set forth in this rule. Payment of services made under the authority of this rule shall not exceed the maximum payment rates set forth in appendix A to this rule.
- (L) Certified or licensed waiver providers shall submit claims for the self-empowered life funding services through an approved financial management services agency designated by the DODD and ODJFS.
- (M) Certified or licensed waiver providers of HCBS shall receive payment for the provision of HCBS as indicated in this rule when the following conditions exist:

 - (1) The waiver service is provided by an independent or agency provider that has certification or licensure for each service they provide in accordance with applicable requirements; and
 - (2) The waiver service is provided by an independent or agency provider that has a valid medicaid provider agreement in accordance with rule 5101:3-1-17.2 of the Administrative Code; and
 - (3) The waiver service is provided to an individual who is enrolled in a waiver program at the time of service; and
 - (4) The waiver service is provided in accordance with the enrollee's individual service plan; and
 - (5) The waiver service is provided within the limitations specified by the waiver program in which the individual is enrolled; and
 - (6) The waiver service is provided to an enrollee who is not an inpatient of a hospital, residing in a nursing facility or an intermediate care facility for individuals with mental retardation and other developmental disabilities (ICF/MR).

 - (a) An individual enrolled in a DODD administered waiver program which offers residential respite as one of the waiver services shall not be considered a resident of an ICF/MR if an ICF/MR is providing the residential respite service.
 - (b) An ICF/MR providing residential respite services for any DODD administered waiver program that offers such services shall not bill medicaid through the ICF/MR program. Payments for residential respite services shall be made through the waiver program in which the individual is enrolled.
- (N) Payments made under authority of this rule constitute payment-in-full and shall not be construed as a partial payment.

(O) ODJFS authority.

ODJFS retains the final authority to establish payment rates for waiver services approved under the self-empowered life funding waiver and has final approval of any policies and rules that govern any component of the medicaid program.

(P) Monitoring.

- (1) ODJFS will monitor payment made under authority of this rule as necessary to ensure that the funding applicable to HCBS are used for authorized purposes in compliance with laws, regulations, and the provisions governing the medicaid program.
- (2) ODJFS and DODD may recover any overpayment identified by requesting voluntary repayment, or through provider payment offsets, or formal adjudicatory or non-adjudicatory recovery proceedings.

(Q) Due process.

- (1) Applicants for waiver enrollment or individuals enrolled on any waiver administered by DODD shall be afforded due process in accordance with section 5101.35 of the Revised Code through the state fair hearing process, and as specified in Chapters 5101:6-1 to 5101:6-9 of the Administrative Code.
- (2) If an applicant or enrollee requests a hearing, as specified in Chapters 5101:6-1 to 5101:6-9 of the Administrative Code, the participation of DODD, and/or the county board of developmental disabilities is required during the hearing proceedings to justify the decision under appeal, in accordance with section 5126.055 of the Revised Code.

Effective:

R.C. 119.032 review dates:

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 5111.85, 5111.873, 5111.91, 5111.871

Rule Amplifies: 5111.85, 5111.873

LTCSTL 13-02

Effective Date: January 1, 2013

(A) Purpose.

- (1) The purpose of this rule is to authorize rules governing the transitions developmental disabilities waiver, a component of the medicaid home and community-based services (HCBS) program pursuant to sections [5111.85](#) and [5111.87](#) of the Revised Code.**
- (2) The Ohio department of developmental disabilities (DODD), through an interagency agreement with the Ohio department of job and family services (ODJFS), administers the transitions developmental disabilities waiver program on a daily basis in accordance with section [5111.91](#) of the Revised Code.**

(B) Individuals enrolled in the transitions developmental disabilities HCBS program administered by DODD shall be subject to the service requirements set forth in this rule and in the following rules of the Administrative Code as specified:

- (1) Adult day health center services shall be in accordance with rule [5123:2-9-51](#) of the Administrative Code.**
- (2) Emergency response service shall be in accordance with rule [5123:2-9-52](#) of the Administrative Code.**
- (3) Home-delivered meals shall be in accordance with rule [5123:2-9-53](#) of the Administrative Code.**
- (4) Home modification services shall be in accordance with rule [5123:2-9-54](#) of the Administrative Code.**
- (5) Out-of-home respite shall be in accordance with rule [5123:2-9-55](#) of the Administrative Code.**
- (6) Personal care aide services shall be in accordance with rule [5123:2-9-56](#) of the Administrative Code.**
- (7) Supplemental adaptive and assistive devices shall be in accordance with rule [5123:2-9-57](#) of the Administrative Code.**
- (8) Supplemental transportation services shall be in accordance with rule [5123:2-9-58](#) of the Administrative Code.**
- (9) Waiver nursing services shall be in accordance with rule [5123:2-9-59](#) of the Administrative Code.**
- (10) General program standards shall be in accordance with rule [5123:2-9-50](#) of the Administrative Code.**

(C) Due process.

- (1) Applicants for waiver enrollment or individuals enrolled on a waiver administered by DODD shall be afforded due process in accordance with section 5101.35 of the Revised Code through the state fair hearing process and as specified in Chapters 5101:6-1 to 5101:6-9 of the Administrative Code.**
- (2) If an applicant or enrollee requests a hearing, as specified in Chapters 5101:6-1 to 5101:6-9 of the Administrative Code, the participation of DODD and/or the county board of developmental disabilities is required during the hearing proceedings to justify the decision under appeal in accordance with section 5126.055 of the Revised Code.**

Certification: CERTIFIED ELECTRONICALLY

Date: 12/21/2012

Promulgated Under: 119.03

Statutory Authority: 5111.85

Rule Amplifies: 5111.85, 5111.87, 5111.91, 5111.871

LTCSTL 13-02

Effective Date: January 1, 2013

5101:3-41-22 Appendix A

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

- (1) "Base rate," as used in appendix A to this rule, means the amount paid for up to the first four units of service delivered.
- (2) "Billing unit," as used in appendix A to this rule, means a single fixed item, amount of time or measurement (e.g., a meal, a day, or mile, etc.).
- (3) "Group rate," as used in paragraph (D)(1) of this rule, means the amount that waiver nursing and personal care aide service providers are reimbursed when the service is provided in a group setting.
- (4) "Group setting" means a situation where a waiver nursing and/or personal care aide service provider furnishes the same type of services to two or three individuals at the same address. The services provided in the group setting can be either the same type of waiver service, or a combination of waiver services.
- (5) "Medicaid maximum rate" means the maximum amount that will be paid by medicaid for the service rendered.
 - (a) The medicaid maximum rate is set forth in appendix A to this rule.
 - (b) For the billing codes in appendix A to this rule, the medicaid maximum rate is:
 - (i) The base rate as defined in paragraph (A)(1) of this rule, or
 - (ii) The base rate as defined in paragraph (A)(1) of this rule plus the unit rate as defined in paragraph (A)(7) of this rule for each additional unit of service delivered.
 - (iii) The base rate as defined in paragraph (A)(1) of this rule plus the unit rate as defined in paragraph (A)(7) of this rule for each additional unit of service delivered.
- (6) "Modifier," as used in paragraph (E) of this rule, means the additional two-alpha-numeric-digit billing codes that providers are required to use to provide additional information regarding service delivery.
- (7) "Unit rate," as used in appendix A to this rule, means the amount paid for each fifteen minute unit following the base rate paid for the first four units of service provided.

(B) In order for a provider to submit a claim for transitions developmental disabilities waiver services, the services must be provided in accordance with Chapter 5123:2-9 of the Administrative Code.

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

(D) Required modifiers.

- (1) The "HQ" modifier must be used when a provider submits a claim for billing code T1002, T1003 or T1019 if the service was delivered in a group setting. Reimbursement at a group rate shall be the lesser of the provider's billed charge or seventy-five per cent of the medicaid maximum.
- (2) The "U" modifier must be used when a provider submits a claim for billing code T1002 and the consumer is receiving infusion therapy.
- (3) The "U2" modifier must be used when the same provider submits a claim for billing code T1002, T1003 or T1019 for a second visit to a consumer for the same date of service.

(4) The "U3" modifier must be used when the same provider submits a claim for billing code T1002, T1003 or T1019 for three or more visits to a consumer for the same date of service.

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

(E) Claims shall be submitted to, and reimbursement shall be provided by, the office of medical assistance (OMA).

(F) Monitoring.

The OMA shall monitor reimbursement made under authority of this rule as necessary to ensure that the funding applicable to home and community-based services (HCBS) is used for authorized purposes in compliance with laws, regulations and provisions governing the medicaid program.

(G) OMA authority.

The OMA retains the final authority to establish payment rates for waiver services approved under the transitions developmental disabilities waiver and has final approval of any policies and rules that govern any component of the medicaid program.

Replaces: 5101:3-47-06

Effective: 01/01/2013

R.C. 119.032 review dates: 01/01/2018

Certification: CERTIFIED ELECTRONICALLY

Date: 12/21/2012

Promulgated Under: 119.03

Statutory Authority: 5111.02, 5111.0213, 5111.85

Rule Amplifies: 5111.02, 5111.021, 5111.213, 5111.85, 5111.871

Prior Effective Dates: 10/01/2011

LTCSTL 13-06

Effective Date: September 1, 2013

Most Current Prior Effective Date: September 15, 2011

- (A) The purpose of this rule is to establish the level one waiver as a component of the medicaid home and community-based services program pursuant to sections 5166.20 (5111.87) and 5166.02, (5111.85) of the Revised Code.
- (1) The level one waiver program provides necessary waiver services to individuals of any age who meet the level of care criteria for an intermediate care facility for individuals with mental retardation and other developmental disabilities (ICF/MR) as set forth in rule 5101:3-3-07 of the Administrative Code, and other eligibility requirements established in this rule.
 - (2) The Ohio department of developmental disabilities (DODD), through an interagency agreement with the Ohio department of ~~job and family services (ODJFS)~~ medicaid (ODM), administers the level one waiver on a daily basis in accordance with section 5162.35, (5111.91) of the Revised Code.
- (B) Definitions
- (1) "County board of developmental disabilities" (CBDD) means a board established under Chapter 5126. of the Administrative Code.
 - (2) "Home and community-based services" (HCBS) means any federally approved medicaid waiver service provided to a waiver enrollee as an alternative to institutional care under Section 1915(c) of the Social Security Act, 49 Stat. 620 (1935), 42 U.S.C.A. 1396n as ~~amended~~ in effect on the effective date of this rule under which federal reimbursement is provided for designated home and community-based services to eligible individuals.
 - (3) "Individual" means a person with mental retardation or other developmental disability who is eligible to receive HCBS as an alternative to placement in an intermediate care facility for the mentally retarded under the applicable HCBS waiver. A guardian or authorized representative may take any action on behalf of the individual, may make choices for an individual or may receive notice on behalf of an individual to the extent permitted by applicable law.
 - (4) "Individual Service Plan" (ISP) means a written description of the services, supports, and activities to be provided to an individual in accordance with paragraph (H) of this rule.
 - (5) "Provider" means a person or agency certified or licensed by DODD that has met the provider qualification requirements to provide specific waiver services, as specified in paragraph (J)(1) of this rule, with a valid medicaid provider agreement as specified in paragraph (J)(2) of this rule.
 - (6) "SSA" means a service and support administrator who is certified in accordance with rules adopted by DODD under Chapter 5123:2-5 of the Administrative Code and who provides the functions of service and support administration.
- (C) Application for the level one waiver
- (1) Individuals seeking to enroll in the level one waiver program must complete the JFS 02399 "Request for Medicaid Home and Community-based Services (HCBS)" (~~rev. 1/2006~~)(rev. 5/2013). Forms shall be available at all CBDD. Forms are also available at the county department of job and family services (CDJFS). Forms are to be used in accordance with rule 5101:1-38-01.2 of the Administrative Code.
 - (2) The CBDD is responsible for explaining to individuals requesting HCBS, the services available through the level one waiver benefit package, including the amount, scope and duration of services and the benefit package limitations.

(D) Eligibility criteria for the level one waiver

- (1) The individual applying for the level one waiver program must require the level of care provided in an ICF/MR and be eligible for ICF/MR services upon initial enrollment and no later than every twelve months thereafter, as specified in rules 5101:3-3-07 and [5123:2-9-01](#) of the Administrative Code and in accordance with the process set forth in rule 5101:3-3-15.5 of the Administrative Code; and
- (2) The individual's medicaid eligibility has been determined in accordance with Chapters 5101:1-37 to 5101:1-42 of the Administrative Code; and
- (3) The individual's health and welfare needs can be met through the utilization of level one waiver services at or below the benefit limitations designated in paragraph (G) of this rule, and other formal and informal supports regardless of funding source. Other formal or informal supports are not subject to the benefit limitations in this rule.
- (4) The individual must require, at a minimum, one waiver service, as described in paragraph (F) of this rule, to be considered eligible for this waiver.

(E) Level one waiver enrollment, continued enrollment, and disenrollment

- (1) Individuals who meet the eligibility criteria established in paragraph (D) of this rule, or their legal representative shall be informed of the following:
 - (a) All services available on the level one waiver, as delineated in paragraph (F) of this rule and any choices that the individual may make regarding those services;
 - (b) Any feasible alternative to the waiver program; and
 - (c) The right to choose either institutional or home and community-based services.
- (2) Individuals determined eligible for the level one waiver program in accordance with paragraph (D) of this rule who are seeking to, but are not yet enrolled in the level one waiver program must participate in a prescreening assessment process. This process evaluates whether the individual's health and welfare needs can be met with the level of service provided through the level one waiver program, combined with other non-waiver services regardless of funding source, and within the benefit package limitations specified in paragraph (G) of this rule.
 - (a) If the prescreening assessment process indicates that the eligible individual's health and welfare needs cannot be met with the level of services provided through the level one waiver program, combined with other non-waiver services regardless of funding sources, and within the benefit package limitations specified in paragraph (G) of this rule, then the individual shall not be enrolled in the level one waiver program and notification of hearing rights shall be provided as established in paragraph (M) of this rule; or
 - (b) If the prescreening assessment process indicates that the eligible individual's health and welfare needs can be met with the level of services provided through the level one waiver program, when combined with other non-waiver services regardless of funding source, and within the benefit package limitations specified in paragraph (G) of this rule, then the individual shall be enrolled in the level one waiver program in accordance with this rule.
- (3) The CBDD shall offer available level one waiver slots to eligible individuals in accordance with applicable waiting list category requirements as set forth in rules 5101:3-41-05 and 5123:2-1-08 of the Administrative Code.
- (4) An individual's continued enrollment in the level one waiver program shall be redetermined no less frequently than every twelve months after the individual's initial enrollment or subsequent redetermination date. Individuals must continue to meet the eligibility criteria specified in paragraph (D) of this rule to continue enrollment in the waiver program.
- (5) The individual must require at least one waiver service monthly, or, if less than monthly, require monthly monitoring of the individual's health and welfare. If no services are planned to be delivered in a month, monthly monitoring of the individual's health and welfare must be required

in the ISP, as designated in paragraph (H) of this rule, and must include at least periodic face-to-face monitoring.

- (6) While enrolled in the level one waiver, if the enrollee does not receive any waiver services as described in paragraph (F) of this rule for one month, the county board shall, within fifteen days after the end of the calendar month, assess the enrollee's current need for waiver services, and discuss these needs with the enrollee and their representative. As a result of the assessment and discussion, if no waiver services are needed, the enrollee shall be recommended for disenrollment from the waiver program and shall be given notification of hearing rights as established in paragraph (M) of this rule.
- (7) Disenrollment of level one waiver participants shall be done in accordance with the provisions set forth in this rule.
 - (a) Individuals enrolled in the level one waiver program shall not be disenrolled from the waiver due to an increase in the need for a covered service(s) that causes the total need for the covered service(s) to exceed the benefit package limitations, as specified in paragraph (G) of this rule, unless the county board has assessed the individual and determined that the individual's health and welfare cannot be assured by doing the following:
 - (i) Adding a higher level of available natural supports; and/or
 - (ii) Recommending additional services covered through the level one waiver benefit package; and/or
 - (iii) Accessing emergency services covered through the level one waiver benefit package; and/or
 - (iv) Accessing additional non-waiver services other than natural supports.
 - (b) If the activities identified in paragraph (E)(7)(a) of this rule do not result in an ISP that contains covered services that are within the benefit package limitations outlined in paragraph (G) of this rule and it is determined that services are not sufficient to assure the individual's health and welfare, then the following will apply:
 - (i) The individual will be given the opportunity to apply for an alternate home and community-based waiver program, to the extent that such waiver openings exist, that may be more adequate in meeting the individual's service needs. An individual may take priority over others waiting for waiver services if they have emergency status or meet one of the waiting list priority categories ~~which includes emergency situations~~ as established in rule 5123:2-1-08 of the Administrative Code; and
 - (ii) The individual will be offered an opportunity for placement in an ICF/MR to include a state operated development center;
 - (c) Individuals enrolled in the level one waiver program who are recommended for disenrollment from the waiver program shall be given notification of hearing rights as established in paragraph (M) of this rule.

(F) The level one waiver program benefit package is limited to the following services:

- (1) Homemaker / personal care;
- (2) ~~Institutional~~Residential respite;
- (3) Informal respite;
- (4) Transportation;
- (5) Environmental accessibility adaptations;
- (6) Personal emergency response systems (PERS);
- (7) Specialized medical ~~adaptive/assistive~~ equipment and supplies;

- (8) Adult day support;
- (9) Vocational habilitation;
- (10) Supported employment - enclave;
- (11) Supported employment - community;
- (12) Supported employment - adapted equipment;
- (13) Non-medical transportation to access adult day services;
- (14) Residential and community respite;
- (15) Remote monitoring and remote monitoring equipment;
- (16) Home delivered meals.

(G) Limits on sets of level one waiver services

- (1) Individuals enrolled in the level one waiver program are subject to limitations for specific sets of level one waiver services. DODD, as the level one waiver program administrator, shall ensure that applicants or individuals enrolled in the level one waiver program do not exceed the benefit limitations as identified in paragraphs (G)(2) to (G)(4) of this rule.
- (2) The following services are subject to limitations that when the cost of these services are combined cannot exceed a maximum of five thousand dollars effective in twelve month periods beginning with the individual's enrollment or redetermination date:
 - (a) Homemaker/personal care ~~services~~;
 - (b) ~~Institutional~~Residential respite ~~services~~;
 - (c) Informal respite ~~services~~;
 - (d) Transportation ~~services~~;
 - (e) Community respite.
- (3) The following benefits are subject to specific benefit limitations that when combined cannot exceed a maximum of ~~six~~ seven thousand five hundred dollars during a three year period:
 - (a) Environmental accessibility adaptations;
 - (b) Personal emergency response systems;
 - (c) Specialized medical equipment and supplies;
 - (d) Remote monitoring;
 - (e) Remote monitoring equipment;
 - (f) Home-delivered meals.
- (4) Emergency assistance is available to provide services beyond the limitations in paragraphs (G)(2) and (G)(3) of this rule for the following services: homemaker/personal care, ~~institutional respite~~, transportation, personal emergency response systems, environmental accessibility adaptations, or specialized medical equipment and supplies, remote monitoring, remote monitoring equipment, informal respite and residential respite. Emergency assistance is subject to a benefit limitation not to exceed eight thousand dollars during a three-year period.
- (5) The following benefits are subject to specific benefit limitations that, when combined cannot exceed the maximum amount as specified in appendix B to rule 5101:3-41-15 of the Administrative Code, effective in twelve month periods beginning with the individual's enrollment or redetermination date:
 - (a) Supported employment - enclave;
 - (b) Supported employment - community;
 - (c) Supported employment - adapted equipment;

(d) Adult day ~~support~~support;

(e) Vocational habilitation.

(6) Non-medical transportation services are subject to a benefit limitation not to exceed the amount specified in appendix B to rule 5101:3-41-15 of the Administrative Code.

(H) Level one waiver individual service plan requirements

(1) All services shall be provided to individuals enrolled on the level one waiver pursuant to a written ISP.

(2) The ISP shall be developed by qualified persons with input from the level one waiver enrollee and the SSA in accordance with section [5126.15](#) of the Revised Code. Providers shall participate in the ISP meetings when a request for their participation is made by the individual enrollee.

(a) The ISP shall list the level one waiver services and the non-waiver services, regardless of funding source, that are necessary to ensure the enrollee's health and welfare.

(b) The ISP shall contain the following medicaid required elements:

(i) Type of service to be provided; and

(ii) Amount of service to be provided; and

(iii) Frequency and duration of each service; and

(iv) Type of provider to furnish each service.

(c) The ISP shall be developed on at least an annual basis consistent with the individual's redetermination as referenced in paragraph (E)(2) of this rule or as the individual's needs change and in accordance with Chapter 5123:2 of the Administrative Code.

(d) The ISP shall be developed to include only waiver services which are consistent with efficiency, economy and quality of care. When reasonable, waiver services are not provided entirely at a one to one ratio. When combined with other non-waiver services, waiver services must ensure the health and welfare for the individual for whom the ISP is developed; and

(e) The ISP is subject to approval by ~~ODJFS~~ODM and DODD pursuant to section ~~5111.874~~
[5166.21](#) of the Revised Code. Notwithstanding the procedures set forth in this rule, ~~ODJFS~~ODM may in its sole discretion, and in accordance with section ~~5111.852~~
[5166.05](#) of the Revised Code, authorize services and direct the CBDD or DODD to amend ISPs for individuals if ~~ODJFS~~ODM determines that such services are medically necessary and the procedures set forth in this rule would not accommodate a request for such medically necessary services.

(I) Free choice of provider

Individuals enrolled in the level one waiver program shall be given a free choice of qualified level one waiver providers in accordance with rules [5101:3-41-08](#) and [5123:2-9-11](#) of the Administrative Code. A provider is qualified if they meet the standards established in paragraph (J) of this rule. DODD shall create and maintain an internet-based list of those providers who are qualified to provide level one waiver services in accordance with section 5126.046 of the Revised Code. This list will be accessible to county boards and individuals applying for or receiving services. CBDD shall provide information about the internet-based provider list to applicants and enrollees and shall assist an individual to access this list to assure the individual's free choice of qualified providers.

(J) Provision of level one waiver services

(1) Level one waiver services shall be provided by persons or agencies who hold certification or licensure for each service they provide in accordance with section [5123.045](#) of the Revised Code, and division 5123:2 of the Administrative Code; and

- (2) Level one waiver services shall be provided only by persons or agencies who have a valid medicaid provider agreement in accordance with rule [5101:3-1-17.2](#) of the Administrative Code; and
- (3) Level one waiver services shall be provided only to individuals who have met the eligibility requirements in paragraph (D) of this rule and have been enrolled in the level one waiver program at the time of service delivery; and
- (4) Level one waiver services shall be provided in accordance with each enrollee's individual service plan as specified in paragraph (H) of this rule.
- (5) No provider of level one waiver services shall enter into or maintain any contract for the provision of waiver services except as noted in paragraph (J)(2) of this rule.

(K) Provider payment standards

Provider payment standards for the level one waiver are established in Chapters 5101:3-41 and 5123:2-9 of the Administrative Code.

(L) Monitoring, compliance and sanctions

~~ODJFS~~ODM shall conduct periodic monitoring and compliance reviews related to the level one waiver program in accordance with ~~Chapter 5111~~, section [5162.10](#) of the Revised Code. Reviews may consist of, but are not limited to, physical inspections of records and sites where services are provided, interviews of providers, enrollees, and administrators of waiver services. Certified or licensed level one waiver providers, in accordance with the medicaid provider agreement, DODD, and CBDD shall furnish to ~~ODJFS~~ODM, the center for medicare and medicaid services (CMS), and the medicaid fraud control unit or their designees any records related to the administration and/or provision of level one waiver services. Individuals enrolled in the level one waiver program shall cooperate with all monitoring, compliance and quality assurance reviews conducted by ~~ODJFS~~ODM, CMS and the medicaid fraud control unit or their designee.

(M) Due process

- (1) Whenever an applicant for or enrollee of the level one waiver program is affected by any action proposed or taken by DODD or ~~ODJFS~~ODM or when action is recommended by the entity recommending or taking the action will provide due process according to section 5101.35 of the Revised Code and Chapters 5101:6-1 to 5101:6-9 of the Administrative Code. Such actions may include, but are not limited to, the approval, denial, or termination of enrollment or a denial or change in the level, and/or type of waiver services delivered to a level one waiver enrollee.
- (2) If an applicant or enrollee requests a hearing, as specified in Chapters 5101:6-1 to 5101:6-9 of the Administrative Code, the participation of DODD and the CBDD are required during the hearing proceedings to justify the decision under appeal.

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CATL-MRDD 06-01

Effective Date: July 1, 2006

Most Current Prior Effective Date: July 1, 2005

5101:3-42-11 Appendix A - Provider Payment Standards for Level One Waiver Services

(A) Purpose

This rule sets forth the standards governing the conditions which must exist in order to make payments to certified level one waiver providers and establishes the allowable payment standards for the provision of level one waiver services. The level one waiver is a component of the medicaid program as established by the Ohio department of job and family services (ODJFS) in rule 5101:3-42-01 of the Administrative Code and authorized in sections 5111.02 and 5111.91 of the Revised Code. This rule shall be effective until such time a new reimbursement standard is developed and implemented for the individual enrolled on the level one waiver program in accordance with section 5111.873 of the Revised Code.

(B) Definitions

- (1) "Billing unit" means a fifteen minute unit consisting of fifteen consecutive minutes of level one waiver service delivery time provided to a level one waiver enrollee by a certified level one waiver provider.
- (2) "Day billing unit" for institutional respite means a billing unit that is based upon a consecutive twenty-four hour period in which a level one waiver enrollee receives waiver services from a certified level one waiver provider.
- (3) "County board of mental retardation and developmental disabilities" (CBMRDD) means a board established under Chapter 5126. of the Administrative Code.
- (4) "Provider" means a person or agency certified by ODMRDD that has met the provider qualification requirements to provide specific waiver services, as specified in rule 5101:3-41-01 of the Administrative Code, and with a valid medicaid provider agreement as specified in rule 5101:3-1-17.2 of the Administrative Code.

(C) Payment of provider claims

- (1) The Ohio department of mental retardation and developmental disabilities (ODMRDD) is responsible for the daily administration of the level one waiver as established in rule 5101:3-42-01 of the Administrative Code and pursuant to an interagency agreement with ODJFS. This responsibility includes the processing of claims for payment for waiver services made by certified waiver providers for services rendered to level one waiver enrollees.
- (2) Payments made for level one waiver claims are subject to the conditions and payment standards set forth in this rule and must be within the benefit limitations set forth in rule 5101:3-42-01 of the Administrative Code.
- (3) The submission of level one waiver service claims by certified level one waiver providers and the payment of those claims made must be in accordance with rule 5123:2-8-16 of the Administrative Code.
- (4) Level one waiver service payment standards for homemaker/personal care, transportation, institutional respite, and informal respite services shall be the fee as established in appendix A of this rule.
- (5) Level one waiver service payments standards for specialized medical equipment and supplies, and personal emergency response system (PERS) shall be made on a fee for service

arrangement. Payments for these services cannot exceed the maximum benefit limitations specified in rule 5101:3-42-01 of the Administrative Code and the maximum payment set forth in appendix A of this rule.

- (6) Level one waiver service payment standards for environmental accessibility adaptations shall be made on a fee for service arrangement utilizing the request for information (RFI) process as established in rule 5123:2-8-06 of the Administrative Code. Payments for this service cannot exceed the maximum benefit limitation specified in rule 5101:3-42-01 of the Administrative Code and the maximum payment set forth in appendix A of this rule.
- (7) Level one waiver service payment standards for day habilitation shall be the fee as established in appendix A of rule 5101:3-41-10 of the Administrative Code.
- (8) Level one waiver service payment standards for supported employment shall be the fee established in appendix A of ~~rule 5101:3-41-11 of the Administrative Code~~ this rule.

(D) Provider conditions for claims payment

- (1) Certified level one waiver providers shall submit claims for the provision of level one waiver services in accordance with paragraph (C)(3) of this rule and shall receive payments when all of the following conditions exist:
 - (a) The level one waiver service is provided by a provider that has certification for the service for which the provider is submitting a claim and in accordance with the level one certification requirements established in rule 5101:3-42-01 and Chapter 5123:2-8 of the Administrative Code; and
 - (b) The level one waiver service is provided by an individual or agency provider that has a valid medicaid provider agreement in accordance with rule 5101:3-1-17.2 of the Administrative Code; and
 - (c) The level one waiver service is provided to an individual who is enrolled in the level one waiver program at the time of service; and
 - (d) The level one waiver service is provided in accordance with the enrollee's individual service plan as specified in rule 5101:3-42-01 of the Administrative Code; and
 - (e) The level one waiver service is provided within the identified benefit limitations as specified in rule 5101:3-42-01 of the Administrative Code; and
 - (f) The level one waiver service is provided to an enrollee who is not an inpatient of a hospital, resident of a nursing facility, or a resident of an intermediate care facility for individuals with mental retardation and other developmental disabilities (ICF/MR). An individual enrolled in the level one waiver program receiving level one waiver institutional respite services through an ICF/MR is not considered a resident of the ICF/MR that is providing the institutional respite services.
- (2) Any claims submission that indicates an amount outside of the payment standards specified in appendix A of this rule shall be subject to non-payment of the differing amount.
- (3) Payments for services provided to more than one level one waiver enrollee at the same time shall be made in accordance with the group payment standards established in appendix A of this rule.
- (4) Payments for services provided to a level one waiver enrollee who is receiving the same service at the same time as other individuals not enrolled in the level one waiver shall be made in accordance with the group payment standards established in appendix A of this rule. All individuals being provided the same service at the same time shall be counted as a part of the group, regardless of enrollment in the level one waiver program.

(E) Monitoring

ODJFS will monitor reimbursement made under authority of this rule as necessary to ensure that the funding applicable to level one waiver services is used for the authorized purposes in compliance with laws, regulations, and the provisions governing the medicaid program.

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Targeted Case Management (TCM)

Rate Setting

[LTCSTL 15-07](#)

Effective Date:

Most Current Prior Effective Date: [April 17, 2008](#)

OAC 5101:3-3-99 [Appendix A](#)

OAC 5101:3-3-99 [Appendix B](#)

This rule describes the methodology for calculating payment rates for state-operated intermediate care facilities ~~for the mentally retarded (ICFs-MR)~~ for individuals with intellectual disabilities (ICFs/IID) and includes provisions for a temporary additional payment for off-site day habilitation/active treatment and associated transportation services.

(A) Definitions.

- (1) "State-operated intermediate care facility for ~~the mentally retarded~~ individuals with intellectual disabilities" ~~also referred to as "facility"~~ means an ~~intermediate care facility for the mentally retarded~~ ICF/IID as described in ~~paragraph (N) of rule 5101:3-3-01 of the Administrative Code~~ section 5163.01 of the Revised Code that is operated under a medicaid provider agreement(s) by the Ohio department of ~~mental retardation and~~ developmental disabilities ~~(ODMRDD)~~ (ODODD).
- (2) "Cost report" means form number ~~JFS ODM~~ JFS ODM 01984, "Developmental Center Cost Report" ~~(2/2004)~~ (7/2014) used to report cost and statistical data for the operation of a state-owned ~~ICF-MR~~ ICF/IID. The cost report includes all worksheets as included in appendix A to this rule and covers the period of July first to June thirtieth.
- (3) "Direct care costs" means those costs established by summing the amounts on the cost report worksheet B P1, column 16a, line 16 and worksheet C P1, column 16a, line 16 minus worksheet B P2, column 16a, line 16 and minus worksheet C P2, column 16a, line 16.
- (4) "Ancillary costs" means those costs established by the amounts on the cost report worksheet B P1, column 16a, lines 17 to 21 and worksheet B P2, column 16a, lines 17 through 21. Ancillary costs include pharmacy, radiology, laboratory, clinic and physician services. Audiology, dental and vision costs are included in clinic services.
- (5) "Capital costs" means those costs established by summing the amounts on the cost report worksheet B P2, column 16a, line 16 and worksheet C P2, column 16a, line 16.
- (6) "Total inpatient days" means the sum of inpatient days and leave days as reported on worksheet F of the cost report.
- (7) "Covered services" means ~~ICF-MR~~ ICF/IID covered services.
- (8) "Base year" means the period used to establish the interim payment rate for each state-operated ~~ICF-MR~~ ICF/IID.
- (9) "Rate year" means the period where calculated interim rates are paid using base year cost report data.
- (10) "Base year cost report" means form ~~JFS ODM~~ JFS ODM 01984, "Developmental Center Cost Report" ~~(2/2004)~~ (7/2014) used to report costs and statistical data as filed during a twelve-month period to determine the interim payment rate for each state-operated ~~ICF-MR~~ ICF/IID.
- (11) "Rate year cost report" means form ~~JFS ODM~~ JFS ODM 01984 used to report costs and statistical data during a twelve-month period to determine the final payment rate for each state-operated ~~ICF-MR~~ ICF/IID.

- (12) "Interim payment rate" means the rate of payment calculated using the desk reviewed base year cost report data.
- (13) "Final payment rate" means the rate of payment calculated using the final rate year cost report data.
- (14) "Reasonable and allowable costs" means cost items prepared in accordance with medicare principles governing reasonable and allowable cost reimbursement set forth in the providers' reimbursement manual "CMS Publications 15-1 and 15-2" with the exception of the restrictions related to dental services, available at www.cms.hhs.gov/Manuals/PBM/list.asp#TopOfPage in effect as of ~~September 8, 2005~~ November 5, 2013.
- (15) "Adjusted interim payment rate" means the interim payment rate plus the amount calculated in paragraphs (C)(4) and (C)(5) of this rule applicable for state fiscal year 2006 and 2007 only.

(B) Source data for calculations.

- (1) The calculations described in this rule will be based on the most recent desk reviewed base year cost report data submitted to the department in accordance with division ~~5104:35160-3~~ of the Administrative Code. The state-operated ~~ICF-MR-ICF/IIID~~ cost report must:
 - (a) Be prepared in accordance with medicare principles governing reasonable and allowable cost reimbursement set forth in the providers' reimbursement manual "CMS Publications 15-1 and 15-2" with the exception of the restrictions related to dental services, available at www.cms.hhs.gov/Manuals/PBM/list.asp#TopOfPage in effect as of ~~September 8, 2005~~ November 5, 2013 and 45 CFR part 92. The method used to allocate supporting cost centers shall be the step-down method described in centers for medicare and medicaid services (CMS) publication ~~1515-1~~, section 2306.1 available at the above link. The statistics, on the approved cost reporting form, must be used for cost allocation purposes unless alternative statistics which yield a more accurate and/or appropriate allocation of costs are approved by the department. A written request to use alternative statistics must be submitted to and approved by the department prior to the period in which the statistics are to be used; and
 - (b) Include all information necessary for the proper determination of costs payable under medicaid including financial records and statistical data; and
 - (c) Include the cost report certification executed ~~ODMRDD~~ ODODD fiscal attesting to the accuracy of the cost report; and in addition, all subsequent revisions to the cost report must include an executed certification; and
 - (d) Include costs for all covered services generally available to medicaid recipients and provided to recipients by the state-operated ~~ICFs-MR-ICFs/IIID~~, either directly or by arrangement, shall be included in the costs reported by the state-operated ~~ICFs-MR-ICFs/IIID~~ on the form approved by ~~ODJFS~~ ODM and shall be reimbursed only to the state-operated ~~ICFs-MR-ICFs/IIID~~. These costs are subject to all otherwise applicable audit guidelines and tests of reasonableness; and
 - (e) Not include the cost of pharmacy and legend drugs in their cost reports when these are reimbursed directly to a pharmacy provider.
- (2) A desk review will be performed by the ~~ODJFS~~ ODM on all annual cost reports for the purpose of updating interim payment rates, all of which are subject to cost settlement. Desk review procedures will take into consideration the relationship between the prior year's audited costs and the current year's reported costs. Adjustments may be made to the cost report by the department as necessary to determine reasonable and accurate interim payment rates. Adjustments made by ~~ODJFS~~ ODM do not preclude findings of additional cost exceptions issued as the result of an audit.

(C) Calculation of interim payment rates.

- (1) Interim payment rates for each state-operated ~~ICF-MR~~ICF/IID shall be based upon the source data described in paragraph (B) of this rule.
- (2) The interim payment rate shall be calculated as follows:
 - (a) Calculation of direct care per diem rate.
 - (i) Calculate the direct care per diem for each state-operated ~~ICF-MR~~ICF/IID by dividing direct care costs by total inpatient days.
 - (ii) For each facility multiply the facility's direct care per diem by the facility's inpatient days. Sum results for all facilities and divide by the sum of inpatient days for all facilities.
 - (iii) Calculate the direct care per diem ceiling by taking the amount calculated in paragraph (C)(2)(a)(ii) of this rule and multiplying it by one hundred twelve per cent.
 - (iv) The interim state-operated ~~ICF-MR~~ICF/IID direct care per diem will be the lower of the amount calculated in paragraph (C)(2)(a)(i) of this rule or the direct care per diem ceiling as calculated in paragraph (C)(2)(a)(iii) of this rule.
 - (b) Calculate the ancillary cost per diem for each state-operated ~~ICF-MR~~ICF/IID by dividing ancillary costs by total inpatient days.
 - (c) Calculate the capital cost per diem for each state-operated ~~ICF-MR~~ICF/IID by dividing capital costs by total inpatient days.
 - (d) The interim payment rate for each state-operated ~~ICF-MR~~ICF/IID shall be the sum of the amounts calculated in paragraphs (C)(2)(a)(iv), (C)(2)(b) and (C)(2)(c) of this rule, inflated from the mid-point of the base year to the midpoint of the rate year using the skilled nursing facility (SNF) market basket as calculated by "Global Insight" available at www.globalinsight.net or a successor firm, and submitted to ~~ODJFS~~ODM by March thirty-first, before the beginning of the new rate year.
- (3) For periods after SFY 2007, a state-operated ~~ICF-MR~~ICF/IID certified after June 30, 2003 whose cost report includes less than twelve months of complete data shall be reimbursed the statewide average interim payment rate for state-operated ~~ICFs-MR~~ICFs/IID calculated for that rate year by summing the rates for each state-operated ~~ICF-MR~~ICF/IID as described in paragraph (C)(2)(d) of this rule and dividing by the number of state-operated ~~ICFs-MR~~ICFs/IID. Interim payment rates are subject to final settlement as included in paragraph (E) of this rule.
- (4) Notwithstanding paragraph (C)(1) of this rule, for the period starting on July 1, 2005 and ending on December 31, 2005 only, the interim payment rate shall be adjusted to arrive at the adjusted interim payment rate for each facility by the following process.
 - (a) ~~ODMRDD~~ODODD shall determine, by facility, the number of residents of state-operated ~~ICFs-MR~~ICFs/IID who received off-site day habilitation services/active treatment services in SFY 2004. This shall be referred to as the facility specific residency count used in calculating the adjusted interim payment rate.
 - (b) ~~ODMRDD~~ODODD shall multiply the facility-specific residency count determined under paragraph (C)(4)(a) of this rule by no more than one hundred thirty or a similar estimate of the number of daily units of off-site day habilitation services/active treatment services that each resident of a state-operated ~~ICFs-MR~~ICFs/IID who receives off-site day habilitation services/active treatment services, will receive between July 1, 2005 and December 31, 2005. This shall be referred to as the six-month projected daily units used in calculating the adjusted interim payment rate.
 - (c) ~~ODMRDD~~ODODD shall multiply the product calculated under paragraph (C)(4)(b) of this rule by the county-specific rates from appendix B of this rule that are applicable to the counties in which state-operated ~~ICFs-MR~~ICFs/IID are located.

- (d) ~~ODMRDD~~ODODD shall divide the product calculated under paragraph (C)(4)(c) of this rule by total inpatient days for SFY 2004 as reported by each state-operated ~~ICF-MR~~ICF/IID on the ~~JFS~~ODM 01984 cost reports for the period January 1, 2004 to June 30, 2004.
 - (e) ~~ODMRDD~~ODODD shall add the quotient calculated under paragraph (C)(4)(d) of this rule to the interim payment rates for each facility.
 - (f) The adjustment process set forth in paragraph (C)(4) of this rule shall apply exclusively to periods between July 1, 2005 and December 31, 2005, and shall not be used for adjustments for any other period. The additional amount to be paid in the rate for off-site day habilitation/active treatment and associated transportation services shall not be subject to the direct care per diem ceiling calculated in accordance with paragraph (C)(2)(a)(iii) of this rule.
- (5) Notwithstanding paragraph (C)(1) of this rule, for the period starting on January 1, 2006 and ending on June 30, 2007 only, the interim payment rate shall be adjusted to arrive at the adjusted interim payment rate for each facility by the following process.
- (a) ~~ODMRDD~~ODODD shall for each facility, multiply the six month projected daily units determined under paragraph (C)(4)(b) of this rule by three and then by the county-specific rates in appendix B of this rule. The rates in appendix B to this rule may be amended to reflect revised rates approved by CMS. The rate applicable to a county where the state-operated ~~ICF-MR~~ICF/IID is located shall be used for determining the rate used for this purpose.
 - (b) ~~ODMRDD~~ODODD shall divide the product calculated under paragraph (C)(5)(a) of this rule by one-and a half times the total inpatient days for SFY 2004 as reported on the ~~JFS~~ODM 01984 cost report for each facility to arrive at the adjusted interim payment rate.
 - (c) ~~ODMRDD~~ODODD shall add the quotient calculated under paragraph (C)(5)(b) of this rule to the interim direct care per diem rate to arrive at the adjusted interim payment rate. The additional amount to be paid in the rate for off-site day habilitation/active treatment and associated transportation services shall not be subject to the direct care per diem ceiling calculated in accordance with paragraph (C)(2)(a)(iii) of this rule.
 - (d) The adjustment process set forth in paragraph (C)(5) of this rule shall apply exclusively to periods between January 1, 2006 and June 30, 2007, and shall not be used for adjustments for any other period.
- (6) Effective for the period of July 1, 2005 to December 31, 2005, the amount included in the ~~JFS~~ODM 01984 cost report shall be the rate paid to off-site providers of day habilitation/active treatment and associated transportation services limited to no more than the county specific rate included in appendix B of this rule times actual units of service.
- (7) Effective for the period of January 1, 2006 to September 30, 2006, the amount included in the ~~JFS~~ODM 01984 cost report for payments to off-site providers of day habilitation/active treatment and associated transportation services shall be limited to the lower of:
- (a) The county specific rate included in appendix B to this rule times actual units of service; or
 - (b) Where a state operated ~~ICF-MR~~ICF/IID is in the same county where a non-developmental center/private ~~ICF-MR~~ICF/IID contracts with a county board of ~~ODMRDD~~ODODD for off-site day habilitation/active treatment and related transportation services, the facility shall be limited to no more than the lowest contracted daily rate as included in a contract in effect during the corresponding fiscal year times the actual units of service provided; or
 - (c) In those counties where no non developmental center private ~~ICF-MR~~ICF/IID has a contract to provide services for consumers of a county board of ~~MRDD~~DD for offsite day habilitation/active treatment and associated transportation services, the rate shall be

limited to the county specific rates in appendix B to this rule times the actual units of services provided.

- (8) Effective for the period of October 1, 2006 to June 30, 2007, the amount included in the ~~JFS~~ODM 01984 cost report for payments to off-site providers of day habilitation/active treatment and associated transportation service shall be limited to the lower of:
 - (a) The county specific rate included in appendix B to this rule times actual units of service;
or
 - (b) Eighty-seven dollars times actual units of service.
- (9) For SFY 2006 and 2007 only, each state-operated ~~ICF-MR~~ICF/IID certified after June 30, 2003 whose cost report includes less than twelve months of complete data shall be reimbursed the statewide average interim payment rate for state-operated ~~ICFs-MR~~ICFs/IID plus an additional amount to be paid in the rate for off-site day habilitation/active treatment and associated transportation services as calculated in paragraphs (C)(4) and (C)(5) of this rule. When the calculation requiring the use of SFY 2004 inpatient days in paragraph (C)(4)(d) or (C)(5)(b) of this rule does not apply then an estimate of inpatient days shall be used.
- (10) A state-operated ~~ICF-MR~~ICF/IID certified cost report shall be filed within one hundred eighty days of the end of the fiscal year. If the cost report is not received within one hundred eighty days of the end of the fiscal year the rate paid will be the lower of ninety per cent of the state wide average or the current rate.

(D) Audit.

- (1) ~~ODJFS~~ODM will perform field audits of the most current cost report for each state-operated ~~ICFs-MR~~ICFs/IID at least once every three years. Cost reports for other periods may also be audited as determined necessary by the ~~ODJFS~~ODM. The audits will be performed in accordance with auditing standards adopted by the ~~ODJFS~~ODM. To determine which state-operated ~~ICFs-MR~~ICFs/IID are subject to audit, ~~ODJFS~~ODM will develop a risk-based methodology.
- (2) The audit scope will be determined by the ~~ODJFS~~ODM and will be sufficient to determine if costs reflected in the cost report are accurate, made in compliance with pertinent regulations, and based on actual cost.
- (3) ~~ODMRDD~~ODODD must maintain documentation to support all transactions, to permit the reconstruction of all transactions and the proper completion of all reports required by state and federal laws and regulations, and to substantiate compliance with all applicable federal statutes or regulations, state statutes or administrative rules. This documentation must be maintained for the greater of seven years after the cost report is filed or, if ~~ODJFS~~ODM issues an audit report, six years after all appeal rights relating to the audit report are exhausted. ~~ODMRDD~~ODODD must make available to the ~~ODJFS~~ODM personnel all records necessary to document all transactions, regardless of where records are maintained. Accounting records must include sufficient detail to disclose:
 - (a) Services provided; and
 - (b) Administrative costs of services provided; and
 - (c) Costs of operating the organizations, agencies, program, activities, and functions; and
 - (d) Accuracy of inpatient days; and
 - (e) Services claimed are covered under the medicaid program and made in accordance with applicable rules of the Administrative Code; and
 - (f) Amounts of third-party payments reported are indicative of actual amounts received; and
 - (g) Costs reported to the ~~ODJFS~~ODM represent actual incurred, reasonable, and allowable costs in accordance with provisions of the CMS provider manual 15-1, Chapter ~~5404:3-~~

~~35160-3~~ of the Administrative Code as applicable, and 45 CFR 92 dated ~~October 1, 2009~~ October 1, 2014.

- (4) Each facility shall collect, report, and maintain separately all data and records sufficient to support the rate calculation including but not limited to statistical and financial data:
 - (a) Related to costs that are included in or listed in the cost report as reimbursable costs; and
 - (b) Relate to non-reimbursable costs; and
 - (c) Related to the contracted rate, amount, time period of those contracts between private ~~ICFs-MR~~ICFs/IID and county boards of ~~MRDDD~~DD as included in paragraph (C)(6)(a) of this rule; and
 - (d) Necessary to support the use of the rate schedule referenced in paragraph (C)(5)(a) of this rule.
- (5) ~~ODJFS~~ODM shall recognize costs subject to this rule as evidenced through executed contracts for off-site day habilitation/active treatment and associated transportation services which comply with paragraphs (C)(6)(a) and (C)(6)(b) of this rule. Where records and data are not available or not provided on request, those costs shall be excluded from the ~~JFS~~ODM 01984 cost report.
- (6) ~~ODMRDD~~ODODD must maintain adequate systems of internal control as related to federal funding to ensure:
 - (a) Accurate and reliable financial and administrative records; and
 - (b) Efficient and effective use of resources; and
 - (c) Compliance with pertinent laws and regulations.

(E) Final settlement.

- (1) Final settlement is the process where allowable and reasonable costs included in the rate year cost report are used to establish a final payment rate that is reconciled to the interim payment rate.
- (2) The rate year cost report shall include adjustments included in paragraphs (B)(2) and (D)(1) to (D)(5) of this rule.
- (3) The final payment rate shall be calculated as follows:
 - (a) Calculation of direct care per diem rate.
 - (i) Calculate the direct care per diem for each state-operated ~~ICF-MR~~ICF/IID by dividing direct care costs by total inpatient days as described in paragraph (A) of this rule.
 - (ii) For each facility multiply the facility's direct care per diem by the facility's inpatient days as described in paragraph (A) of this rule. Sum results for all facilities and divide by the sum of inpatient days for all facilities.
 - (iii) Calculate the direct care per diem ceiling by taking the amount calculated in paragraph (E)(3)(a)(ii) of this rule and multiplying it by one hundred twelve per cent.
 - (iv) The final state-operated ~~ICF-MR~~ICF/IID direct care per diem will be the lower of the amount calculated in paragraph (E)(3)(a)(i) of this rule or the direct care per diem ceiling as calculated in paragraph (E)(3)(a)(iii) of this rule.
 - (b) Calculate the ancillary cost per diem for each state-operated ~~ICF-MR~~ICF/IID by dividing ancillary costs by total inpatient days as described in paragraph (A) of this rule.
 - (c) Calculate the capital cost per diem for each state-operated ~~ICF-MR~~ICF/IID by dividing capital costs by total inpatient days as described in paragraph (A) of this rule. The final

rate for each state-operated ~~ICF-MR~~ICF/IID shall be the sum of the amounts calculated in paragraphs (E)(2)(a)(iv), (E)(2)(b) and (E)(2)(c) of this rule.

- (d) Calculation of the additional amount paid for off-site day habilitation/active treatment and associated transportation services for SFY 2006 and 2007 only for each state operated facility.
- (i) For the period July 1, 2005 to December 30, 2005, divide the allowable costs as restricted by paragraph (C)(6) of this rule by total inpatient days described in paragraph (A) of this rule for July 1, 2005 to December 30, 2005.
 - (ii) For the period January 1, 2006 to June 30, 2006, divide the allowable costs as restricted by paragraph (C)(7) of this rule by total inpatient days described in paragraph (A) of this rule for January 1, 2006 to June 30, 2006.
 - (iii) For SFY 2006, add the quotients calculated in paragraphs (E)(3)(d)(i) and (E)(3)(d)(ii) of this rule.
 - (iv) For the period July 1, 2006 to September 30, 2006, divide the allowable costs as restricted by paragraph (C)(7) of this rule by total inpatient days described in paragraph (A) of this rule for July 1, 2006 to September 30, 2006.
 - (v) For the period October 1, 2006 to June 30, 2007, divide the allowable costs as restricted by paragraph (C)(8) of this rule by total inpatient days described in paragraph (A) of this rule for October 1, 2006 to June 30, 2007.
 - (vi) For SFY 2007, add the quotients calculated in paragraphs (E)(3)(d)(iv) and (E)(3)(d)(v) of this rule.

(4) The final payment rate calculated in paragraph (E)(3) of this rule is subtracted from the interim payment rate calculated in paragraph (C)(2) or (C)(3) of this rule, as applicable. The result is multiplied by the paid days and applicable federal financial participation (FFP) rate. The result of this calculation is the final settlement amount. Where the interim rate exceeds the final rate, the excess payment shall be remitted to ~~ODJFS~~ ODM. If the final rate exceeds the interim rate, ~~ODJFS~~ ODM shall remit the amount to ~~ODMRDD~~ ODODD.

(5) For periods after SFY 2007, the final payment rate calculated in paragraph (E)(3) of this rule is subtracted from the adjusted interim payment rate calculated in paragraphs (C)(4), (C)(5) and (C)(7) of this rule, as applicable. The result is multiplied by the paid days and applicable FFP rate. The result of this calculation is the final settlement amount. Where the adjusted interim rate exceeds the final rate, the excess payment shall be remitted to ~~ODJFS~~ ODM. If the final rate exceeds the interim rate, ~~ODJFS~~ ODM shall remit the amount to ~~ODMRDD~~ ODODD. The costs incurred for providing the off-site day program/active treatment and transportation services are included when calculating the direct care ceiling for the purposes of final settlement.

(6) The audit and final settlement shall be issued within thirty-six months of receipt of the cost report for the rate year. If an audit is not issued for final settlement within thirty-six months, the rates calculated using the desk reviewed rate year cost report shall be used for final settlement.

(7) No further adjustments to payments or rates can occur after the implementation of the final cost settlement.

(F) Upper payment limit assurance.

Payments made to state-operated ~~ICFs-MR~~ICFs/IID in accordance with this rule under medicaid are, in the aggregate on a statewide basis, equal to or less than amounts which would have been recognized under Title XVIII (medicare) for comparable services in accordance with 42 CFR 447.272 effective ~~October 31, 2009~~ October 1, 2014, and available at www.cms.hhs.gov.

(G) Dispute resolution.

All disputes regarding the application of this rule, including but not limited to desk reviews, payment, rate setting, and audits shall be resolved between ~~ODJFS~~ ODM and ~~ODMRDD~~ ODODD in accordance

with terms set forth in the interagency agreement. Disputes that arise from the application of this rule shall not be subject to hearings conducted under Chapter 119. of the Revised Code.

(H) Rule exclusion.

Excluding those rules referring to reasonableness ceilings, cost limitations, cost reimbursement, occupancy levels, disallowance of costs, payment calculations, payment methodology, and appeals, all other rules which govern the operation of medicaid-certified intermediate care facilities for ~~the mentally retarded~~ individuals with intellectual disabilities under Chapters ~~5101:3-1~~5160-1 and ~~5101:3-3~~5160-3 of the Administrative Code shall apply to state-operated ~~ICFs-MR~~ICFs/IID. The payment methodology specified in this rule shall govern the reimbursement of medicaid costs for state-operated ~~ICFs-MR~~ICFs /IID.

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Five Year Review (FYR) Dates: 02/10/2015 and 06/01/2020

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Chapter 3 Ohio Department of Mental Health

LTCSSTL 12-06

Effective Date: July 1, 2012

Most Current Prior Effective Date: March 15, 1993

- (A) An "eligible provider" for purposes of this chapter is one of the following:
- (1) The Ohio department of mental health, when providing a community mental health service that meets the requirements set forth in section ~~5111.022~~5111.023 of the Revised Code and Chapters ~~5122-23~~5122-24 to 5122-29 of the Administrative Code; or
 - (2) For services provided prior to July 1, 2012, An agency meeting the requirements set forth in section ~~5111.022~~5111.023 of the Revised Code that has negotiated a contract with a community mental health board as defined in rule 5122-24-01 of the Administrative Code. For such an agency that is a government entity which receives nonfederal public funds, including but not limited to county departments of human services, county children's services boards and local education agencies, eligibility is further contingent upon demonstration by the agency, ~~as requested by the department of mental health,~~ that sufficient state and/or local public funds not otherwise encumbered to match other federal funds will be committed to match Title XIX funds for reimbursement of the contracted services.
 - ~~(3) In addition to the requirements of paragraph (A)(1) or (A)(2) of this rule, any medicaid covered service as set forth in rule 5101:3-27-02 of the Administrative Code must be provided.~~
 - (3) For services provided on or after July 1, 2012, a community mental health agency or facility that has its community mental health services certified by the Ohio department of mental health under section 5119.611 of the Revised Code. For such an agency that is a government entity which receives nonfederal public funds, including but not limited to county departments of human services, county children's services boards and local education agencies, eligibility is further contingent upon demonstration by the agency that sufficient state and/or local public funds not otherwise encumbered to match other federal funds will be committed to match Title XIX funds for reimbursement of the services.
- (B) In addition to the requirements of paragraph (A)(1), A(2), and (A)(3) of this rule, an eligible provider must provide one or more of the medicaid covered services as set forth in rule 5101:3-27-02 of the Administrative Code.
- ~~(B)~~(C) An eligible provider may subcontract for services. For such services to be billable, the services must be certified in accordance with section ~~5119.61~~5119.611 of the Revised Code and provided in accordance with the provisions set forth in Chapter 5101:3-27 of the Administrative Code.
- (D) An eligible provider must have a valid Ohio health plans provider agreement approved by and on file with the Ohio department of job and family services.

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Rule Amplifies: 5111.01, 5111.02, section 5111.912 in Am. Sub. HB153 of the 129th General Assembly

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LTCSTL 14-08

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Most Current Prior Effective Date: October 1, 2012

5101:3-27-02 Appendix A

5101:3-27-02 Appendix B

- (A) The following describes those services reimbursable as medicaid community mental health services when rendered by eligible medicaid providers as defined in rule ~~5101:3-27-01~~5160-27-01 of the Administrative Code. For the purposes of this rule, a twelve month period means the time period from July first of any given year to June thirtieth of the subsequent year.
- (1) Behavioral health counseling and therapy services as defined in rule 5122-29-03 of the Administrative Code. A combined maximum of fifty-two hours of individual and group behavioral health counseling and therapy services are allowed per twelve month period. In accordance with the requirements of "Healthchek" (Ohio's early periodic screening, diagnosis, and treatment (EPSDT) benefit), children up to the age of twenty-one may receive services beyond established limits when medically necessary.
 - (2) Mental health assessment services as defined in rule 5122-29-04 of the Administrative Code. Psychological testing, when performed as a component of the mental health assessment, must be face-to-face. A provider billing for or receiving medicaid reimbursement for psychological testing as a component of a mental health assessment under this rule shall not bill for or be reimbursed for that same psychological testing under other medicaid programs.
 - (a) A maximum of two hours of psychiatric diagnostic interview services are allowed per twelve month period. In accordance with the "Healthchek" benefit, children up to the age of twenty-one may receive services beyond established limits when medically necessary.
 - (b) A maximum of four hours of mental health assessment services are allowed per twelve month period. In accordance with the "Healthchek" benefit, children up to the age of twenty-one may receive services beyond established limits when medically necessary.
 - (3) Pharmacologic management services as defined in rule 5122-29-05 of the Administrative Code. All psychiatric/mental health medical interventions billed through this service must be used to reduce, stabilize and/or eliminate psychiatric symptoms of the person served. A maximum of twenty-four hours of pharmacologic management services are allowed per twelve month period. In accordance with the "Healthchek" benefit, children up to the age of twenty-one may receive services beyond established limits when medically necessary. Pharmacologic management services, as defined in this rule, are not covered during an inpatient stay in a hospital.
 - (4) Partial hospitalization services as defined in rule 5122-29-06 of the Administrative Code and meet the following requirements:
 - (a) Partial hospitalization services provided in social, recreational or education settings (internal or external to the partial hospitalization site) are allowable only if there are documented mental health interventions that address the specific individualized mental health treatment needs as identified in the individual service plan (ISP) of the person being served;
 - (b) Partial hospitalization services includes activity therapies, group activities, or other services and programs designed to enhance skills needed for living in the least restrictive environment are allowable.
 - (c) Unallowable partial hospitalization activities are listed in paragraph (H)(7) of this rule.

- (5) Crisis intervention mental health services as defined in rule [5122-29-10](#) of the Administrative Code and meet the following requirements:
- (a) Crisis intervention mental health service must be face-to-face interventions that are responding to emergent situations with the intended result of crisis stabilization or prevention of crisis escalation.
 - (b) Routine monitoring of clients in a crisis residential facility is not considered a crisis intervention mental health service.
- (6) Community psychiatric supportive treatment (CPST) services as defined in rule [5122-29-17](#) of the Administrative Code and meet the following requirements:
- (a) All CPST services provided in social, recreational, vocational, or educational settings are allowable only if they are documented mental health service interventions addressing the specific individualized mental health treatment needs as identified in the ISP of the person served.
 - (b) A billable unit of service for CPST service may include either face-to-face or telephone contacts between the mental health professional and the client or an individual essential to the mental health treatment of the client.
 - (c) A combined maximum of one-hundred and four hours of individual and group CPST services are allowed per twelve month period. In accordance with the "Healthchek" benefit, children up to age of twenty-one may receive services beyond established limits when medically necessary and approved through the prior authorization process. Adults may receive services beyond established limits when medically necessary and approved through the prior authorization process.
 - (d) CPST services are not covered under this rule when provided to an adult or child in a hospital setting, except for the purpose of coordinating admission to the inpatient hospital or facilitating discharge to the community following inpatient treatment for an acute episode of care.
- (7) ~~Eligibility for Health health home services is determined as follows: for persons with serious and persistent mental illness as defined in rule 5122-29-33 of the Administrative Code and reimbursed in accordance with rule 5101:3-27-05 of the Administrative Code. Services shall be covered only in geographical regions approved by the centers for medicare and medicaid services (CMS).~~
- (a) Health home enrollment is restricted to persons with serious and persistent mental illness as defined in rule [5122-29-33](#) of the Administrative Code and in accordance with additional eligibility criteria defined by the Ohio department of medicaid in collaboration with the Ohio department of mental health and addiction services as stated in [appendix B](#) to this rule.
 - (b) Persons who do not meet the eligibility criteria in appendix B to this rule will continue to be eligible for health home services until July 1, 2015 if they meet the following criteria:
 - (i) They are enrolled in a health home located in Adams, Butler, Lawrence, Lucas, or Scioto counties for an effective date prior to July 1, 2014, and
 - (ii) The health home in which they were enrolled prior to July 1, 2014 delivered a health home service to the person during the month of June 2014.
 - (c) Health home services shall be covered only in geographical regions approved by the centers for medicare and medicaid services (CMS).
 - (d) When a health home enrollee or the parent or guardian requests to disenroll from the health home, the health home must process the disenrollment within three business days. The request for disenrollment, including the date the request was made, must be recorded in the client record.

- (B) All medicaid community mental health services are to be billed on a unit rate basis in accordance with definitions, standards and eligible providers of service requirements as set forth in Chapter ~~5101:3-27~~5160-27 of the Administrative Code.
- (C) Medicaid community mental health services must be recommended by an individual who is qualified to supervise the specific service. The identification of individuals qualified to supervise each specific service is set forth in each applicable rule of Chapter 5122-29 of the Administrative Code and as defined in rule 5122-24-01 of the Administrative Code. Provisions set forth in rule 5122-25-06 of the Administrative Code do not affect the provisions of this paragraph.
- (D) Medicaid community mental health services must be performed by an individual who is qualified to perform the specific service. The identification of individuals qualified to perform each specific service is set forth in each applicable rule of Chapter 5122-29 of the Administrative Code and as defined in rule 5122-24-01 of the Administrative Code. Provisions set forth in rule 5122-25-06 of the Administrative Code do not affect the provisions of this paragraph.
- (E) With the exception of the limitations in paragraphs (C) and (D) of this rule, the provisions set forth in rule 5122-25-06 of the Administrative Code apply.
- (F) For the purposes of medicaid community mental health services, a billable unit of service is defined as the following:
- (1) A face-to-face contact between a client and a professional authorized to provide medicaid reimbursable services as described in this rule; or
 - (2) A face-to-face contact with family members, parent, guardian and/or significant others as defined in rule 5122-24-01 of the Administrative Code for children or adolescents receiving behavioral health counseling and therapy, pharmacologic management, mental health assessment, or crisis intervention mental health services, when the purpose of the contact is directed to the exclusive benefit of the medicaid eligible beneficiary; or
 - (3) A face-to-face contact with family members or significant others of adults receiving crisis intervention mental health services, when the purpose of the contact is directed to the exclusive benefit of the medicaid eligible beneficiary; or
 - (4) Community psychiatric supportive treatment interventions provided to individuals other than the client as allowed in paragraphs (A)(6)(b) and (A)(6)(c) of this rule; or
 - (5) Services rendered via interactive video conferencing as described in paragraph (I) of this rule, and in rules 5122-29-03, 5122-29-04, 5122-29-05 and 5122-29-17 of the Administrative Code.
 - (6) Health home services provided in accordance with rule 5122-29-33 of the Administrative Code. Health home services performed after the development of the single, person-centered, integrated care plan must be directly linked to the goals and actions documented in the single, person-centered integrated care plan.
- (G) All medicaid community mental health services contacts, other than health home services, must be documented in the individual client record (ICR) of the person served and satisfy the requirements in rule 5122-27-06 of the Administrative Code. Health home services shall be documented as necessary to establish medical necessity as defined in Chapter ~~5101:3-4~~5160-1 of the Administrative Code.
- (H) Non-covered medicaid community mental health services include:
- (1) Community meetings or group sessions that are not designed to provide specific mental health treatment services to clients. Examples of such activities include, but are not limited to, orientation sessions for new clients, mental health presentations to community groups (high school classes, parent teacher associations, etc.), and informal presentations about the community mental health program.
 - (2) Monitoring clients while they are sleeping.
 - (3) Observing clients when not performing a therapeutic intervention (e.g., when client is watching television, resting, eating, etc.)

- (4) Transportation in and of itself.
 - (5) Unallowable vocational job training activities include, but are not limited to, job shadowing, job coaching, teaching computer skills, math skills, or other trade skills.
 - (6) Services which are considered mental health residential treatment facility services as set forth in Chapter 5122-30 of the Administrative Code.
 - (7) Unallowable partial hospitalization activities include, but are not limited to, crafts, general non-therapeutic art projects, recreational outings purely for recreational purposes, exercise groups, etc.
- (I) Services rendered via interactive video conferencing technology must be provided in accordance with rules established by Ohio department of mental health (ODMH). All services rendered via interactive video conferencing technology must also meet the following conditions:
- (1) The services rendered via interactive video conferencing technology are consistent with rules [5122-29-03](#), [5122-29-04](#), [5122-29-05](#) and [5122-29-17](#) of the Administrative Code; and
 - (2) The documentation requirements of the interactive video conferencing technology contacts remain the same as the face-to-face contacts; and
 - (3) The purpose of the interactive video conferencing technology contact is not the scheduling of appointments.
- (J) The medications listed in [appendix A](#) to this rule are covered by the department when rendered and billed by an eligible provider as described in rule ~~5101: 3-27-01~~[5160-27-01](#) of the Administrative Code. The medication must be administered by a qualified provider acting within the provider's professional scope of practice.

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Statutory Authority: 5164.02

Rule Amplifies: 5164.02, 5164.03, 5164.15, 5164.76, 5164.88

Prior Effective Dates: 4/30/82(Temp), 8/1/82, 7/1/84, 1/1/86, 3/19/87, 7/1/91, 11/1/93, 6/30/95(Emer.), 9/28/95, 7/15/01, 6/1/07, 7/1/08, 11/1/11(Emer.), 1/30/12

LTCSTL 14-08

Effective Date: July 1, 2014

Most Current Prior Effective Date: October 1, 2012

5101:3-27-05 Appendix A

- (A) This rule sets forth the reimbursement and rate setting for the following medicaid covered community mental health services:
- (1) "Behavioral health counseling and therapy" as described in rule [5122-29-03](#) of the Administrative Code.
 - (2) "Community psychiatric supportive treatment" as described in rule [5122-29-17](#) of the Administrative Code.
 - (3) "Crisis intervention mental health" as described in rule [5122-29-10](#) of the Administrative Code.
 - (4) "Mental health assessment" as described in rule [5122-29-04](#) of the Administrative Code.
 - (5) "Partial hospitalization" as described in rule [5122-29-06](#) of the Administrative Code.
 - (6) "Pharmacologic management" as described in rule [5122-29-05](#) of the Administrative Code.
 - (7) "Health home services for persons with serious and persistent mental illness" as described in rule [5122-29-33](#) of the Administrative Code.
- (B) Each agency shall maintain a fee schedule of usual and customary charges for all community mental health medicaid services it provides. The agency shall bill the community medicaid program its usual and customary charge for a medicaid-covered service. The reimbursement rate to each agency shall be the lesser of the agency's usual and customary charge or the amount established in appendix A to this rule with the exception for community psychiatric supportive treatment (CPST) as described in paragraph (C) of this rule and health home services for persons with serious and persistent mental illness as described in ~~paragraph~~ paragraphs (H) to (J) of this rule. Reimbursement for community mental health medicaid services is considered payment in full.
- (C) The reimbursement rate for CPST shall be as follows:
- (1) For CPST services not rendered in a group setting, the medicaid maximum amount is calculated as follows:
 - (a) If the total number of service units rendered by a provider per date of service is less than or equal to six, the medicaid maximum amount is equal to the unit rate according to the department's service fee schedule multiplied by the number of units rendered.
 - (b) If the total number of services units rendered by a provider per date of service is greater than six, the medicaid maximum amount is equal to the sum of:
 - (i) The unit rate according to the department's service fee schedule multiplied by six; and
 - (ii) Fifty per cent of the unit rate according to the department's service fee schedule multiplied by the difference between the total number of units rendered minus six.
 - (2) For CPST services rendered in a group setting, the medicaid maximum amount is calculated as follows:
 - (a) If the total number of service units rendered by a provider per date of service is less than or equal to six, the medicaid maximum amount is equal to the unit rate according to the department's service fee schedule multiplied by the number of units rendered.

- (b) If the total number of services units rendered by a provider per date of service is greater than six, the medicaid maximum amount is equal to the sum of:
 - (i) The unit rate according to the department's service fee schedule multiplied by six; and
 - (ii) Fifty per cent of the unit rate according to the department's service fee schedule multiplied by the difference between the total number of units rendered minus six.

(D) The community medicaid program will not pay for community mental health medicaid services for medicaid clients when those same services are routinely provided to non-medicaid clients at no charge, except when medicaid reimbursement for such services are prescribed by federal law or in rule ~~5101:3-1-03~~5160-1-03 of the Administrative Code. If a reduced charge or no charge is made, the lowest charge made becomes the medicaid rate for that service. The community mental health medicaid services are not considered to be provided to non-medicaid clients at no charge or at a reduced charge if all of the following requirements are met:

- (1) The agency establishes a fee schedule of usual and customary charges (UCC) for each service available and the agency utilizes a sliding fee schedule whereby individuals without third party insurance are charged; and
- (2) The agency collects third-party insurance information from all medicaid and non-medicaid clients; and
- (3) The agency bills other responsible third party insurers or payers, including medicare, in accordance with ~~rule 5101:3-1-08~~rules 5160-1-05 and 5160-1-08 of the Administrative Code where such insurers or payers are known.

(E) The agency may enter into arrangements with insurers and other responsible payers for reimbursement at levels that may differ from the published usual and customary fee schedule.

(F) Services reimbursed under this rule are subject to review in accordance with 42 C.F.R. 456.3, ~~dated October 1, 2007~~as in effect on October 1, 2013, and rule ~~5101:3-1-27~~5160-1-27 of the Administrative Code.

(G) Notwithstanding the provisions set forth in paragraph (G) of rule ~~5101:3-27-02~~5160-27-02 of the Administrative Code the agency shall be deemed to be in compliance with paragraph (G) of rule ~~5101:3-27-02~~5160-27-02 of the Administrative Code if it satisfies all the requirements in rule 5122-27-06 of the Administrative Code.

(H) Health home services for persons with serious and persistent mental illness, as defined in rule 5122-29-33 of the Administrative Code, are reimbursed using a monthly case rate specific to the health home service ~~provider~~ providers located in Ohio counties Adams, Butler, Lawrence, Lucas, and Scioto, and shall be calculated as follows:

- (1) Annual costs must be compiled in accordance with the uniform cost report principles and cost categories described in rule 5122: 26-19 of the Administrative Code.
- (2) Calculation of the monthly case rate is as follows:
 - (a) Divide the annual cost as developed in accordance with paragraph (H)(1) of this rule by the caseload, then
 - (b) Divide the result of the calculation in paragraph (H)(2)(a) of this rule by twelve.
- (3) ~~A provider's cost will be reviewed annually to determine whether it is necessary to rebase the case rate, based on the information from the provider's actual costs for the prior year.~~ The monthly case rates calculated using the methodology in paragraphs (H)(1) and (H)(2) of this rule shall be reduced by ten percent for the period of July 1, 2014 through June 30, 2015.

~~(4) Health home service payments are not subject to cost reconciliation.~~

~~(5)~~(4) Reimbursement for health home services is considered payment in full for all components of the service as defined in rule 5122-29-33 of the Administrative Code, including service components that may otherwise be reimbursable as CPST.

(I) Beginning July 1, 2014, reimbursement for health home service providers located in Ohio counties Cuyahoga, Erie, Franklin, Hamilton, Portage, and Summit will be made using the base rate as stated in appendix A to this rule. Rates will remain in effect until changed by the Ohio department of medicaid in consultation with the Ohio department of mental health and addiction services and certified health home providers.

(J) Beginning July 1, 2014, health home service providers located in Cuyahoga, Franklin, Hamilton, Portage, and Summit counties that render health home services to individuals enrolled in a MyCare Ohio plan, as specified in rule [5160-58-01](#) of the Administrative Code, shall bill the MyCare Ohio plan for the monthly case rate stated in [appendix A](#) to this rule. Health home service providers located in Butler and Lucas counties that render health home services to individuals enrolled in a MyCare Ohio plan, as specified in rule 5160-58-01 of the Administrative Code, shall bill the MyCare Ohio plan for the monthly case rate outlined in paragraph (H) of this rule.

~~(H)~~(K) The reimbursement amount for an injectable or provider-administered medication listed in appendix A to rule ~~5101:3-27-02~~[5160-27-02](#) of the Administrative Code is the lesser of the provider's submitted charge or the maximum fee listed, described, or referenced in rule ~~5101:3-1-60~~ [5160-1-60](#) of the Administrative Code.

Effective: 07/01/2014

R.C. 119.032 review dates: 10/01/2015

Certification: CERTIFIED ELECTRONICALLY

Date: 06/19/2014

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5164.02, 5164.03, 5164.15, 5164.88

Prior Effective Dates: 8/1/82, 12/22/86(Emer.), 7/1/91, 9/1/05, 2/15/10, 10/4/10, 7/1/11(Emer.), 9/29/11

CATL-MH 10-03

Effective Date: October 4, 2010

Most Current Prior Effective Date: September 1, 2005

- (A) Purpose: this rule sets forth the cost reconciliation calculation method to be used by the Ohio department of mental health, the notification of overpayment requirement to and the repayment for medicaid participating mental health agencies.

The cost reconciliation process described in this rule is no longer applicable to medicaid covered community mental health services provided on or after October 4, 2010 due to the fee schedule payment methodology implemented in rule [5101:3-27-05](#) of the Administrative Code.

- (B) Definitions:

- (1) "Actual uniform cost report" means the uniform cost report completed retrospectively after the close of the state fiscal year (SFY) using actual cost data.
- (2) "Actual unit rate" means the unit cost found in column twelve of the actual uniform cost report.
- (3) "Agency" means a community mental health provider as defined in section 5122.01 of the Revised Code which has been certified by the Ohio department of mental health in accordance with the requirements of section [5119.611](#) of the Revised Code.
- (4) "Budgeted uniform cost report" means a uniform cost report completed prospectively using anticipated budgeted cost data for an upcoming SFY.
- (5) "Full payment" means federal financial participation and match participation.
- (6) "Interim unit rate" means the unit cost found in column twelve of a budgeted uniform cost report.
- (7) "MACSIS" means multi-agency community services information system.
- (8) "Medicaid paid claims" means claims sourced from MACSIS which were submitted to and approved for reimbursement by ODJFS.
- (9) "Medicaid participating mental health agency" means an agency that has met the requirements of rule [5101:3-27-01](#) of the Administrative Code and has received payment for medicaid covered mental health services as defined in rule 5101:3-27-02 of the Administrative Code.
- (10) "ODJFS" means the Ohio department of job and family services.
- (11) "ODMH" means the Ohio department of mental health.
- (12) "Rate ceiling" means the maximum amount per unit of service a medicaid participating mental health agency may be paid for a medicaid covered mental health service listed in rule 5101:3-27-05 of the Administrative Code.
- (13) "Uniform cost report" means the cost report as contained in rule [5122-26-19](#) of the Administrative Code as in effect for the SFY being reconciled.
- (14) "Unit of service" means the length of time defined in rule 5122-26-19 of the Administrative Code as in effect for the SFY being reconciled for each medicaid covered community mental health service as defined in rule [5101:3-27-02](#) of the Administrative Code.
- (15) "UPI" means the unique provider identification number. This number represents an ODMH certified community mental health program and owner (indicated by a single federal tax identification number) operating at a discrete physical location.

- (C) Each medicaid participating mental health agency shall complete all the budgeted uniform cost reports and the actual uniform cost report for any given SFY in accordance with rule 5122-26-19 of the Administrative Code as in effect for the SFY being reconciled. The methods of cost reporting selected

when completing the first budgeted uniform cost report submitted in accordance with rule 5101:3-27-05 of the Administrative Code for a SFY must be the same methods the medicaid participating mental health agency shall use when completing and submitting any subsequent budgeted uniform cost report and the actual uniform cost report for that same SFY.

(D) Cost reconciliation process:

- (1) The actual allowable amount a medicaid participating mental health agency could have received for medicaid covered mental health services for the state fiscal year being reconciled shall be determined by ODMH as follows:
 - (a) For each service, the maximum allowable rate will be determined by selecting the lower of the following: the medicaid rate ceiling in effect for the SFY being reconciled or the actual cost. The total allowable payment shall be determined by multiplying the number of service units from MACSIS associated with the medicaid paid claims by the maximum allowable rate. If a medicaid participating mental health agency fails to submit an actual uniform cost report in accordance with rule 5122-26-19 of the Administrative Code as in effect for the SFY being reconciled, the number of service units from MACSIS associated with the medicaid paid claims shall be multiplied by the lowest actual unit cost as documented on all filed actual uniform cost reports for the SFY being reconciled for each service the medicaid participating mental health agency received medicaid payment. If a medicaid participating mental health agency fails to submit an actual uniform cost report in accordance with rule 5122-26-19 of the Administrative Code as in effect for the SFY being reconciled, the medicaid participating mental health agency's ODMH certification/license may be revoked in accordance with rule 5122-26-19 of the Administrative Code as in effect for the SFY being reconciled.
 - (b) From each of the calculations described in paragraph (D)(1)(a) of this rule the value of third party payments, as reported by the medicaid participating mental health agency associated with the service specific medicaid paid claims shall be deducted. The result is the actual allowable amount of medicaid payment for each service for the medicaid participating mental health agency for the SFY being reconciled.
 - (2) The actual amount of medicaid payment paid to the medicaid participating mental health agency for each service for the SFY being reconciled shall be determined by summing the net amount from MACSIS claims detail associated with medicaid paid claims for that service.
 - (3) For each service, subtract the result of paragraph (D)(1)(b) of this rule from paragraph (D)(2) of this rule.
 - (a) If the result of this calculation is greater than zero, the medicaid participating mental health agency has been overpaid for the service for the SFY being reconciled.
 - (b) If the result of this calculation is equal to or less than zero, no overpayment of the service exists.
 - (4) The medicaid participating mental health agency is required to repay the full amount of the sum of all overpayments identified in paragraph (D)(3)(a) of the rule to ODMH.
- (E) ODMH shall send the medicaid participating mental health agency a notification, by certified mail, of the overpayment amount calculated. ODMH will send a copy to ODJFS.

Effective: 10/04/2010

R.C. 119.032 review dates: 07/20/2010 and 10/01/2015

Certification: CERTIFIED ELECTRONICALLY

Date: 09/24/2010

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.022

Prior Effective Dates: 8/1/82, 12/22/86(Emer.), 7/1/91, 9/1/05

Chapter 4 Ohio Department of Alcohol and Drug Addiction Services

LTCSSTL 12-06

Effective Date: July 1, 2012

Most Current Prior Effective Date: August 1, 1993

- (A) An eligible provider for purposes of this chapter is an entity that is operating a program certified in accordance with the requirements set forth in Chapters 3793:2-1 and 3793:2-2 of the Administrative Code, or certified in accordance with the requirements set forth in Chapters 3793:2-1 and 3793:2-2 of the Administrative Code and licensed according to Chapter 3793:2-3 of the Administrative Code ~~to provide~~ as a methadone program, or certified in accordance with the requirements set forth in Chapters 3793:2-1 and 3793:2-5 of the Administrative Code. ~~An~~ For services provided prior to July 1, 2012 an eligible provider must contract with an alcohol and drug addiction services board or an alcohol, drug addiction and mental health services board to receive medicaid reimbursement for the medicaid covered services defined in rule 5101:3-30-02 of the Administrative Code. For services provided after July 1, 2012, no contract between the provider and board is required for reimbursement of medicaid covered services. Alcohol and other drug ~~addiction~~ treatment services must be provided in accordance with Chapter 5101:3-30 and Chapter 5101:3-1 of the Administrative Code.
- (B) For any provider that is a government entity which receives nonfederal public funds, including but not limited to county departments of human services, county children services boards and local education agencies, eligibility is further contingent upon demonstration by the agency, ~~as requested by the department of alcohol and drug addiction services,~~ that sufficient state and/or local public funds not otherwise encumbered to match other federal funds will be committed to match Title XIX funds for reimbursement of the contracted service(s) and certified as representing expenditures eligible for federal financial participation.
- (C) An eligible provider must have a signed valid Ohio health plans provider agreement approved by and on file with the Ohio department of job and family services.

Effective: 07/01/2012

R.C. 119.032 review dates: 04/16/2012 and 07/01/2017

Certification: CERTIFIED ELECTRONICALLY

Date: 06/21/2012

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 3793.06, 3793.11, section 5111.913 in Am. Sub. HB153 of the 129th General Assembly

Prior Effective Dates: 7/1/91 (Emer.), 9/30/91, 8/1/93

LTCSTL 12-08

Effective Date: October 1, 2012

Most Current Prior Effective Date: September 30, 1991

5101:3-30-02, Appendix A

- (A) The following identifies alcohol and other drug ~~addiction~~ treatment services that may be covered by medicaid and the limitation policies applicable to these services.
- (1) "Assessment ~~services~~" ~~are those services~~ is the service defined in rule 3793:2-1-08 of the Administrative Code and provided ~~in accordance with Chapters 3793:2-1 and 3793:2-2 of the Administrative Code~~ by an eligible provider as defined in this chapter.
 - (2) "Crisis intervention ~~services~~" ~~are those services~~ is the service defined in rule ~~3793:2-1-09~~ 3793:2-1-08 of the Administrative Code and provided ~~in accordance with Chapters 3793:2-1 and 3793:2-2 of the Administrative Code~~ by an eligible provider as defined in this chapter.
 - (3) "Individual counseling ~~services~~" and "group counseling ~~services~~" are those services defined in rule ~~3793:2-1-11~~ 3793:2-1-08 of the Administrative Code and provided ~~in accordance with Chapters 3793:2-1 and 3793:2-2 of the Administrative Code~~ by an eligible provider as defined in this chapter.
 - (4) "Medical somatic ~~services~~" ~~are those services~~ is the service defined in rule ~~3793:2-1-13~~ 3793:2-1-08 of the Administrative Code and provided ~~in accordance with Chapters 3793:2-1 and 3793:2-2 of the Administrative Code~~ by an eligible provider as defined in this chapter.
 - (5) ~~"Drug screening/urinalysis services" are those services~~ "Laboratory urinalysis" is the service defined in rule ~~3793:2-1-14~~ 3793:2-1-08 of the Administrative Code and provided ~~in accordance with Chapters 3793:2-1 and 3793:2-2 of the Administrative Code~~ by an eligible provider as defined in this chapter. Notwithstanding the provisions found in Chapters 3793:2-1 and 3793:2-2 of the Administrative Code, a physician must order the drug screening/urinalysis for medicaid to cover the service.
 - (6) ~~"Methadone administration services" are those services~~ "Opioid agonist administration" is the service defined in rule ~~3793:2-1-15~~ 3793:2-1-08 of the Administrative Code and provided ~~in accordance with Chapters 3793:2-1 and 3793:2-2 of the Administrative Code and licensed in accordance with Chapter 3793:2-3 of the Administrative Code~~ by an eligible provider as defined in this chapter.
 - (7) "Case management ~~services~~" ~~are those services~~ is the service defined in rule ~~3793:2-1-16~~ 3793:2-1-08 of the Administrative Code and provided ~~in accordance with Chapters 3793:2-1 and 3793:2-2 of the Administrative Code~~ by an eligible provider as defined in this chapter.
 - (8) "Intensive outpatient ~~services~~" ~~are those services~~ is the service defined in rule ~~3793:2-1-17~~ 3793:2-1-08 of the Administrative Code and provided ~~in accordance with Chapters 3793:2-1 and 3793:2-2 of the Administrative Code~~ by an eligible provider as defined in this chapter.
 - (9) ~~"Ambulatory medical" or "social detoxification services" are those services~~ "Ambulatory detoxification" is the service defined in ~~paragraph (F) of rule 3793:2-1-10~~ 3793:2-1-08 of the Administrative Code and provided ~~in accordance with Chapters 3793:2-1 and 3793:2-2 of the Administrative Code~~ by an eligible provider as defined in this chapter.
- (B) ~~Services meeting the requirements identified in paragraphs (A)(1) to (A)(9) of this rule are covered when recommended by an individual who has one of the following credentials:~~
- (1) ~~Certified chemical dependency counselor three;~~
 - (2) ~~Licensed physician;~~

- ~~(3) Licensed psychologist;~~
- ~~(4) Licensed professional clinical counselor with a declared scope of practice of alcohol and drug addiction counseling;~~
- ~~(5) Licensed professional counselor with a declared scope of practice of alcohol and drug addiction counseling;~~
- ~~(6) Licensed independent social worker with a declared scope of practice of alcohol and drug addiction counseling; or~~
- ~~(7) Registered nurse with a declared scope of practice of alcohol and drug addiction nursing.~~

(B) Alcohol and other drug treatment services must be recommended by a professional who is qualified to sign an individualized treatment plan in accordance with rule [3793:2-1-06](#) of the Administrative Code.

(C) Alcohol and other drug treatment services must be performed by a professional who is qualified to perform the specific service. The identification of professionals qualified to perform each specific service is set forth in rule [3793:2-1-08](#) of the Administrative Code.

(D) The medications listed in [Appendix A](#) of this rule are covered by the department when rendered and billed by an eligible provider as described in rule [5101: 3-30-01](#) of the Administrative Code. The medication must be administered by an individual qualified to do so and is acting within the individual's scope of practice.

Replaces: 5101:3-30-02

Effective: 10/01/2012

R.C. 119.032 review dates: 10/01/2017

Certification: CERTIFIED ELECTRONICALLY

Date: 09/21/2012

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 3793.06, 3793.11, 5111.01, 5111.02

Prior Effective Dates: 7/1/91 (Emer.), 9/30/91

LTCSTL 12-06

Effective Date: July 1, 2012

Most Current Prior Effective Date: September 30, 1991

- (A) All covered services are to be billed on a unit rate basis in accordance with definitions, standards, and eligible ~~providers~~ provider of service ~~criteria as set forth in rule~~ rules 5101:3-30-01, 5101:3-30-02, and 5101:3-30-04 of the Administrative Code.
- (B) For purposes of alcohol and ~~other drug-addiction~~ treatment services, unless otherwise ~~noted,~~ described in this chapter, a "billable unit of service" is defined as an hour-measured face-to-face contact between a client and a professional authorized qualified to provide services delineated in rule 5101:3-30-02 of the Administrative Code as covered under the medicaid program. For an alcohol and ~~other drug addiction~~ treatment service to be defined as a unit, it must meet the definition set forth in this paragraph and must be recorded in the individual client record (ICR) in accordance with rule 3793:2-1-06 of the Administrative Code. ~~Case management services can be delivered face-to-face or by telephone and be a "billable unit of service." Billable case management services may include face-to-face or telephone contact with persons other than the client; such services must be recorded in the clients ICR.~~
- (1) Billable units of services are limited to those which take place at the site certified ~~for participation in the alcohol and drug addiction~~ as a treatment program by the Ohio department of alcohol and drug addiction services or at ~~a site deemed~~ any other appropriate location according to the standard referenced in rule 5101:3-30-02 of the Administrative Code as relative to the covered service.
- (2) Units of service with individuals other than the client (e.g., conferences and consultations with a family member) are not billable. However, individual counseling and diagnostic assessment may include face-to-face interaction with family members and/or parent parents, guardian guardians and/or significant other others of a child or adolescent when the intended outcome is improved functioning of the child or adolescent and when such intervention is part of the individualized treatment plan. ~~It is recognized also that case management services include contact with individuals other than the client and is billable as a unit of service.~~
- (3) Case management services can be billable units of service delivered face-to-face or by telephone and may include contact with a client or with individuals other than the client; such services must be recorded in the client's ICR.
- ~~(3)~~(4) Covered services delineated in rule 5101:3-30-02 of the Administrative Code, with the exception of ambulatory detoxification, intensive outpatient services, laboratory urinalysis and opioid agonist administration are considered hour-measured billable services. Ambulatory detoxification and Intensive intensive outpatient services are considered day-measured billable services and, drug screening/urinalysis services are the laboratory urinalysis service is considered a per screening (independent of the number of panels) billable unit and opioid agonist administration is considered a per dose billable unit of service. ~~for purposes of the alcohol and drug addiction treatment services program.~~
- ~~(4)~~ ~~The billable unit of service criterion is not met nor is coverage available under medicaid for costs involved when a provider participates in community meetings or group sessions which are not designed to provide alcohol and drug addiction treatment services to program users. Examples of such activities include orientation sessions for new clients, presentations to community groups (high school classes, PTA, etc.), and informal presentations about alcohol and drug addiction treatment programs.~~
- (C) ~~It is recognized that eligible~~ Eligible providers may ~~wish to~~ augment staff delivered services through contractual arrangements. Such arrangements are recognized to the extent that the conditions set forth

in paragraphs (C)(1) and (C)(2) of this rule are met. ~~Services provided by contract may either be included as a cost item in determining the prospective rates or may be billed independently by the contract provider. If the contract provider bills independently, any such services will not be subject to prospective cost-related reimbursement, but will instead be reimbursed in accordance with methods established under 5101:3 of the Administrative Code other than the provisions set forth in Chapter 5101:3-30 of the Administrative Code (e.g., physician psychiatric services will be reimbursed under provisions set forth in Chapter 5101:3-4 of the Administrative Code).~~ In order for contractual arrangements to be recognized, eligible providers must provide upon request the following information to the Ohio department of alcohol and drug addiction and/or the Ohio department of job and family services ~~at the point of entry into the program and any subsequent point when new contracts are negotiated or when existing contracts are revised:~~

- (1) Identification by name and, where applicable, Ohio medicaid provider number of each individual practitioner providing services under contractual arrangements. Where the contract is let with a legal entity other than the individual practitioner, both the name of the legal entity and the name(s) of any individual practitioner(s) involved must be furnished.
- (2) A written statement indicating, for each legal entity or individual practitioner, whether the contracted services are:
 - (a) To be included as ~~a cost item and reimbursed under the applicable prospective rate for the type of service provided~~ billable services by the participating Ohio department of alcohol and drug addiction services certified treatment program; or
 - (b) To be billed independently by the legal entity or individual practitioner under contract.

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R.C. 119.032 review dates: 04/16/2012 and 07/01/2017

Certification: CERTIFIED ELECTRONICALLY

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Rule Amplifies: 5111.01, 5111.02, 3793.06, 3793.11

Prior Effective Dates: 7/1/91 (Emer.), 9/30/91

5160-30-04 Reimbursement for Community Medicaid Alcohol and Other Drug Treatment Services

Formerly 5101:3-30-04 Reimbursement for Community Medicaid Alcohol and Other Drug Treatment Services

LTCSTL 13-09

Effective Date: November 10, 2013

Most Current Prior Effective Date: October 1, 2012

5101:3-30-04, Appendix A

- (A) This rule sets forth the reimbursement for the following community medicaid alcohol and other drug treatment services:
- (1) "Ambulatory detoxification" as defined in paragraph (X) of rule 3793:2-1-08 of the Administrative Code.
 - (2) "Assessment" as defined in paragraph (K) of rule 3793:2-1-08 of the Administrative Code.
 - (3) "Case management" as defined in paragraph (M) of rule 3793:2-1-08 of the Administrative Code.
 - (4) "Crisis intervention" as defined in paragraph (L) of rule 3793:2-1-08 of the Administrative Code.
 - (5) "Group counseling" as defined in paragraph (O) of rule 3793:2-1-08 of the Administrative Code.
 - (6) "Individual counseling" as defined in paragraph (N) of rule 3793:2-1-08 of the Administrative Code.
 - (7) "Intensive outpatient" as defined in paragraph (Q) of rule 3793:2-1-08 of the Administrative Code.
 - (8) "Laboratory urinalysis" as defined in paragraph (R) of rule 3793:2-1-08 of the Administrative Code.
 - (9) "Medical/somatic" as defined in paragraph (S) of rule 3793:2-1-08 of the Administrative Code.
 - (10) "Opioid agonist administration" as defined in paragraph (T) of rule 3793:2-1-08 of the Administrative Code.
- (B) Each agency shall maintain a fee schedule of usual and customary charges for all community medicaid alcohol and other drug treatment services it provides. The agency shall bill the community medicaid program its usual and customary charge for a medicaid-covered service. The reimbursement rate to each agency shall be the lesser of the agency's usual and customary charge or the amount established in appendix A to this rule with the exception for case management as described in paragraph (C) of this rule.
- (C) The reimbursement rate for the case management service shall be as follows:
- (1) If the total number of service units rendered and billed by a provider per date of service to a unique client is less than or equal to 1.5, the medicaid payment amount is equal to the unit rate according to the department's service fee schedule (specified in [appendix A](#) to this rule) multiplied by the number of units billed or the provider billed amount based upon their established usual and customary charge, whichever is less.
 - (2) If the total number of service units rendered and billed by a provider per date of service to a unique client is greater than 1.5, the medicaid payment amount is equal to:
 - (a) The sum of:
 - (i) The unit rate according to the department's service fee schedule (specified in appendix A to this rule) multiplied by 1.5; and
 - (ii) Fifty per cent of the unit rate according to the department's service fee schedule (specified in appendix A to this rule) multiplied by the difference between the total number of units billed minus 1.5.

- (D) The community medicaid program will not pay for community medicaid alcohol and other drug treatment services for medicaid clients when those same services are routinely provided to non-medicaid clients at no charge, except when medicaid reimbursement for such services are prescribed by federal law or in rule ~~5101:3-1-03~~5160-1-03 of the Administrative Code. If a reduced charge or no charge is made, the lowest charge made becomes the medicaid rate for that service. The community medicaid alcohol and other drug treatment services are not considered to be provided to non-medicaid clients at no charge or at a reduced charge if all of the following requirements are met:
- (1) The agency establishes a fee schedule of usual and customary charges (UCC) for each service available and the agency utilizes a sliding fee schedule whereby individuals without third party insurance are charged; and
 - (2) The agency collects third-party insurance information from all medicaid and non-medicaid clients; and
 - (3) The agency bills other responsible third party insurers or payers in accordance with rule ~~5101:3-1-08~~5160-1-08 of the Administrative Code when such insurers or payers are known.
- (E) The community medicaid program will not pay for more than thirty cumulative hours of the following services when provided to the same adult individual during a week, Sunday through Saturday:
- (1) Group counseling,
 - (2) Individual counseling, and
 - (3) Medical/somatic.
- In accordance with the early periodic screening, diagnosis, and treatment (EPSDT) program, services to children are not subject to the limit of thirty cumulative hours per week.
- (F) The agency may enter into arrangements with insurers and other responsible payers for reimbursement at levels that may differ from the published usual and customary fee schedule.
- (G) Services reimbursed under this rule are subject to review in accordance with 42 C.F.R. 456.3, dated October 1, 2007, and rule ~~5101:3-1-27~~5160-1-27 of the Administrative Code.
- (H) The reimbursement amount for injectable naltrexone as listed in appendix A to rule ~~5101:3-30-02~~5160-30-02 of the Administrative Code is the lesser of the provider's submitted charge or the maximum fee listed, described, or referenced in rule ~~5101:3-1-60~~5160-1-60 of the Administrative Code. Reimbursement for buprenorphine based medications, when administered in accordance with rule 3793: 2-1-08 of the Administrative Code, shall be fifty-five cents per one milligram unit and must be billed using HCPCS code J8499. The reimbursement amount for this medication will be reviewed and updated as necessary.

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R.C. 119.032 review dates: 10/01/2015

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Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.02

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CATL-MH 10-03

Effective Date: October 4, 2010

Most Current Prior Effective Date: September 1, 2005

- (A) Purpose: this rule sets forth the cost reconciliation calculation method to be used by the Ohio department of alcohol and drug addiction services, the notification of overpayment requirement to and the repayment for medicaid participating alcohol and other drug programs.

The cost reconciliation process described in this rule is no longer applicable to medicaid covered alcohol and other drug treatment services provided on or after October 4, 2010 due to the fee schedule payment methodology implemented in rule [5101:3-27-05](#) of the Administrative Code.

(B) Definitions:

- (1) "Actual uniform cost report" means the uniform cost report completed retrospectively after the close of the state fiscal year (SFY) using actual cost data.
- (2) "Actual unit rate" means the unit cost found in column twelve of the actual uniform cost report.
- (3) "AOD program" means an alcohol and drug addiction program as defined in section [3793.01](#) of the Revised Code which has been certified by the Ohio department of alcohol and drug addiction services in accordance with the requirements of section [3793.06](#) of the Revised Code or has been issued a license from the Ohio department of alcohol and drug addiction services in accordance with the requirements of section [3793.11](#) of the Revised Code.
- (4) "Budgeted uniform cost report" means a uniform cost report completed prospectively using anticipated budgeted cost data for an upcoming SFY.
- (5) "Full payment" means federal financial participation and match participation.
- (6) "Interim unit rate" means the unit cost found in column twelve of a budgeted uniform cost report.
- (7) "MACSIS" means multi-agency community services information system.
- (8) "Medicaid paid claims" means claims sourced from MACSIS which were submitted to and approved for reimbursement by ODJFS.
- (9) "Medicaid participating AOD program" means an AOD program that has met the requirements of rule [5101:3-30-01](#) of the Administrative Code and has received payment for medicaid covered AOD treatment services as defined in rule [5101:3-30-02](#) of the Administrative Code.
- (10) "ODADAS" means the Ohio department of alcohol and drug addiction services.
- (11) "ODJFS" means the Ohio department of job and family services.
- (12) "Rate ceiling" means the maximum amount per unit of service a medicaid participating AOD program may be paid for a medicaid covered AOD treatment service listed in rule [5101:3-30-04](#) of the Administrative Code.
- (13) "Uniform cost report" means the cost report as contained in rule [3793:2-1-09](#) of the Administrative Code as in effect for the SFY being reconciled.
- (14) "Unit of service" means the length of time as defined in rule 3793:2-1-09 of the Administrative Code as in effect for the SFY being reconciled. For each medicaid covered AOD treatment service as defined in rule 5101:3-30-02 of the Administrative Code on the uniform cost report.
- (15) "UPI" means the unique provider identification number. This number represents an ODADAS certified community alcohol and drug addiction program and owner (indicated by a single federal tax identification number) operating at a discrete physical location.

- (C) Each medicaid participating AOD program shall complete all the budgeted uniform cost reports and the actual uniform cost report for any given SFY in accordance with rule 3793:2-1-09 of the Administrative Code as in effect for the SFY being reconciled. The methods of cost reporting selected when completing the first budgeted uniform cost report submitted in accordance with rule 5101:3-30-04 of the Administrative Code for a SFY must be the same methods the medicaid participating AOD program shall use when completing and submitting any subsequent budgeted uniform cost report and the actual uniform cost report for that same SFY.
- (D) Cost reconciliation process:
- (1) The actual allowable amount a medicaid participating AOD program could have received for medicaid covered AOD treatment services for the state fiscal year being reconciled shall be determined by ODADAS as follows:
 - (a) For each service, the maximum allowable rate will be determined by selecting the lower of the following: the medicaid rate ceiling in effect for the SFY being reconciled or the actual unit cost. The total allowable payment shall be determined by multiplying the number of service units from MACSIS associated with the medicaid paid claims by the maximum allowable rate. If the medicaid participating AOD program fails to submit an actual uniform cost report in accordance with rule 3793:2-1-09 of the Administrative Code as in effect for the SFY being reconciled, the number of service units from MACSIS associated with the medicaid paid claims shall be multiplied by the lowest actual unit cost as documented on all filed actual uniform cost reports for the SFY being reconciled for each service the medicaid participating AOD program received medicaid payment. If a medicaid participating AOD program fails to submit an actual uniform cost report in accordance with rule 3793:2-1-09 of the Administrative Code as in effect for the SFY being reconciled, the medicaid participating AOD program's ODADAS certification/license may be revoked in accordance with rule 3793:2-1-09 of the Administrative Code as in effect for the SFY being reconciled.
 - (b) From each of the calculations described in paragraph (D)(1)(a) of this rule the value of third party payments, as reported by the medicaid participating AOD program associated with the service specific medicaid paid claims shall be deducted. The result is the actual allowable amount of medicaid payment for each service for the medicaid participating AOD program for the SFY being reconciled.
 - (2) The actual amount of medicaid payment paid to the medicaid participating AOD program for each service for the SFY being reconciled shall be determined by summing the net amount from MACSIS claims detail associated with medicaid paid claims for that service.
 - (3) For each service, subtract the result of paragraph (D)(1)(b) of this rule from paragraph (D)(2) of the rule.
 - (a) If the result of this calculation is greater than zero, the medicaid participating AOD program has been overpaid for the service for the SFY being reconciled.
 - (b) If the result of this calculation is equal to or less than zero, no overpayment for the service exists.
 - (4) The medicaid participating AOD program is required to repay the full amount of the sum of all overpayments identified in paragraph (D)(3)(a) to ODADAS.
- (E) ODADAS shall send the medicaid participating AOD program a notification, by certified mail, of the overpayment amount calculated. ODADAS will send a copy to ODJFS.

Effective: 10/04/2010

R.C. 119.032 review dates: 07/20/2010 and 10/01/2015

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Chapter 5 Ohio Department of Education

[LTCSSTL 15-05](#)

Effective Date: April 1, 2015

Most Current Prior Effective Date: [October 15, 2009](#)

- (A) For the purposes of Chapter ~~5101:3-35~~5160-35 of the Administrative Code, the following terms are defined as:
- (1) At the direction of: communication of a plan of care to a licensed practical nurse by a licensed physician or registered nurse who is acting within the scope of his or her practice under Ohio law for the provision of nursing services by the licensed practical nurse.
 - (2) Clinical setting: for the purpose of counseling and social work roles, a location in the school, or a location for which the medicaid school program provider has contracted for the delivery of services, where the child's confidentiality can be maintained when a service is being rendered.
 - (3) Community school: a public school, independent of any school district, established in accordance with Chapter 3314. of the Revised Code that is part of the state's program of education.
 - (4) Common procedural terminology (CPT): a list of descriptive terms and identifying codes for reporting medical services and procedures performed.
 - (5) Direct service costs: costs associated with salaries, benefits, and contract compensation for individuals and entities delivering services to an eligible child, services as defined in rule [5160-35-05](#) of the Administrative Code and as defined in paragraph (B)(2) of rule [5160-35-06](#) of the Administrative Code.
 - ~~(4) Direct supervision: the licensed practitioner of the healing arts shall conduct face-to-face client evaluations initially and periodically thereafter, and be present with the licensed aide in the same space designated for service delivery throughout the time the licensed aide is providing service and immediately available to provide assistance and direction throughout the time the aide is performing services. Direct supervision does not mean the licensed practitioner of the healing arts must be in the same room while the aide is providing services, except when the room is the only service delivery space. The availability of the licensed practitioner of the healing arts by telephone or the presence of the licensed practitioner of the healing arts somewhere else in the building does not constitute direct supervision.~~
 - ~~(5)~~(6) Eligible child: a student for whom medicaid reimbursement may be sought through the medicaid school program who is enrolled in an entity defined in paragraph (B)(1) of rule ~~5101:3-35-02~~5160-35-02 of the Administrative Code, who is between the age of three to twenty-one, and has an individualized education program in which is indicated services that are allowable under medicaid.
 - ~~(6) General supervision: the licensed practitioner of the healing arts is available, but not necessarily present in the same space designated for service delivery or on-site, to monitor the provision of service. However, if the licensed practitioner of the healing arts is not physically present in the same space designated for service delivery, he or she shall be immediately available to the assistant for consultation purposes at all times. The supervision requires an interactive process and shall include, but is not limited to, an initial face-to-face client evaluation and periodically thereafter, routine consult with the assistant before the assistant's initiation of any client treatment plan and/or modification of the treatment plan, and review of the following: client assessment, reassessment, treatment plan, intervention and the discontinuation of intervention, and/or treatment plan. Co-signing client documentation alone does not meet the general supervision requirements.~~
 - (7) Healthcare common procedure coding system (HCPCS): is a uniform method for health care providers and medical suppliers to report professional services, procedures and supplies.

- (7)(8) ~~IEP: the~~ The individualized education program (IEP) ~~as described~~ is as defined in section [3323.011](#) of the Revised Code.
- (9) Licensed practitioner of the healing arts: for purposes of these rules, includes the following qualified practitioners delineated in rule 5160-35-05 of the Administrative Code - occupational therapist; physical therapist; speech-language pathologist; and audiologist.
- (8)(10) Local education agency: city school district, local school district, exempted village school district, as defined in sections 3311.01 to 3311.04 of the Revised Code.
- (9) ~~Maintenance: services provided to individuals for the purpose of maintaining a level of functionality, not improvement of functionality.~~
- (10)(11) Medicaid authorized prescriber: a physician (M.D. or D.O.), podiatrist, dentist, or advanced practice nurse working within his or her scope of practice as defined by state law.
- (11)(12) Medical home: a physician, physician group practice, or an advanced practice nurse with a current medicaid provider agreement, or a provider with a contract with an Ohio medicaid managed care plan. This provider serves as an ongoing source of primary and preventive care and provides assistance with care coordination for the patient.
- (12)(13) Medically necessary: skilled services recommended by a qualified licensed practitioner in accordance with rules ~~5101:3-35-05~~ [5160-35-05](#) and ~~5101:3-35-06~~ [5160-35-06](#) of the Administrative Code who is acting within the scope of his or her licensure ~~and based on his or her professional judgment regarding medical services~~ that meet the requirements in rule [5160-1-01](#) of the Administrative Code ~~are necessary for the eligible child for the diagnosis or treatment of disease, illness, or injury and without which the eligible child can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. A medically necessary service shall: meet generally accepted standards of medical practice; be appropriate to the illness or injury for which it is performed as to type of service and expected outcome; be appropriate to the intensity of service and level of setting; provide unique, essential, and appropriate information when used for diagnostic purposes; be the lowest cost alternative that effectively addresses and treats the medical problem;~~ and meet general principles regarding reimbursement for medicaid covered services found in rule ~~5101:3-1-02~~ [5160-1-02](#) of the Administrative Code.
- (13)(14) ~~MSP: the medicaid~~ Medicaid school program (MSP): is as set forth in Chapter ~~5101:3-35~~ [5160-35](#) of the Administrative Code.
- (14)(15) MSP provider: entity that meets the qualifications delineated in rule ~~5101:3-35-02~~ [5160-35-02](#) of the Administrative Code.
- (16) Other costs: costs for service-related activities for which there is no CPT or HCPCS code and for which claiming is not possible by the MSP provider due to medicaid rule restrictions; administrative claiming, equipment, supplies, indirect costs, and billing fees.
- (15)(17) Skilled services: services of such complexity and sophistication that the service can be safely and effectively performed only by or under the supervision of a licensed practitioner of the healing arts practicing within the scope of their licensure. Skilled services do not include services provided by persons not licensed in accordance with the Ohio Revised Code.
- (16)(18) State school: school under the control and supervision of the state board of education established for students who are deaf or blind as defined by section 3325.01 of the Revised Code.
- (19) Supervision: is as defined in rules [4753-7-02](#), [4755-27-01](#), [4755-27-04](#), and [4755-7-04](#) of the Administrative Code.

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Five Year Review (FYR) Dates: 12/08/2014 and 04/01/2020

Certification: CERTIFIED ELECTRONICALLY

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LTCSTL 15-05

Effective Date: April 1, 2015

Most Current Prior Effective Date: October 15, 2009

- (A) The purpose of this rule is to set forth the qualifications to become a medicaid school program provider (MSP) and ~~the~~ requirements for a ~~medicaid school program (MSP)~~ MSP provider must follow.
- (B) An MSP provider shall:
- (1) Be one of the following:
 - (a) Local education agency (LEA) city school district, local school district, exempted village school district as defined in sections 3311.01 to 3311.04 of the Revised Code;
 - (b) State school for the deaf as defined by section 3325.01 of the Revised Code;
 - (c) State school for the blind as defined by section 3325.01 of the Revised Code;
 - (d) Community school as defined by Chapter 3314. of the Revised Code.
 - (2) Obtain and maintain a current valid medicaid provider agreement in accordance with rule ~~5101:3-1-17.2~~5160-1-17.2 of the Administrative Code. ~~The medicaid provider agreement shall indicate the services to be provided as well as an attestation of compliance with paragraph (B)(3) of this rule.~~
 - (3) Employ or contract for at least one of the following:
 - (a) Occupational therapist who holds a current, valid license to practice occupational therapy issued under Chapter 4755. of the Revised Code.
 - (b) Physical therapist who holds a current, valid license to practice physical therapy issued under Chapter 4755. of the Revised Code.
 - (c) Speech-language pathologist who holds a current, valid license to practice speech-language pathology issued under Chapter 4753. of the Revised Code.
 - (d) Audiologist who holds a current, valid license to practice audiology issued under Chapter 4753. of the Revised Code.
 - (e) Licensed clinical counselor or licensed counselor who holds a current, valid license to practice professional counseling issued under Chapter 4757. of the Revised Code.
 - (f) Licensed psychologist or licensed school psychologist who holds a current, valid license to practice psychology or school psychology issued under Chapter 4732. of the Revised Code or under rule 3301-24-05 of the Administrative Code.
 - (g) Licensed independent social worker or social worker who holds a current, valid license to practice social work issued under Chapter 4757. of the Revised Code.
 - (h) Licensed registered nurse who holds a current, valid license to practice nursing issued under Chapter 4723. of the Revised Code.
- (C) An MSP provider shall ensure all employees and contractors who have in-person contact with consumers for the provision of services undergo and successfully complete criminal records checks pursuant to rules adopted under section ~~5111.032~~5164.34 of the Revised Code.
- (D) An MSP provider shall provide services in accordance with rules ~~5101:3-35-05~~5160-35-05 and ~~5101:3-35-06~~5160-35-06 of the Administrative Code.
- (E) An MSP provider shall submit claims in accordance with rule ~~5101:3-35-04~~5160-35-04 of the Administrative Code to receive reimbursement for the provision of services.
- (F) An MSP provider shall comply with the following for cost reporting and cost reconciliation purposes:

- (1) Participate in ~~all the~~ random moment time ~~study studies~~(RMTS); RMTS are designed to document the level of effort of MSP providers on a state-wide basis, in compliance with the applicable RMTS guide provided by the Ohio department of education (ODE).
- (2) Submit ~~a December~~the federal child count of special education students included as a part of the total student count defined in [3301.011](#) of the revised code.
- (3) Prepare a cost report in accordance with paragraph (K)(2) of rule ~~5101:3-35-04~~5160-35-04 of the Administrative Code.
- (4) Contract with an ~~authorized entity~~independent certified public accountant or firm to perform an agreed upon procedures review of the cost report and to document adjustments to the cost report, in accordance with paragraph (K)(2) of rule ~~5101:3-35-04~~5160-35-04 of the Administrative Code.
- (5) Adhere to all applicable rules, including, but not limited to 45 C.F.R. 92, dated ~~October 1, 2007~~December 24, 2013, Revised Code, Administrative Code, CMS Publication 15-1(found at www.cms.gov/manuals), and provisions outlined in the cost report instructions.

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LTCSTL 15-05

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Most Current Prior Effective Date: March 27, 2014

Appendix A- Ohio Medicaid School Program CPT Code Assignments

- (A) The purpose of this rule is to set forth the provisions for claiming to receive medicaid reimbursement for the provision of services by medicaid school program (MSP) providers as defined in Chapter 5160-35 of the Administrative Code.
- (B) The CPT (common procedural terminology) and HCPCS (healthcare common procedure coding system) ~~Covered~~covered services provided through MSP providers that are allowable for medicaid reimbursement are listed in the appendix to this rule and are provided in accordance with Chapter 5160-35 of the Administrative Code. The following limits apply:
- (1) Assessment/evaluation services cannot be billed more than once per continuous twelve month period.
 - (2) Re-assessment/re-evaluation services cannot be billed more than once per continuous six-month period.
 - (3) Skilled services cannot be billed for dates of service beyond twelve months of the initial assessment/evaluation or re-assessment/re-evaluation.
- (C) Medically necessary services for individuals under age twenty-one that go beyond the coverage and limitations established in this rule shall be:
- (1) Prior authorized by the Ohio department of medicaid (ODM) in accordance with rule 5160-1-31 of the Administrative Code; and
 - (2) Services defined as medical assistance in accordance with section 1905(a) of the Social Security Act, 42 U.S.C. 1396d ~~(December 9, 2013)~~(January 1, 2013).
- (D) The following conditions shall be met in order to receive medicaid reimbursement for services provided through the medicaid school program:
- (1) The school district shall be a qualified MSP provider in accordance with rule 5160-35-02 of the Administrative Code.
 - (2) The MSP provider shall submit claims for reimbursement for ~~only those services~~all direct service costs provided in accordance with rule 5160-35-05 of the Administrative Code and paragraph (B)(3) of rule 5160-35-06 of the Administrative Code for which the MSP provider will submit a cost report seeking cost reconciliation~~it has statutory responsibility to provide to either an eligible child or for assessment/evaluation for a medicaid eligible child for whom they are trying to determine the appropriateness of developing an individualized education program (IEP).~~Costs for direct services for which a provider has not submitted an interim claim will not be paid to the provider in any final cost report settlement.
 - (3) The MSP provider shall submit claims for only those services for which it has statutory responsibility to provide to either an eligible child with an IEP or for assessment/evaluation for a medicaid eligible child for whom they are trying to determine the appropriateness of developing an individualized education program (IEP).
 - ~~(3)~~(4) The executive officer of the MSP provider or his/her designee shall attest to the validity of the non-federal share of expenditures in accordance with paragraph (G) of this rule.
 - ~~(4)~~(5) The service provided through the MSP provider shall be ~~provided by or under the direction of a licensed practitioner of the healing arts and provided~~ in accordance with rules 5160-35-05 and 5160-35-06 of the Administrative Code.

~~(5)(6)~~ The service for which reimbursement is sought shall be one clearly identified in the IEP of an eligible child, with the exception of the initial assessment/evaluation as described in paragraph (B)(7) of rule 5160-35-05 of the Administrative Code.

~~(6) The MSP provider must be enrolled as a MSP provider no later than February 28, 2009 in order to receive reimbursement for services provided during the back claiming period (July 1, 2005 through September 30, 2009), and must adhere to the methodology for claiming and cost reconciliation developed by ODM in cooperation with ODE and approved by the centers for medicare and medicaid services (CMS).~~

(E) The MSP provider is required to enroll and submit claims as an ODM electronic data interchange (EDI) trading partner or contract with an ODM EDI trading partner for the submission of claims to ODM.

(F) Claims shall be submitted in accordance with rule [5160-1-02](#) of the Administrative Code.

(G) When a medicaid claim is submitted through an EDI trading partner, the claim shall include a ten character code that is the first item listed in the NTE02 field, and that is an attestation of whether or not the claim is certified by the executive officer of the MSP provider or his/her designee as follows:

(1) Attest yes: used if the claim is certified by the executive officer of the MSP provider or his/her designee to only include expenditures under the medicaid program under Title XIX of the Social Security Act (the Act), and as applicable, under the state children's health insurance program (SCHIP), under Title XXI of the Act, that are allowable in accordance with applicable implementing federal, state, and local statutes, regulations, and policies, and the state plan approved by the secretary of health and human services and in effect at the time of the submission of this claim; and the expenditures included in the claim are based on the MSP provider's accounting of actual recorded expenditures; and the required amount of local public funds were available and used to match the MSP provider's (local public school district's) allowable expenditures included in this claim, and such local public funds were in accordance with all applicable federal requirements for the non-federal share match of expenditures; and federal matching funds are not being claimed in this claim submission to match any expenditure under any medicaid and/or SCHIP state plan amendment that has not been approved by the secretary of health and human services effective for the period of this claim.

(2) Attest nay: used if the claim is not certified by the executive officer of the MSP provider or his/her designee to only include expenditures under the medicaid program under Title XIX of the Social Security Act (the Act), and as applicable, under the state children's health insurance program (SCHIP), under Title XXI of the Act, that are allowable in accordance with applicable implementing federal, state, and local statutes, regulations, and policies, and the state plan approved by the secretary of health and human services and in effect at the time of the submission of this claim; and the expenditures included in the claim are based on the MSP provider's accounting of actual recorded expenditures; and the required amount of local public funds were available and used to match the MSP provider's (local public school district's) allowable expenditures included in this claim, and such local public funds were in accordance with all applicable federal requirements for the non-federal share match of expenditures; and federal matching funds are not being claimed in this claim submission to match any expenditure under any medicaid and/or SCHIP state plan amendment that has not been approved by the secretary of health and human services effective for the period of this claim. If attest nay is used, the claim will be denied for payment.

(H) ~~With the exception of claims for services provided with a date of service between July 1, 2005 through September 30, 2008, claim submissions must be received by ODM within three-hundred sixty-five days of the actual date the service was provided. Claim submission for services provided with a date of service between July 1, 2005 through September 30, 2008 must be received by ODM no later than September 30, 2009. All claims shall be submitted using only the EDI billing method as defined by rule [5160-1-19.3](#) of the Administrative Code.~~ Claim submissions must be received by ODM within three-hundred sixty-five days of the actual date the service was provided.

- (I) References to cartridge tape, paper claim and pharmacy-point-of-sale in rule ~~5160-1-19.3~~5160-1-20 of the Administrative Code are not applicable to the claim and shall not be allowed.
- (J) A billing unit for a service code reported in minutes is as indicated in the appendix to this rule, and claims shall be for minutes of actual service delivery time as follows:
- (1) If service is provided in a group of two or more, the total number of minutes of each type of service, as distinguished by service codes, provided during the school or calendar day to the group of children is divided by the number of children in the group. This resulting number is then divided by the number of minutes identified for the service code to determine the number of units of service to an eligible child.
 - (2) The number of units is equivalent to the total number of minutes of each type of service, as distinguished by service codes, provided during the school or calendar day to the eligible child, divided by the number of minutes (a per hour unit is sixty minutes), or minimum minutes of the range identified for the service code.
 - (3) For service codes with a fifteen minute billing unit, one additional unit of service may be added to this quotient if the remainder equals eight or more minutes.
 - (4) For service codes with a per hour billing unit, one additional unit of service may be added to this quotient if the remainder equals fifty-two or more minutes.
 - (5) For service codes with a billing unit range, one additional unit of service may be added to this quotient if the remainder equals at least the minimum minutes of the range.
- (K) The following applies to medicaid reimbursement:
- (1) Interim payments. ODM shall reimburse the MSP provider interim payments. The interim payments shall be the federal financial participation (FFP) portion of the lesser of the billed charge (not to exceed the usual and customary charge) or the medicaid maximum according to the department's procedure code reference files for the particular services performed.
 - (2) Cost reports. Each MSP provider shall complete the Ohio department of education (ODE) developed medicaid school based cost report. The cost report is to be completed by the MSP provider in compliance with all state and federal provisions the cost report instructions also developed by ODE. The MSP provider shall contract with an independent certified public accountant (CPA) firm, the state auditor, or other entity authorized to conduct audits in the state of Ohio to perform an agreed upon procedures review of the cost report and document adjustments to the cost report. Once the agreed upon procedures review is completed, the reviewed cost report shall be submitted to ODE no later than eighteen months after the end of the cost reporting period as identified in the cost report instructions. The submitted cost report will be used by ODE and ODM in the cost reconciliation and final settlement process. ODM or ODE may conduct a desk or field audit up to three years after the fiscal year end based on risk assessment criteria developed by ODM. All cost reports for each fiscal year prior to the effective date of this rule but not starting earlier than July 1, 2005 shall be submitted in accordance with the schedule developed by ODM in cooperation with ODE and approved by CMS.
 - (3) Cost report extension. For good cause and upon written request from the MSP provider, ODE may grant an extension of the cost report filing deadline. The written request must be submitted to the grants management unit at ODE thirty calendar days before the cost report submission deadline specified in paragraph (K)(2) of this rule. The request must include information explaining the facts and circumstances giving rise to the need for a cost report extension, projected time line for filing the cost report, and any other information which the MSP provider would like to have considered. Upon reviewing the written request, ODE may, at its sole discretion, request additional information, approve or deny the extension.
 - (4) Final cost settlement and reconciliation. The ODM and /or its designee shall review the cost reports identify adjustments needed, reconcile compare the federal financial participation (FFP) identified in the cost report against the interim payments made by ODM to the MSP provider, identify the number of students for which claims for services were received and paid and

determine the proportionate costs for those students using the costs from the cost report for the total population of medicaid eligible IEP students, and issue a notice of intended action pursuant to rule [5160-70-03](#) of the Administrative Code that denotes the amount due to or from the MSP provider as a result of the reconciliation. ~~and issue a notice of reconciliation that denotes the amount due to or from the MSP provider~~ The MSP provider will have thirty-days from the date of the notice during which it may request a hearing. If no hearing request is received, ODM will process the reconciled amount. ~~ODM shall review this notice of reconciliation and certify for payment.~~ An overpayment determined as a result of this annual reconciliation to actual cost shall be collected from the MSP provider by ODM. An underpayment determined as a result of this annual reconciliation to actual cost shall be paid to the MSP provider by ODM. Failure by a MSP provider to submit an acceptable cost report in accordance with paragraphs (K)(2) and (K)(3) of this rule, will result in full repayment by the MSP provider of the total interim payment received by the MSP provider for the cost reporting period. In addition, failure to submit an acceptable cost report will result in possible revocation of the MSP provider agreement and number.

- (5) The provider shall accept reimbursement for all covered services as payment in full with limitations as set forth in accordance with rule [5160-1-60](#) of the Administrative Code.
- (6) The MSP providers shall comply with all applicable federal and state rules, including but not limited to 45 C.F.R. Part 92 (December 24, 2013), 45 C.F.R. Part 74 (December 24, 2013), Chapters 5160-1 and 5160-35 of the Administrative Code, CMS Publication 15-1 (found at www.cms.gov/manuals), and the terms and conditions set forth within the provider agreement.
- (L) Records shall be maintained and disclosed by providers in accordance with rule [5160-1-27](#) of the Administrative Code. Records necessary to fully disclose the extent of services provided and costs associated with these services shall be maintained for a period of six years from the end of the cost reporting period based upon those records or until any initiated audit, review, investigation or other activities are completed and appropriately resolved, whichever is longer. Records shall be made available upon request to ODM, ODE or the U.S. department of health and human services. ~~Failure to supply requested records, documentation and/or information as indicated in this rule may result in no payment for outstanding services or other legal recourse~~ Failure to supply requested records, documentation or information as required in this rule may result in no payment for outstanding services, recoupment of any reimbursements provided for services that cannot be validated, termination from the medicaid program and/or any sanctions available pursuant to section [5162.10](#) of the Revised Code.
- (M) State monitoring: ODM or its designee may conduct audits, reviews, investigations, or any other activities necessary to assure a medicaid school program provider, its subgrantee(s) or subcontractor(s) are compliant with federal and state requirements. Based on the results of an audit, review, investigation or other activities, ODM may seek ~~legal recourse, including but not limited to,~~ recoupment of funding related to overpayments, misuse, fraud waste or abuse or noncompliance with federal or state requirements from the ~~medicaid school~~ MSP provider.

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[LTCSSTL 15-05](#)

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Most Current Prior Effective Date: [October 15, 2009](#)

- (A) The purpose of this rule is to set forth the services authorized for medicaid coverage that a MSP provider can provide, and to set forth the conditions for providing the services.
- (B) A MSP provider may provide skilled services. Following are the skilled services an MSP provider may provide:
 - (1) Occupational therapy services:
 - (a) Description: services that evaluate and treat, as well as services to analyze, select, and adapt activities for an eligible child whose functioning is impaired by developmental deficiencies, physical injury or illness. The occupational therapy service shall be recommended by a licensed occupational therapist acting within the scope of his or her practice under Ohio law who holds a current, valid license to practice occupational therapy issued under Chapter 4755. of the Revised Code. Services provided by an individual holding a limited permit, as described in section 4755.08 of the Revised Code, are not allowable.
 - (b) Qualified practitioners who can deliver the services:
 - (i) Licensed occupational therapist who holds a current, valid license to practice occupational therapy issued under Chapter 4755. of the Revised Code, who is employed or contracted with the MSP provider, and who is acting within the scope of his or her practice under Ohio law.
 - (ii) Licensed occupational therapy assistant who holds a current, valid license issued under Chapter 4755. of the Revised Code, who is employed or contracted with the MSP provider, and who is acting within the scope of his or her practice under Ohio law. Further, the licensed occupational therapy assistant shall be practicing under the **general** supervision of a licensed occupational therapist who is employed or contracted by the MSP provider.
 - (c) Allowable activities include:
 - (i) Evaluation and re-evaluation to determine the current sensory and motor functional level of the eligible child and identifying appropriate therapeutic interventions to address the findings of the evaluation/re-evaluation.
 - (ii) Therapy to improve the sensory and motor functioning of the eligible child, to teach skills and behaviors crucial to the eligible child's independent and productive level of functioning.
 - (iii) Application and instruction in the use of orthotic and prosthetic devices, and other equipment to accomplish the goal of therapy in accordance with paragraph (B)(1)(c)(ii) of this rule.
 - (2) Physical therapy services
 - (a) Description: services that evaluate and treat an eligible child by physical measures and the use of therapeutic exercises and procedures, with or without assistive devices, for the purpose of correcting, or alleviating a disability. The physical therapy service shall be recommended by a licensed physical therapist acting within the scope of his or her practice under Ohio law who holds a current, valid license to practice physical therapy issued under Chapter 4755. of the Revised Code.
 - (b) Qualified practitioners who can deliver the services:

- (i) Licensed physical therapist who holds a current, valid license to practice physical therapy issued under Chapter 4755. of the Revised Code, who is employed or contracted with the MSP provider, and who is acting within the scope of his or her practice under Ohio law.
 - (ii) Licensed physical therapist assistant who holds a current, valid license issued under Chapter 4755. of the Revised Code, who is employed or contracted with the MSP provider, who is acting within the scope of his or her practice under Ohio law, and who is practicing under the ~~general~~ supervision of a licensed physical therapist employed or contracted by the MSP provider.
- (c) Allowable activities include:
- (i) Evaluation and re-evaluation to determine the current level of physical functioning of the eligible child and to identify appropriate therapeutic interventions to address the findings of the evaluation/re-evaluation.
 - (ii) Therapy, with or without assistive devices, for the purpose of preventing, correcting or alleviating the impairment of the eligible child.
 - (iii) Application and instruction in the use of orthotic and prosthetic devices, and other equipment to accomplish the goal of therapy in accordance with paragraph (B)(2)(c)(ii) of this rule.
- (3) Speech-language pathology services
- (a) Description: services that are planned, directed, supervised and conducted for individuals or groups of individuals who have or are suspected of having disorders of communication. The application of principles, methods, or procedures related to the development and disorders of human communication can include identification, evaluation, and treatment. The speech-language pathology service shall be recommended by a licensed speech-language pathologist acting within the scope of his or her practice under Ohio law who holds a current, valid license to practice speech-language pathology issued under Chapter 4753. of the Revised Code.
 - (b) Qualified practitioners who can deliver the services:
 - (i) Licensed speech-language pathologist who holds a current, valid license to practice speech-language pathology issued under Chapter 4753. of the Revised Code, who is employed or contracted with the MSP provider, and who is acting within the scope of his or her practice under Ohio law.
 - (ii) Licensed speech-language pathology aide who holds a current, valid license issued under Chapter 4753. of the Revised Code, who is employed or contracted with the MSP provider, who is acting within the scope of his or her practice under Ohio law, and who is practicing under the ~~direct~~ supervision of the licensed speech-language pathologist who completed, signed and submitted to the Ohio board of speech-language pathology and audiology the speech-language pathology aide plan. The supervising speech-language pathologist shall be employed or contracted by the MSP provider.
 - (iii) A person holding a conditional license to practice speech-language pathology, if the eligible provider supervising the professional experience keeps on file a copy of the conditionally-licensed speech-language pathologist's plan of supervised professional experience, required by section [4753.071](#) of the Revised Code.
 - (c) Allowable activities include:
 - (i) Evaluation and re-evaluation to determine the current level of speech-language of the eligible child and to identify the appropriate speech-language treatment to address the findings of the evaluation/re-evaluation.

- (ii) Therapy, with or without assistive devices, for the purpose of preventing, correcting or alleviating the impairment of the eligible child.
 - (iii) Application and instruction in the use of assistive devices.
- (4) Audiology services
 - (a) Description: hearing exams, diagnostic tests, and services requiring the application of principles, methods, or procedures related to hearing and the disorders of hearing. ~~Services provided for the purpose of maintenance or habilitation are not allowable.~~ The audiology service shall be recommended by a licensed audiologist acting within the scope of his or her practice under Ohio law who holds a current, valid license to practice audiology issued under Chapter 4753. of the Revised Code.
 - (b) Qualified practitioners who can deliver the services:
 - (i) Licensed audiologist who holds a current, valid license to practice audiology issued under Chapter 4753. of the Revised Code, who is employed or contracted with the MSP provider, and who is acting within the scope of his or her practice under Ohio law.
 - (ii) Licensed audiology aide holds a current, valid license issued under Chapter 4753. of the Revised Code, who is employed or contracted with the MSP provider, who is acting within the scope of his or her practice under Ohio law, and who is practicing under the **direct** supervision of the licensed audiologist who completed, signed and submitted to the Ohio board of speech-language pathology and audiology the audiology aide plan. The supervising audiologist shall be employed or contracted by the MSP provider.
 - (c) Allowable activities include:

Evaluation and re-evaluation to determine the current level of hearing of the eligible child and to identify the appropriate audiology treatment, and treatment to address the findings of the evaluation/re-evaluation.
- (5) Nursing services
 - (a) Description: services from a registered nurse that provides to individuals and groups nursing care as defined in Chapter 4723. of the Revised Code. And, services from a licensed practical nurse that provides to individuals and groups nursing care as defined in Chapter 4723. Revised Code. The nursing service, with the exception of evaluations and assessments, shall be prescribed by a medicaid authorized prescriber acting within the scope of his or her practice under Ohio law who holds a current, valid license.
 - (b) Qualified practitioners who may deliver the services:
 - (i) Licensed registered nurse who holds a current, valid license issued under Chapter 4723. of the Revised Code, who is employed or contracted with the MSP provider, and who is acting within the scope of his or her practice under Ohio law.
 - (ii) Licensed practical nurse who holds a current, valid license issued under Chapter 4723. of the Revised Code, who is employed or contracted with the MSP provider, who is practicing at the direction of a medicaid authorized prescriber, and who is acting within the scope of his or her practice under Ohio law.
 - (c) Allowable activities include:
 - (i) Assessment/evaluation and re-assessment/re-evaluation to determine the current health status of the eligible child in order to identify and facilitate provision of appropriate nursing treatment to address the findings of the assessment/evaluation or re-assessment/re-evaluation.
 - (ii) Administering medications prescribed by a medicaid authorized prescriber.

- (iii) The implementation of medical/nursing procedures/treatments prescribed by a medicaid authorized prescriber for the medicaid eligible child, which may include tube feeds, bowel and bladder care, colostomy care, catheterizations, respiratory treatment, wound care, and any other services that are prescribed by a medicaid authorized prescriber.

(6) Mental health services

(a) Description:

- (i) Counseling services rendered to an individual or group and involves the application of clinical counseling principles, methods, or procedures to assist individuals in achieving more effective personal or social development and adjustment, including the diagnosis and treatment of mental and emotional disorders;
- (ii) Social work services that involve the application of specialized knowledge of human development and behavior and social, economic, and cultural systems in directly assisting individuals, families, and groups in a clinical setting to improve or restore their capacity for social functioning, including counseling, the use of psychosocial interventions, and the use of social psychotherapy, which includes the diagnosis and treatment of mental and emotional disorders; and
- (iii) Psychology services that are the application of psychological procedures to assess, diagnose, prevent, treat, or ameliorate psychological problems or emotional or mental disorders of individuals or groups; or to assess or improve psychological adjustment or functioning of individuals or groups, whether or not there is a diagnosable pre-existing psychological problem.

(b) Qualified practitioners who can deliver the services:

- (i) Licensed clinical counselor, licensed counselor who holds a current, valid license to practice professional counseling issued under Chapter 4757. of the Revised Code, who is employed by or contracted with the MSP provider, and who is acting within the scope of his or her practice under Ohio law;
- (ii) Licensed independent social worker, or licensed social worker who holds a current, valid license to practice social work issued under Chapter 4757. of the Revised Code, who is employed by or contracted with the MSP provider, and who is acting within the scope of his or her practice under Ohio law;
- (iii) Licensed psychologist or a licensed school psychologist who holds a current, valid license to practice psychology issued under Chapter 4732. of the Revised Code, or to practice school psychology issued under Chapter 4732. of the Revised Code or under rule 3301-24-05 of the Administrative Code who is employed or contracted with the MSP provider, and who is acting within the scope of his or her practice under Ohio law.

(c) Allowable activities include:

- (i) Diagnosis and rehabilitative treatment of mental and emotional disorders performed by a licensed independent social worker, licensed social worker, professional counselor, or professional clinical counselor acting within his or her scope of practice under Ohio law.
- (ii) Assessment and diagnostic services performed by a licensed psychologist or a licensed school psychologist acting within his or her scope of practice under Ohio law to determine the current psychological condition of the eligible child and to identify appropriate psychological treatment and/or therapy for the eligible child to address the findings of the assessment/diagnosis.

- (iii) Psychological and neuropsychological testing when performed to assist in determining the possible presence of a psychological or neuropsychological disorder.
- (iv) Rehabilitative treatment using psychological procedures for the purpose of treating, correcting or alleviating the mental and emotional impairment of the eligible child.

(d) Unallowable activities include sensitivity training, sexual competency training, educational activities (including testing and diagnosis - this does not include initial assessments nor re-assessment as indicated in paragraph (B)(7) of this rule), monitoring activities of daily living, recreational therapies, teaching grooming skills, sensory stimulation, teaching social interaction/diversion skills, crisis intervention not included in an eligible child's individualized educational program (IEP), and family therapy that is not as a direct benefit to the eligible child.

(7) Assessments/evaluations

- (a) Description: the initial assessment/evaluation that is part of the ~~multi-factored evaluation or MFE~~ evaluation team report (ETR) process (reimbursement is limited to one per continuous twelve month period per child unless prior authorization is obtained) conducted for an eligible child without an IEP or conducted for a two year old child with a disability to determine whether or not an IEP is appropriate. The assessment/evaluation shall include a recommendation that describes the services and supports which are needed to address the findings from the assessment/evaluation and shall be signed by the qualified practitioner who conducted the assessment/ evaluation. Reimbursement is not available for the development of the IEP.
- (b) Description: the re-assessment/re-evaluation conducted thereafter and identified in the eligible child's IEP (reimbursement is limited to one per continuous six month period per child unless prior authorization is obtained). The re-assessment/re-evaluation shall include a recommendation that describes the services and supports which are needed to address the findings from the re-assessment/re-evaluation and be signed by the qualified practitioner who conducted the re-assessment/re-evaluation. Reimbursement is not available for the development of the IEP.
- (c) Qualified practitioners who may deliver the initial assessment/evaluation, or re-assessment/re-evaluation services: one of the qualified practitioners identified in paragraphs (B)(1) to (B)(6) of this rule who holds a current, valid license, who is employed or contracted with the MSP provider, and who is acting within the scope of his or her practice under Ohio law.

(C) Although the following list is not all-inclusive, the following are not allowable for reimbursement through the medicaid school program:

- (1) Attending IEP and ETR meetings, and ~~Development~~development of the IEP.
- (2) Services provided for the purpose of ~~maintenance or~~ habilitation (in accordance with rule ~~5101:3-1-02~~ 5160-1-02 of the Administrative Code).
- (3) Services and activities that go beyond the recommendation of the qualified practitioner conducting the assessment/evaluation, re-assessment/re-evaluation and therefore are provided solely for the purpose of education, special education or special instruction.
- (4) Health/medical screens, including mass screens provided to an eligible child with an IEP.
- (5) Counseling parents and teachers regarding hearing loss.
- (6) ~~In-services~~ In-house training.
- (7) Fittings for amplification devices, and equipment troubleshooting and/or repair.
- (8) Nursing services provided as a part of immunizations process.

- (9) Instruction on self-care that does not require the expertise of the licensed practitioner.
 - (10) Services provided to a child who does not have an IEP with the exception of the initial assessment/evaluation as described in paragraph (B)(7) of this rule.
 - (11) Services not indicated in an eligible child's IEP prior to the provision of the service with the exception of the initial assessment/evaluation as described in paragraph (B)(7) of this rule.
 - (12) Services provided to a child who does not have a disability and a need for special education and related services with the exception of the initial assessment/evaluation as described in paragraph (B)(7) of this rule.
 - (13) Services provided on days or at times when the eligible child is not in attendance in the IEP designated school setting with the exception of the initial assessment/evaluation as described in paragraph (B)(7) of this rule.
 - (14) Services that are not provided under the appropriate supervision and/or at the appropriate direction of a licensed practitioner of the healing arts.
 - (15) Services provided by a non-licensed person.
 - (16) Services for which an eligible child fails to show progress toward IEP identified goals over two consecutive three-month periods and there is no documentation that the methods and/or techniques applied have been modified to improve progress.
 - (17) Services provided as a part of the eligible child's waiver services, or as a part of services through an intermediate care facility ~~for the mentally retarded~~ or of a nursing facility.
 - (18) Services and activities that are not a direct benefit to the eligible child.
- (D) In accordance with rule ~~5101:3-1-01~~5160-1-01 of the Administrative Code, the services provided shall be medically necessary and the type, frequency, scope and duration of the services shall fall within the normal range of services considered under acceptable standards of medical and healing arts professional practice, as appropriate.
- (E) The services provided are of such level of complexity and sophistication, or the condition of the patient is such that the service can be safely and effectively performed only by or under the supervision of a licensed practitioner as indicated in this rule.
- (F) The eligible child's IEP shall contain the following components that, taken together and for the purposes of Chapter ~~5101:3-35~~5160-35 of the Administrative Code, are called the plan of care. This plan of care does not supplant any practitioner plan of care, and shall:
- (1) Be based on the initial assessment/evaluation conducted during the ~~multi-factored evaluation~~ ETR or the subsequent assessments/evaluations and re-assessments/re-evaluations.
 - (2) Be signed by the qualified practitioner who recommends the service as a result of the assessment/evaluation, re-assessment/re-evaluation.
 - (3) Include specific services to be used, and the amount, duration and frequency of each service.
 - (4) Include specific goals to be achieved as a result of service provided, including the level or degree of improvement expected.
 - (5) For nursing services, reference and identify the location of the prescription of a physician, and for medications, reference and identify the location of the prescription of a physician or an advanced practice nurse with certification to prescribe in accordance with Ohio law.
 - (6) Specify timelines for re-assessment/re-evaluation, which should be no more than twelve-months from the date of the initial assessment/evaluation, of the eligible child and updates to the plan of care/IEP.
- (G) The documentation for the provision of ~~each~~ service shall be maintained for purposes of supporting the delivery of the service and to provide an audit trail. Documentation shall include:
- (1) The date (i.e., day, month, and year) that the activity was provided.

- (2) The full legal name of the child for whom the activity was provided.
 - (3) A description of the service, procedure, and method provided, as well as the location where the service is delivered (may be in case notes or a coded system with a corresponding key).
 - (4) Group size if the service was provided to more than one individual during the service delivery time.
 - (5) The duration in minutes or time in/time out of the activity provided. Duration in minutes is acceptable if the schedule of the person delivering the service is maintained on file.
 - (6) A description of the actual progress demonstrated by the eligible child toward the stated goals outlined in the plan of care for each continuous three-month reporting period.
 - (7) The signature or initials of the person delivering the service on each entry of service delivery. Each documentation recording sheet shall contain a legend that indicates the name (typed or printed), title, signature, and initials of the person delivering the service to correspond with each entry's identifying signature or initials.
 - (8) Evidence in either the child's case file or a separate supervision log that the appropriate supervision was provided when required in accordance with appropriate licensing standards.
 - (9) A description of efforts made to coordinate services with the eligible child's medical home in accordance with the medicaid provider agreement.
- (H) The claims for reimbursement for services shall be submitted in accordance with rule ~~5101:3-35-04~~5160-35-04 of the Administrative Code.

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- (A) The purpose of this rule is to set forth the services authorized for medicaid coverage, beyond those indicated in rule ~~5101:3-35-05~~ 5160-35-05 of the Administrative Code, that a MSP provider can provide, and to set forth the conditions for providing the services.
- (B) In addition to the services indicated in rule ~~5101:3-35-05~~ 5160-35-05 of the Administrative Code, a MSP provider may render and receive payment for the following services~~provide the following~~:
- (1) ~~Specialized medical transportation services~~ Transportation:
- (a) ~~Description: the transportation service, not reimbursed through other medicaid programs, and that is provided in accordance with the requirements for ambulette services in rule 5101:3-15-02 of the Administrative Code. The transportation service shall be provided through use of a specially adapted vehicle to transport a medicaid eligible child to and from the medicaid school provider to receive medically necessary medicaid services allowable under section 1905(a) of the Social Security Act~~ For purposes of Chapter 5160-35 of the Administrative Code, "transportation" is specialized conveyance that accommodates the specific needs of an eligible child (for example, transportation by wheelchair-accessible vehicle or adapted school bus) for the purpose of traveling to or from the MSP provider to receive medically necessary services allowable under rule 5160-35-05 of the Administrative Code.
- ~~(b) Qualified practitioners who can deliver the services: MSP providers using a vehicle adapted to serve the needs of the disabled, including a specially adapted school bus.~~
- ~~(c)(b)~~ Claims for transportation mileage are paid in accordance with the rate established in appendix A of rule 5160-35-04 of the Administrative Code; the service unit is a one-way trip~~The service unit will be per trip.~~
- ~~(d)(c)~~ Unallowable: transportation that is provided in a vehicle that has not been specially adapted to transport an eligible child with a disability, transportation that is not indicated in an eligible child's individualized education program (IEP), and transportation provided from home to school and from school to home is unallowableUnallowable services include transportation that is otherwise available to all students, transportation that is provided in a vehicle that is not used specifically to accommodate an eligible child, transportation accommodations that are not indicated in an eligible child's individualized education program (IEP), and transportation provided from home to school or from school to home if no medicaid-covered service allowable under rule 5160-35-05 of the Administrative Code was received at school on that day.
- (2) Targeted case management services (TCM):
- (a) Description: assessment, care planning, referral and linkage, monitoring and follow-up activities specified in an eligible child's IEP that will assist the eligible child in gaining access to medical, social, educational and other needed services. The amount, frequency, and duration of the case management services, as well as the case manager responsible for providing the case management service, shall be indicated in the eligible child's IEP.
- (b) Qualified practitioners who may deliver the services:
- (i) A licensed registered nurse who holds a current, valid license issued under section 4723.09 of the Revised Code, and who is employed or contracted with the MSP provider.

- (ii) An individual with a baccalaureate degree with a major in education or social work, and who is employed or contracted with the MSP provider.
 - (iii) An individual who has earned credit in course work equivalent to that required for a major in a specific special education area, and who is employed or contracted with the MSP provider.
 - (iv) A person who is employed or contracted with the MSP provider, and who has a minimum of three years personal experience in the direct care of an individual with special needs.
- (c) The service unit will be fifteen minutes.
- (d) Targeted case management shall be billed on a separate claim from all other services. If it is billed on a claim with other services, the targeted case management claim will be denied. This is strictly a billing issue and does not effect the provision of services.
- (e) Activities under targeted case management are:
- (i) Assessment: for an eligible child with an IEP, ensuring the prescription, by a medicaid authorized prescriber for services for which medicaid reimbursement shall be sought, is in the eligible child's case file; gathering of comprehensive information concerning the eligible child's preferences, personal goals, needs, abilities, health status and other available supports; determining the eligible child's need for case management; obtaining agreement from the eligible child and/or parent/legal guardian, whichever is appropriate, to allow the provision of case management; making arrangements to obtain from therapists and appropriately qualified persons the initial and on-going evaluation of the eligible child's need for any medical, educational, social, and other services.
 - (ii) Care planning: for an eligible child with an IEP, ensuring the active participation of the eligible child and the eligible child's parent/legal guardian and family; working with the eligible child's IEP team to develop the IEP goals and course of action to respond to the assessed needs of the eligible child; coordinating with the eligible child's medical home.
 - (iii) Referral and linkage: connecting an eligible child with an IEP to individuals capable of providing needed medical, social, educational and other needed services.
 - (iv) Monitoring and follow-up: ensuring that the IEP is effectively implemented and adequately addresses the needs of the eligible child; conducting quality assurance reviews on behalf of the eligible child and incorporating the results of quality assurance reviews into amendments of the IEP; reviewing the progress toward goals in the IEP and making recommendation for assessment as appropriate based upon progress reviews; ensuring that services are provided in accordance with the IEP and that IEP services are effectively coordinated through communication with service providers, including the medical home.
- (f) Although the following list is not all-inclusive, the following activities are not allowable as targeted case management through an MSP provider:
- (i) Providing medical, educational, vocational, transportation, or social services to which the eligible individual has been referred.
 - (ii) Providing the direct delivery of foster care services.
 - (iii) Providing services, other than assessment services, to an eligible child who has not been determined to ~~not~~ have a developmental disability according to section [5123.01](#) of the Revised Code.

- (iv) Providing services to an eligible child who is on a waiver program receiving targeted case management from county boards of development disabilities (CBDD).
- (v) Conducting quality assurance systems reviews.
- (vi) Conducting activities related to the development, monitoring or implementation of an individual service plan (ISP) for an eligible child on a waiver.
- (vii) Performing activities for or providing services to groups of individuals.
- (viii) Activities performed and services provided by someone who is not an employee of or contracted with an MSP provider to provide targeted case management.
- (ix) Activities performed and services provided by someone who is not the case manager specified in the eligible child's IEP.
- (x) Providing services for which claims are submitted through or should have been submitted through another program.

(3) Medical supplies and equipment:

- (a) Supplies and equipment that are medically necessary as described in rule ~~5101:3-1-04~~5160-1-01 of the Administrative Code for the care and treatment of a medicaid eligible child with an IEP while attending school and that are necessary for the qualified practitioner, as described in rule ~~5101:3-35-05~~5160-35-05 of the Administrative Code, to perform his or her function for an eligible child.
- (b) Claim for the cost of medical supplies and equipment are reimbursed through the cost reporting process in accordance with paragraph (J)(2) of rule ~~5101:3-35-04~~5160-35-04 of the Administrative Code.
- (c) Unallowable: supplies and equipment furnished to a medicaid eligible child for use outside the school. In order to be reimbursed for supplies and equipment furnished to an eligible child for use outside the school, the school shall be approved under the medicaid program as a medical supplies provider. See Chapter ~~5101:3-10~~5160-10 of the Administrative Code for coverage, limitation, billing, and reimbursement provisions relative to medical supplies providers.
- (d) Claims cannot be submitted for medical supplies and equipment for which a claim was submitted or should have been submitted through another program.

(C) The service provided shall be necessary to enable the recipient to access medically necessary services of the type, frequency, scope and duration that fall within the normal range of services considered under acceptable standards of medical and healing arts professional practice, as appropriate, in accordance with rule ~~5101:3-1-01~~5160-1-01 of the Administrative Code.

(D) The eligible child's IEP shall contain the following components that, taken together and for the purposes of Chapter ~~5101:3-35~~5160-35 of the Administrative Code, are called the plan of care. This plan of care does not supplant any practitioner plan of care, and shall:

- (1) Be based on the initial assessment/evaluation conducted during the multi-factored evaluation or the subsequent assessments/evaluations and re-assessments/re-evaluations.
- (2) Be signed by the qualified practitioner who recommends the service as a result of the assessment/evaluation, re-assessment/re-evaluation.
- (3) Include specific services to be provided, and the amount, duration and frequency of each service.
- (4) Include specific goals to be achieved for each service.
- (5) Specify timelines for re-assessment/re-evaluation of the eligible child and updates to the plan of care.

- (E) The documentation for the provision of each service shall be maintained for purposes of an audit trail. Documentation shall include:
- (1) The date (i.e., day, month, and year) that the services, medical supplies and/or equipment were provided.
 - (2) The full legal name of the child for whom the services, medical supplies and/or equipment was provided.
 - (3) A description of the services, medical supplies and/or equipment provided and location where the services, medical supplies and/or equipment are delivered (may be in case notes or a coded system with a corresponding key).
 - (4) The duration in minutes or time in/time out of the transportation and/or targeted case management service provided. Duration in minutes is acceptable if the schedule of the person delivering the service is maintained on file.
 - (5) A description of actual progress the eligible child is making/has made toward the stated goals in the plan of care for each continuous three-month reporting period.
 - (6) The signature or initials of the person delivering the services, medical supplies and/or equipment on each entry of services, medical supplies and/or equipment delivery. Each documentation recording sheet shall contain a legend that indicates the name (typed or printed), title, signature, and initials of the person delivering the services, medical supplies and/or equipment to correspond with each entry's identifying signature or initials.
 - (7) A description of efforts made to coordinate services with the eligible child's medical home in accordance with the medicaid provider agreement.
- (F) The claims for reimbursement for services shall be submitted in accordance with rule ~~5101:3-35-04~~5160-35-04 of the Administrative Code.

Effective: 04/01/2015

Five Year Review (FYR) Dates: 12/08/2014 and 04/01/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 03/12/2015

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5162.03, 5162.20, 5164.02, 5164.70

Prior Effective Dates: 11/26/08 (Emer.), 3/02/09, 7/30/09, 10/15/09

Long Term Care Services and Supports Transmittal Letter (LTCSTL)

LTCSSSTL 15-19 (Eligibility for Enrollment in the PASSPORT HCBS Waiver Program)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 15-19

March 26, 2015

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health and Addiction Services
Providers, ODM-Administered Home and Community-Based Services
Case Managers and Administrators, CareStar and CareSource
Statewide Provider Oversight Contractor, Public Consulting Group Inc. (PCG)
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Chairperson, Ohio Olmstead Task Force
President/CEO, Ohio Council for Home Care and Hospice
President/CEO, Midwest Care Alliance
Vice-President, SEIU District 1199, WV/KY/OH

FROM: John B. McCarthy, Director

SUBJECT: Eligibility for Enrollment in the PASSPORT HCBS Waiver Program

Attached please find one rule governing eligibility for enrollment in the PASSPORT home and community-based services (HCBS) waiver program administered by the Ohio Department of Aging (ODA).

Rule [5160-31-03](#), entitled "Eligibility for enrollment in the PASSPORT HCBS waiver program" has been amended in order to update administrative policy related to the waiver. This rule sets forth the eligibility requirements for an individual to participate in the PASSPORT Waiver Program. Changes include, but are not limited to:

- The individual cost limit used to determine eligibility for PASSPORT has been changed to \$14,700 per month for waiver services.
- If the PASSPORT Administrative Agency (PAA) determines that the applicant's waiver service needs cannot be met within the individual cost limit, the individual shall not be enrolled in PASSPORT.
- Once enrolled in PASSPORT, additional waiver services may not be authorized in excess of \$14,700 per month. When a change in condition occurs that necessitates the provision of additional waiver services, referral to other community services, including institutional services, will be explored.
- If the individual's waiver service needs exceed the individual cost limit, the individual shall be disenrolled from the waiver.
- An individual may concurrently receive PASSPORT services and hospice care under Medicaid and Medicare.

- Ohio Administrative Code rules and Code of Federal Regulations effective dates have been updated.

Instructions:

Remove as Obsolete	Insert Replacement
5160-31-03 (effective 3/1/2014)	<u>5160-31-03</u> (effective 04/01/2015)

Web Pages:

ODM uses the Ohio Department of Job and Family Services' "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Long Term Care Services and Supports Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Medicaid

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

(614) 466-6742

LTCSSSTL 15-18 (Targeted Case Management)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 15-18

March 26, 2015

TO: Ohio Association of County Boards
Ohio Developmental Disabilities Council
Ohio Provider Resource Association
Department of Developmental Disabilities (DODD)
Ohio Legal Rights Service
Advocacy and Protective Services

FROM: John B. McCarthy, Director

SUBJECT: Targeted Case Management

The Department of Medicaid (ODM) rule 5160-48-01 of the Ohio Administrative Code is being proposed for amendment. The rule sets forth Medicaid coverage of Targeted Case Management (TCM) services provided to individuals with intellectual disabilities and establishes the payment standards governing reimbursement for TCM administered by the Ohio Department of Developmental Disabilities (DODD).

5160-48-01 Medicaid coverage of targeted case management services provided to individuals with intellectual disabilities.

The purpose of this rule is to specify the conditions for Medicaid payment of Targeted Case Management (TCM) services, which is comprised of activities described in section 5126.15 of the Revised Code and in rule 5123:2-1-11 of the Administrative Code. Activities are reimbursable only to the extent that they are listed in paragraph (D) of the rule for Medicaid eligible individuals with intellectual disabilities.

Instructions:

Remove and File as Obsolete	Insert /Replacement
5160-48-01 (effective 07/01/2011)	<u>5160-48-01</u> (effective 04/01/2015)

Web Pages:

ODM maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

At the "electronic manuals" web page, this LTCSSSTL and rules may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Community Access."
- (3) From the drop-down menu entitled "Table of Contents" at the top of the page, scroll to and select the desired LTCSSSTL 15-18.

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Medicaid

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

LTCSSSTL 15-10 (Five-Year Review - Hospice Rules)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 15-10

March 26, 2015

TO: Midwest Care Alliance
Ohio Council for Home Care and Hospice
Ohio Department of Aging
Ohio Department of Health
Ohio Department of Mental Health and Addiction Services
Ohio Department of Developmental Disabilities
Long Term Care Ombudsman Office
Ohio Olmstead Task Force
Ohio Health Care Association
The Academy of Senior Health Sciences
Leading Age Ohio

FROM: John B. McCarthy, Director

SUBJECT: Five-Year Review - Hospice Rules

Proposed Amendment of Administrative Code Rules 5160-56-01, 5160-56-02, 5160-56-03, 5160-56-03.3, 5160-56-04, 5160-56-05, and 5160-56-06

The following rule changes are being made in accordance with sections 119.03 and 119.032 of the Ohio Revised Code, which outline the procedures for the adoption, amendment, and rescission of administrative rules, and the assignment of rule review dates.

Proposed for Amendment

Rule 5160-56-01, entitled "Hospice services: definitions" defines terms used in the rules governing the Medicaid hospice program as set forth in Chapter 5160-56 of the Administrative Code. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being proposed for amendment. The changes to the rule are:

- The term "consumer" is being changed to "individual" throughout the rule.
- The terms "advanced practice nurse" and "certified nurse specialist" are being changed to "advanced practice registered nurse" and "clinical nurse specialist" to be consistent with the terminology used in Chapter 4723. of the Revised Code.
- In the second opening paragraph, a paragraph reference is being corrected from (GG) to (HH).
- Ohio Administrative Code references are being updated due to the creation of the Ohio Department of Medicaid by Am. Sub. HB 59 of the 130th General Assembly and the subsequent renumbering of rules by the Legislative Services Commission.
- The Department's name is being updated from the Ohio Department of Job and Family Services (ODJFS) to the Ohio Department of Medicaid (ODM).
- The name of the Ohio Department of Developmental Disabilities (DODD) is being updated from the Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD).

- References to an intermediate care facility for the mentally retarded or an ICF-MR are being changed to intermediate care facility for individuals with intellectual disabilities or ICF-IID.
- A reference to the Social Security Act in paragraph (J) is being clarified, and dates are being added to that reference and other references to the Social Security Act throughout the rule.
- In paragraph (M), a reference to the Code of Federal Regulations (C.F.R.) is being corrected from 42 C.F.R. 418.68 to 42 C.F.R. 418.56, and the revision date is being updated.

Rule [5160-56-02](#), entitled "Hospice services: eligibility and election requirements" sets forth the criteria that must be met for a consumer to be eligible to enroll in the Medicaid hospice benefit. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being proposed for amendment. The changes to the rule are:

- The term "consumer" is being changed to "individual" throughout the rule.
- Ohio Administrative Code references are being updated due to the creation of the Ohio Department of Medicaid by Am. Sub. HB 59 of the 130th General Assembly and the subsequent renumbering of rules by the Legislative Services Commission.
- In paragraph (A) (7), language is being changed so that individuals enrolled in hospice may be enrolled concurrently on a home and community based services (HCBS) waiver.

Rule [5160-56-03](#), entitled "Hospice services: discharge requirements" sets forth the provisions for a consumer to terminate hospice services, to revoke election of hospice services, and to transfer to another hospice. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being proposed for amendment. The changes to the rule are:

- The term "consumer" is being changed to "individual" throughout the rule.
- In paragraph (A) (2), language is being added to clarify that the written statement of discharge must state the reason for discharge except when the patient expires.
- In paragraph (B)(1), language is being changed so that, after revocation of the Medicaid hospice benefit, an individual may choose to re-elect the hospice benefit at any time rather than forfeiting any rights to re-election for the remaining days in the revoked benefit period.
- The Department's name is being updated from ODJFS to the Ohio Department of Medicaid (ODM).

Rule [5160-56-03.3](#), entitled "Hospice services: reporting requirements" sets forth the requirements for recording hospice spans and certification information using the telephone-based Interactive Voice Response (IVR) system. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being proposed for amendment. The changes to the rule are:

- The term "consumer" is being changed to "individual" throughout the rule.
- Ohio Administrative Code references are being updated due to the creation of the Ohio Department of Medicaid by Am. Sub. HB 59 of the 130th General Assembly and the subsequent renumbering of rules by the Legislative Services Commission.

Rule [5160-56-04](#), entitled "Hospice services: provider requirements" sets forth the requirements a hospice provider must meet to be eligible to provide Medicaid hospice services. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being proposed for amendment. The changes to the rule are:

- The term "consumer" is being changed to "individual" throughout the rule.

- Ohio Administrative Code references are being updated due to the creation of the Ohio Department of Medicaid by Am. Sub. HB 59 of the 130th General Assembly and the subsequent renumbering of rules by the Legislative Services Commission.
- Revision dates to references to the Code of Federal Regulations (C.F.R.) are being updated.
- References to an intermediate care facility for the mentally retarded or an ICF-MR are being changed to intermediate care facility for individuals with intellectual disabilities or ICF-IID.
- Typographical errors are being corrected, and other non-substantive revisions are being made to enhance clarity.

Rule [5160-56-05](#), entitled "Hospice services: covered services" sets forth the services that are covered by the Medicaid hospice program. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being proposed for amendment. The changes to the rule are:

- The term "consumer" is being changed to "individual" throughout the rule.
- The first three opening paragraphs are being moved to new paragraph (A), (B), and (C) in order to comply with rule writing guidelines of the Ohio Legislative Service Commission, and paragraph references within the rule are being updated accordingly.
- In new paragraph (A), a cross reference is being added to rule 5160-56-04 of the Administrative Code for purposes of clarification.
- In new paragraph (B), acronyms are being spelled out in order to comply with rule writing guidelines of the Ohio Legislative Service Commission.
- References to an intermediate care facility for the mentally retarded or an ICF-MR are being changed to intermediate care facility for individuals with intellectual disabilities or ICF-IID.
- An Ohio Administrative Code reference is being updated due to the creation of the Ohio Department of Medicaid by Am. Sub. HB 59 of the 130th General Assembly and the subsequent renumbering of rules by the Legislative Services Commission.

Rule [5160-56-06](#), entitled "Hospice services: reimbursement" sets forth the reimbursement provisions for providers of Medicaid hospice services. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being proposed for amendment. The changes to the rule are:

- The term "consumer" is being changed to "individual" throughout the rule.
- The Department's name is being updated from ODJFS to the Ohio Department of Medicaid (ODM).
- Revision dates to references to the Code of Federal Regulations (C.F.R.) are being updated.
- Ohio Administrative Code references are being updated due to the creation of the Ohio Department of Medicaid by Am. Sub. HB 59 of the 130th General Assembly and the subsequent renumbering of rules by the Legislative Services Commission.
- In paragraph (C), acronyms are being spelled out in order to comply with rule writing guidelines of the Ohio Legislative Service Commission.
- References to an intermediate care facility for the mentally retarded or an ICF-MR are being changed to intermediate care facility for individuals with intellectual disabilities or ICF-IID.
- In paragraph (G), the revision date of a reference to a Section of the Social Security Act is being updated.

Instructions:

Remove and file as obsolete:	Insert new:
5160-56-01 (effective 03/02/2008)	<u>5160-56-01</u> (effective 04/01/2015)
5160-56-02 (effective 02/01/2011)	<u>5160-56-02</u> (effective 04/01/2015)
5160-56-03 (effective 03/02/2008)	<u>5160-56-03</u> (effective 04/01/2015)
5160-56-03.3 (effective 09/01/2007)	<u>5160-56-03.3</u> (effective 04/01/2015)
5160-56-04 (effective 02/01/2011)	<u>5160-56-04</u> (effective 04/01/2015)
5160-56-05 (effective 03/02/2008)	<u>5160-56-05</u> (effective 04/01/2015)
5160-56-06 (effective 02/01/2011)	<u>5160-56-06</u> (effective 04/01/2015)

Web Pages:

ODM uses the Ohio Department of Job and Family Services' "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Long Term Care Services and Supports Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Medicaid
Bureau of Long Term Care Services and Supports
P.O. Box 182709
Columbus, Ohio 43218-2709
(614) 466-6742

LTCSSSTL 15-07 (State-Operated Intermediate Care Facilities)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 15-07

May 19, 2015

TO: Ohio Association of County Boards
Ohio Developmental Disabilities Council
Ohio Provider Resource Association
Department of Developmental Disabilities (DODD)
Ohio Legal Rights Service
Advocacy and Protective Services

FROM: John B. McCarthy, Director
Department of Medicaid

SUBJECT: State-operated Intermediate Care Facilities

The Ohio Department of Medicaid (ODM) rule [5160-3-99](#) of the Ohio Administrative Code has been proposed for amendment. The rule describes the methodology for calculating payment rates for state-operated intermediate care facilities and includes provisions for a temporary additional payment for off-site day habilitation/active treatment and associated transportation services.

Instructions:

Remove and File as Obsolete	Insert /Replacement
5101-3-99 (effective 04/17/2008)	5160-3-99 (effective 06/01/2015)

Web Pages:

ODM uses the Ohio Department of Job and Family Services' "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

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- (2) Select "Ohio Home Care" (left column).
- (3) Select "Long Term Care Services and Supports Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Medicaid
Bureau of Long Term Care Services and Supports
P.O. Box 182709
Columbus, Ohio 43218-2709
(614) 466-6742

LTCSSSTL 15-06 (ODM-Administered Waiver Program: Individual Rights and Responsibilities)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 15-06

March 26, 2015

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health and Addiction Services
Providers, ODM-Administered Home and Community-Based Services
Case Managers and Administrators, CareStar and CareSource
Statewide Provider Oversight Contractor, Public Consulting Group Inc. (PCG)
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Chairperson, Ohio Olmstead Task Force
President/CEO, Ohio Council for Home Care and Hospice
President/CEO, Midwest Care Alliance
Vice-President, SEIU District 1199, WV/KY/OH

FROM: John B. McCarthy, Director

SUBJECT: ODM-administered Waiver Program: Individual Rights and Responsibilities

Attached please find two rules governing the rights and responsibilities of individuals enrolled on the Ohio Department of Medicaid (ODM) -administered waiver program.

OAC Rule 5160-45-03, ODJFS-administered Waiver Program: Consumer Choice and Control, has been rescinded as a result of five year review. This rule described the ways in which an individual enrolled on an ODM-administered waiver had choice and control over the arrangement/direction of his or her home and community-based waiver services, and the selection and control over the direction of providers of those services. This rule was replaced with new OAC Rule 5160-45-03.

OAC Rule 5160-45-03, Ohio Home Care Waiver Program: Individual Rights and Responsibilities, was adopted as a result of five year review and replaces the previous version of OAC rule 5160-45-03, which was rescinded. This rule sets forth the rights and responsibilities of individuals enrolled on an ODM-administered waiver program. This rule offers the same opportunities for choice and control of provider as the rule it replaces, and holistically, offers more clarity regarding an individual's rights and responsibilities under the ODM-administered waiver program. For example, an individual has the right to:

- Be treated with dignity and respect;
- Be protected from abuse, neglect, exploitation and other threats to personal health, safety and well-being;
- Appoint an authorized representative to act on his or her behalf;
- Receive waiver services in a person-centered manner that maximizes personal independence;

- Choose his or her case management agency and case managers, and receive the full range of assistance and support from those entities as set forth in this rule;
- Make informed choices regarding the services and supports he or she receives, and from whom;
- Request reports of any criminal record checks about current providers or provider applicants;
- Be assured confidentiality; and
- Be informed about the right to appeal decisions.

Additionally, upon enrollment in an ODM-administered waiver, the individual must sign an ODM-administered waiver agreement accepting certain responsibilities including, but not limited to the following:

- Participate in, and cooperate during assessments to determine eligibility and enrollment in the waiver and service needs;
- Decide who, besides the case manager, will participate in the service planning process;
- Participate in, and cooperate with, the case manager and team in the development and implementation of all services plans and plans of care;
- Participate in the recruitment, selection and dismissal of his or her providers;
- Participate in the development and maintenance of back-up plans that meet the needs of the individual;
- 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;
- Validate service delivery;
- Utilize services in accordance with the approved all services plan;
- Communicate personal preferences about duties, tasks and procedures to be performed; and
- Pay patient liability when required, and comply with third-party liability requirements.

If the individual fails to uphold the responsibilities set forth in this rule, or the health and welfare of an 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 will be afforded notice and hearing rights.

Instructions:

Remove as Obsolete	Insert Replacement
<u>5160-45-03</u> (effective 7/1/2010)	<u>5160-45-03</u> (effective 04/01/2015)

Web Pages:

ODM uses the Ohio Department of Job and Family Services' "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Ohio Home Care" (left column).

- (3) Select "Long Term Care Services and Supports Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSTL should be addressed to:

Ohio Department of Medicaid

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

(614) 466-6742

LTCSSSTL 15-05 (Amendment of Medicaid School Program Rules - Five Year Review)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 15-05

March 26, 2015

TO: All Interested Parties
FROM: John B. McCarthy, Director
SUBJECT: Amendment of Medicaid School Program Rules - Five Year Review

The Ohio Department of Medicaid is proposing to implement the following rules as a result of the five-year rule review of the Medicaid School Program (MSP).

Overall changes:

- The chapter and rule numbers referenced were updated throughout.
- Minor grammatical and language clarification changes were made.
- Dates were updated throughout.

Rule [5160-35-01](#), entitled **Definitions**, sets forth terms and definitions used in Chapter 5160-35 of the Administrative Code. Following are changes made:

- The definitions section was revised to add a definition for Common procedural terminology (CPT), Direct service costs, Healthcare common procedure coding system (HCPCS), Licensed practitioner of the healing arts, Other costs, and Supervision.
- The definitions section was revised to delete the definition of Direct supervision, General supervision, and maintenance.

Rule [5160-35-02](#), entitled **Qualifications to be a medicaid school program (MSP) provider**, sets forth the qualifications to become and the requirements for a medicaid school program (MSP) provider. Following are changes made:

- Reference to the count of special education students was revised to reflect the correct title and time frame.
- Language was revised to clarify the authorized entity who can perform the agreed upon procedures review of cost reports is an independent certified public accountant or firm.

Rule [5160-35-04](#), entitled **Reimbursement for services provided by medicaid school program (MSP) providers**, sets forth the provisions for claiming and cost reconciliation to receive medicaid reimbursement for the provision of services by medicaid school program (MSP) providers as defined in Chapter 5160-35 of the Administrative Code. Following are changes made:

- Obsolete language was removed from the reimbursement rule.
- Language was added to the reimbursement rule to clarify the need to submit ALL direct service claims for reimbursement for which cost reconciliation would be sought.
- Language was added to the reimbursement rule in the "Final cost settlement and reconciliation" section to identify time frames for hearing requests, and to clarify the reconciliation process to include identifying the number of students for which claims for services were received and paid and determine the proportionate costs for those students using the costs from the cost report for the total population of Medicaid eligible IEP students.
- Language was removed to allow claim submission through the web portal as well as through EDI.

Rule 5160-35-05, entitled **Services authorized for medicaid coverage that can be provided by medicaid school program (MSP) providers**, sets forth the services authorized for medicaid coverage that a MSP provider can provide, and to set forth the conditions for providing the services. Following are changes made:

- Reference to the multi-factored evaluation (MFE) was revised to evaluation team report (ETR) process.
- A person holding a conditional license was added to the list of those qualified to deliver speech-language pathology services.
- IEP and ETR meetings were added to the list of activities for which Medicaid reimbursement is not allowed.

Rule 5160-35-06, entitled **Other services, medical supplies and equipment authorized for medicaid coverage that can be provided by medicaid school program (MSP) providers**, sets forth the services authorized for medicaid coverage, beyond those indicated in rule 5160-35-05 of the Administrative Code, that a MSP provider can provide, and to set forth the conditions for providing the services. Following are changes made:

- Reference to the multi-factored evaluation (MFE) was revised to evaluation team report (ETR) process.
- IEP and ETR meetings were added to the list of activities for which Medicaid reimbursement is not allowed.
- Overall language modification was made to the Transportation section, as well as specific language modifications to allow Medicaid reimbursement for specialized transportation to school from home and from school to home.

Instructions:

Remove and file as obsolete:	Insert new:
5160-35-01 (effective 10/15/2009)	<u>5160-35-01</u> (effective 04/01/2015)
5160-35-02 (effective 10/15/2009)	<u>5160-35-02</u> (effective 04/01/2015)
5160-35-04 (effective 3/28/2013)	<u>5160-35-04</u> (effective 04/01/2015)
5160-35-05 (effective 10/15/2009)	<u>5160-35-05</u> (effective 04/01/2015)
5160-35-06 (effective 10/15/2009)	<u>5160-35-06</u> (effective 04/01/2015)

Web Pages:

ODM uses the Ohio Department of Job and Family Services' "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Long Term Care Services and Supports Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Medicaid

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

(614) 466-6742

LTCSSSTL 15-04 (ODM-Administered Waiver Programs: ODM-Administered Waiver Programs: Provider Conditions of Participation)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 15-04

February 2, 2015

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health and Addiction Services
Providers, ODM-Administered Home and Community-Based Services
Case Managers and Administrators, CareStar and CareSource
Statewide Provider Oversight Contractor, Public Consulting Group Inc. (PCG)
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Chairperson, Ohio Olmstead Task Force
President/CEO, Ohio Council for Home Care and Hospice
President/CEO, Midwest Care Alliance
Vice-President, SEIU District 1199, WV/KY/OH

FROM: John B. McCarthy, Director

SUBJECT: ODM-administered Waiver Programs: ODM-administered Waiver Programs: Provider Conditions of Participation

Attached please find four rules governing the conditions of participation for providers of Ohio Department of Medicaid (ODM) -administered waiver services, two of which were rescinded, and another two that are new.

Rule [5160-45-06](#), entitled "ODJFS-administered waiver program: structural reviews of providers and investigation of alleged provider occurrences and overpayments" has been rescinded pursuant to five-year rule review. This rule previously set forth policy and procedures governing structural reviews of ODM-administered waiver service providers, and the provider occurrence process. It has been replaced by new OAC Rule 5160-45-06.

Rule [5160-45-06](#), entitled "Ohio department of Medicaid (ODM) -administered program: structural reviews of providers and investigation of provider occurrences" has been adopted as a result of five-year rule review and replaces former OAC rule 5160-45-06. This rule 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. Among other things, Medicare-certified and/or otherwise accredited agencies are subject to reviews in accordance with their certification and accreditation bodies, are exempt from regularly scheduled reviews, and shall submit a copy of their updated certification and/or accreditation, and upon request, all review reports and accepted plans of correction. All other ODM-administered waiver providers are subject to structural reviews during each of the first three years after they begin furnishing waiver services. Thereafter, at ODM's discretion, the provider may be subject to biennial structural reviews. Reviews include an evaluation of the provider's compliance with ODM-administered waiver rules and a unit of service verification to assure that all waiver services are properly authorized, delivered and reimbursed. Proposed OAC rule 5160-45-06 also sets forth the definition of and process and requirements for investigating provider occurrences. ODM or its designee shall investigate provider occurrences. If a provider occurrence is substantiated, the provider will be notified in writing. A plan of correction for all findings is

required within 45 days. Overpayments of provider claims must be adjusted by the provider and ODM may take action against a provider for failure to comply with any of the requirements set forth in this rule.

Rule 5160-45-10, entitled "Conditions of participation for Ohio department of job and family services (ODJFS) administered waiver service providers" was rescinded pursuant to five-year rule review. This rule previously contained the core conditions of participation that a provider had to meet in order to furnish ODM-administered waiver services. It has been replaced by a new OAC Rule 5160-45-10.

Rule 5160-45-10, entitled "ODM-administered waiver programs: Provider conditions of participation" has been adopted as a result of five-year review and replaces former OAC rule 5160-45-10. This rule contains the core conditions of participation that a provider must meet in order to furnish ODM-administered waiver services. ODM-administered waiver service providers shall maintain a professional relationship with the individuals to whom they provide services. Among other things, services shall be provided in a person-centered manner in accordance with the individual's approved all services plan, and in a manner that is attentive to the individual's needs and maximizes the individual's independence. Providers must maintain an active, valid Medicaid provider agreement and comply with all applicable provider requirements set forth in the Administrative Code and federal and state law. The rule also establishes what a provider can never do and what they cannot do while rendering services. For example, ODM-administered waiver service providers shall never engage in behavior that may cause abuse or distress, or that may compromise the individual's health and welfare; nor shall they engage in behavior that may be manipulative or pose a conflict of interest. While rendering services, a provider is prohibited from taking the individual to the provider's place of residence, or bringing children, animals, or other persons to the individual's place of residence so as not to distract from, or interfere with service delivery.

Instructions:

Remove as Obsolete	Insert Replacement
<u>5160-45-06</u> (effective 9/19/09)	<u>5160-45-06</u> (effective 02/01/2015)
<u>5160-45-10</u> (effective 10/25/2010)	<u>5160-45-10</u> (effective 02/01/2015)

Web Pages:

ODM uses the Ohio Department of Job and Family Services' "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Long Term Care Services and Supports Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Medicaid
Bureau of Long Term Care Services and Supports
P.O. Box 182709
Columbus, Ohio 43218-2709
(614) 466-6742

LTCSSSTL 15-03 (PASRR Rule Changes)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 15-03

February 2, 2015

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health and Addiction Services
Providers, ODM-Administered Home and Community-Based Services
Case Managers and Administrators, CareStar, CareSource and Council on Aging
Members of the HOME Choice Consumer Advisory Council
Statewide Provider Oversight Contractor, Public Consulting Group Inc. (PCG)
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Chairperson, Ohio Olmstead Task Force
President/CEO, Ohio Council for Home Care and Hospice
President/CEO, Midwest Care Alliance
Vice-President, SEIU District 1199, WV/KY/OH

FROM: John B. McCarthy, Director

SUBJECT: Pre-Admission Screening and Resident Review (PASRR) rule changes

The Ohio Department of Medicaid (ODM) has amended rule: [5160-3-15.2](#) of the Administrative Code entitled "Resident review requirements for individuals residing in nursing facilities." This rule has been reviewed in compliance with the five-year rule review process. Changes made to the rule include:

- Changed state agency name references, form numbers, and rule number references to reflect agency name and statutory and Administrative Code numbering changes.
- Replaced the term "mental retardation" with the term "developmental disability."
- Added the opportunity for providers to submit a resident review electronically through the system approved by ODM.

Remove as Obsolete	Insert Replacement
5160-3-15.2 (effective 12/01/2009)	5160-3-15.2 (effective 03/01/2015)

Web Pages:

ODM uses the Ohio Department of Job and Family Services' "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Ohio Home Care" (left column).

- (3) Select "Long Term Care Services and Supports Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Medicaid
Bureau of Long Term Care Services and Supports
P.O. Box 182709
Columbus, Ohio 43218-2709
(614) 466-6742

LTCSSSTL 15-02 (HOME Choice Rules)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 15-02

February 2, 2015

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health and Addiction Services
Providers, ODM-Administered Home and Community-Based Services
Case Managers and Administrators, CareStar, CareSource and Council on Aging
Members of the HOME Choice Consumer Advisory Council
Statewide Provider Oversight Contractor, Public Consulting Group Inc. (PCG)
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Chairperson, Ohio Olmstead Task Force
President/CEO, Ohio Council for Home Care and Hospice
President/CEO, Midwest Care Alliance
Vice-President, SEIU District 1199, WV/KY/OH

FROM: John B. McCarthy, Director

SUBJECT: Helping Ohioans Move, Expanding Choice (HOME Choice) Rules

The Ohio Department of Medicaid (ODM) has rescinded and filed as new rules: 5160-51-01, 5160-51-02, 5160-51-03 and 5160-51-04 of the Administrative Code. ODM has also rescinded rule 5160-51-05 of the Administrative Code and amended rule 5160-51-06 of the Administrative Code. These rules pertain to the Money Follows the Person (MFP) demonstration program "Helping Ohioans Move, Expanding Choice" or "HOME Choice".

These rules have been reviewed in compliance with the five-year rule review process. Changes made to the rules include the following:

Rule [5160-51-01](#), entitled "HOME choice ("Helping Ohioans Move, Expanding Choice") demonstration program: definitions" is being rescinded and filed as a new rule entitled "Definitions for the helping Ohioans move, expanding choice (HOME choice) program" in compliance with five year rule review.

Changes to rule 5160-51-01 include:

- State agency name references, form numbers, and rule number references were updated to reflect agency name and statutory and Administrative Code numbering changes.
- Removed unnecessary references to home and community based services waivers where applicable.
- Clarified, added and removed definitions not applicable to the HOME Choice program.
- Removed redundancies.

Rule [5160-51-02](#), entitled "Helping Ohioans move, expanding choice (HOME choice) application process, participant eligibility, and enrollment" is being rescinded and filed as a new rule entitled "Helping Ohioans

move, expanding choice (HOME choice) program application process, participant eligibility, and enrollment” in compliance with five year rule review.

Changes to rule 5160-51-02 include:

- State agency name references, form numbers, and rule number references were updated to reflect agency name and statutory and Administrative Code numbering changes.
- Removed unnecessary references to home and community based services waivers where applicable.
- Added the application name and form number needed to apply for participation in the HOME Choice program and clarified the enrollment process.

Rule [5160-51-03](#), entitled “HOME choice ("Helping Ohioans Move, Expanding Choice") demonstration program: conditions of participation for providers” is being rescinded and filed as a new rule entitled “Helping Ohioans move, expanding choice (HOME choice) program conditions of participation and enrollment for providers” in compliance with five year rule review.

Changes to rule 5160-51-03 include:

- State agency name references, form numbers, and rule number references were updated to reflect agency name and statutory and Administrative Code numbering changes.
- Removed unnecessary references to home and community based services waivers where applicable.
- Clarified definitions and removed definitions not applicable to the HOME Choice program.
- Removed redundancies.
- Added the application/agreement name and form number for provider enrollment and clarified the enrollment process for providers of services to HOME Choice participants.
- Added language from Rule 5160-51-05 regarding the processing of provider applications.
- Removed hearing rights language for a provider whose provider agreement is terminated due to failure to meet the requirements set forth in the rule.

Rule [5160-51-04](#), entitled “HOME choice ("Helping Ohioans Move, Expanding Choice") demonstration program: definitions of the covered services and program service limitations, provider qualifications and specifications” is being rescinded and filed as a new rule entitled “Helping Ohioans move, expanding choice (HOME choice) program definitions of covered services and provider qualifications” in compliance with five year rule review.

Changes to rule 5160-51-04 include:

- State agency name references, form numbers, and rule number references were updated to reflect agency name and statutory and Administrative Code numbering changes.
- Removed unnecessary references to home and community based services waivers where applicable.
- Clarified covered services definitions.
- Added language from Rule 5160-51-05 pertaining to each of the covered service providers listed.
- Removed redundancies.

Rule [5160-51-05](#), entitled “HOME choice ("Helping Ohioans Move, Expanding Choice") demonstration program: process for enrolling service providers” is being rescinded. The necessary content has been incorporated into rules 5160-51-03 and 5160-51-04 of the Administrative Code.

Rule [5160-51-06](#), entitled “HOME Choice (“Helping Ohioans Move, Expanding Choice”) demonstration program reimbursement rates and billing procedures” is being amended and will be entitled “Helping Ohioans

move, expanding choice (HOME choice) program definitions of billing terms, reimbursement rates and billing procedures for providers of covered services” in compliance with five year rule review.

Changes to rule 5160-51-06 include:

- State agency name references, form numbers, and rule number references were updated to reflect agency name and statutory and Administrative Code numbering changes.
- Removed unnecessary references to home and community based services waivers where applicable.
- Clarified definitions.
- Added language regarding recoupment of funds for overpayment to a provider.
- Extended the length of time a provider is allowed to submit a claim for reimbursement for community transition services from 15 days to 30 days.

Remove as Obsolete	Insert Replacement
5160-51-01 (effective 9/9/2010)	<u>5160-51-01</u> (effective 02/01/2015)
5160-51-02 (effective 8/1/2011)	<u>5160-51-02</u> (effective 02/01/2015)
5160-51-03 (effective 9/9/2010)	<u>5160-51-03</u> (effective 02/01/2015)
5160-51-04 (effective 8/1/2011)	<u>5160-51-04</u> (effective 02/01/2015)
<u>5160-51-05</u> (effective 9/9/2010)	
5160-51-06 (effective 8/1/2011)	<u>5160-51-06</u> (effective 02/01/2015)

Web Pages:

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- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Long Term Care Services and Supports Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Medicaid

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

(614) 466-6742

LTCSSSTL 15-01 (Program of All-inclusive Care for the Elderly - Five-Year Rule Review)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 15-01

December 11, 2014

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health and Addiction Services
Providers, ODM-Administered Home and Community-Based Services
Case Managers and Administrators, CareStar, CareSource and Council on Aging
Statewide Provider Oversight Contractor, Public Consulting Group Inc. (PCG)
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Chairperson, Ohio Olmstead Task Force
President/CEO, Ohio Council for Home Care and Hospice
President/CEO, Midwest Care Alliance
Vice-President, SEIU District 1199, WV/KY/OH

FROM: John B. McCarthy, Director

SUBJECT: Program of All-inclusive Care for the Elderly - Five-Year Rule Review

Attached please find six Ohio Department of Medicaid (ODM) -authorizing rules governing the Program of All-inclusive Care for the Elderly (PACE).

Rule [5160-36-01](#), entitled "Program of All-inclusive Care for the Elderly (PACE) Definitions and Acronyms" has been amended pursuant to five-year rule review. This rule sets forth the definitions of the PACE Program. Changes are limited to updated Ohio Administrative Code (OAC) cites, ODM references and Code of Federal Regulations (CFR) effective dates.

Rule [5160-36-02](#), entitled "Program of All-inclusive Care for the Elderly (PACE) Administration" has been amended pursuant to five-year rule review. This rule sets forth the program administration requirements for the PACE Program, including but not limited to designation of the Ohio Department of Aging (ODA) as the state administering agency. Changes are limited to updated OAC cites, ODM references, CFR effective dates and updated reference to "individual" instead of "consumer." Additionally, paragraph (B)(3) has been modified to state that ODA shall "verify that PACE organizations providing PACE services have signed Medicaid provider agreements as required by rule 5160-1-17 of the Administrative Code."

Rule [5160-36-03](#), entitled "Program of All-inclusive Care for the Elderly (PACE) Eligibility" has been amended pursuant to five-year rule review. This rule establishes the participant eligibility requirements for the PACE Program. Changes are limited to updated OAC cites and reference to "individual" instead of "consumer."

Rule [5160-36-04](#), entitled "Program of All-inclusive Care for the Elderly (PACE) Enrollment, Disenrollment and Waiting Lists" has been amended pursuant to five-year rule review. This rule sets forth the enrollment, disenrollment and waiting list policies for the PACE Program. Changes are limited to updated ODM references and reference to "individual" instead of "consumer."

Rule 5160-36-05, entitled "Program of All-inclusive Care for the Elderly (PACE) Interdisciplinary Team, Participant Plan of Care and Services" has been amended pursuant to five-year rule review. This rule sets forth the requirement that each PACE center establish and maintain an interdisciplinary team to assess the care and service needs of participants in the PACE Program. It also sets forth the composition requirements and responsibilities of the team, as well as plan of care and service requirements. Changes are limited to updated CFR effective dates.

Rule 5160-36-06, entitled "Program of All-inclusive Care for the Elderly (PACE) Organization Reimbursement" has been amended pursuant to five-year rule review. This rule sets forth the reimbursement policy governing organizations under contract with the State to provide services under the PACE Program. Changes are limited to updated OAC cites, ODM references and CFR effective dates.

Instructions:

Remove as Obsolete	Insert Replacement
5160-36-01 (effective 3/28/2009)	<u>5160-36-01</u> (effective 01/01/2015)
5160-36-02 (effective 3/28/2009)	<u>5160-36-02</u> (effective 01/01/2015)
5160-36-03 (effective 3/28/2009)	<u>5160-36-03</u> (effective 01/01/2015)
5160-36-04 (effective 3/28/2009)	<u>5160-36-04</u> (effective 01/01/2015)
5160-36-05 (effective 3/28/2009)	<u>5160-36-05</u> (effective 01/01/2015)
5160-36-06 (effective 3/28/2009)	<u>5160-36-06</u> (effective 01/01/2015)

Web Pages:

ODM uses the Ohio Department of Job and Family Services' "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

This transmittal letter and attachments may be viewed as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Long Term Care Services and Supports Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Medicaid

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

(614) 466-6742

LTCSSSTL 14-12 (PASRR Automated Process)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 14-12

November 21, 2014

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health and Addiction Services
Providers, ODM-Administered Home and Community-Based Services
Case Managers and Administrators, CareStar, CareSource, Council on Aging
Statewide Provider Oversight Contractor, Public Consulting Group Inc. (PCG)
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, Centers for Independent Living
Super Intendants, County Boards of Developmental Disabilities
Ohio Long Term Care Ombudsmen
Chairperson, Ohio Olmstead Task Force
President/CEO, Ohio Council for Home Care and Hospice
President/CEO, Midwest Care Alliance
Ohio Hospital Association
Academy of Senior Health Sciences, Inc.
Ohio Health Care Association
Leading Age Ohio

FROM: John B. McCarthy, Director

SUBJECT: Preadmission Screening and Resident Review (PASRR) Automated Process

DATE: October 29, 2014

Preadmission Screening and Resident Review (PASRR) is a mandate of the OBRA 1987 Nursing Home Reform Act. PASRR provisions are contained in section 1919(e)(7) of the Social Security Act. The regulations prohibit a nursing facility from accepting a new applicant, or retaining a resident with Serious Mental Illness or Developmental Disabilities unless the individual requires the level of services provided by the nursing facility. The intent of PASRR is to allow individuals to reside in the least restrictive setting possible while having their long-term services and supports needs met.

Some individuals may meet the criteria to be admitted into a nursing facility under the hospital exemption provision as defined in rule 5160-3-15, entitled "Preadmission screening and resident review (PASRR) definitions." Currently, the discharging hospital may request a hospital exemption by submitting the ODM 7000 "Hospital Exemption from Preadmission Screening Notification" form. Beginning in May, 2011, hospitals were also provided the option to submit the ODM 7000 via an electronic system called the Hospital Exemption Notification System (HENS). This is a secure web-based system maintained by the Ohio Department of Aging (ODA).

Beginning December 1, 2014, submitters of PAS-ID and Resident Review forms (ODM 3622) will have the option to also submit the ODM 3622 electronically via HENS. The web address for HENS is <https://www.HENS.age.ohio.gov>. Information about the changes to HENS, user guides and training modules for the new version of the HENS system are available in the HELP section of the HENS web site. User guides and training modules will be available on the HENS web site beginning November 1, 2014.

System users should consult the tools available in the help section of the HENS web site to be prepared for changes to the system that will take place effective December 1, 2014.

In addition, the Ohio Department of Medicaid (ODM) has revised rules 5160-3-15 and 5160-3-15.1 of the Administrative Code pertaining to the PASRR process. **Effective April 1, 2015, the discharging hospital shall submit any request for hospital exemption electronically through HENS.** Any requests for an exception to the automated process must be submitted to the PASSPORT Administrative Agency (PAA) for approval.

HENS will send the ODM 7000 or ODM 3622 form electronically to the appropriate entities that are required to receive it. When the form is created in HENS, the requirement to obtain the physician's signature and date on the actual form is not applicable and is not required. In lieu of this, the hospital staff person creating the form in HENS must attest that the documentation substantiating the required certification exists and has been signed and dated by the physician.

ODM would like to encourage hospitals and nursing facilities to utilize HENS when submitting any PASRR forms. This automated process will be more efficient and timely than using the paper process.

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Medicaid

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

BHCP@medicaid.ohio.gov

(614) 466-6742

LTCSSSTL 14-11 (ODM-Administered Waiver Eligibility/Enrollment)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 14-11

November 19, 2014

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health and Addiction Services
Providers, ODM-Administered Home and Community-Based Services
Case Managers and Administrators, CareStar and CareSource
Statewide Provider Oversight Contractor, Public Consulting Group Inc. (PCG)
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Chairperson, Ohio Olmstead Task Force
President/CEO, Ohio Council for Home Care and Hospice
President/CEO, Midwest Care Alliance
Vice-President, SEIU District 1199, WV/KY/OH

FROM: John B. McCarthy, Director

SUBJECT: ODM-administered Waiver Eligibility/Enrollment

Attached please find six rules governing Ohio Department of Medicaid (ODM) -administered waiver eligibility and enrollment, four of which were rescinded and two that are new.

OAC Rule 5160-46-02, Ohio Home Care Waiver: Consumer Eligibility for Enrollment, has been rescinded as a result of five year review. It previously set forth the eligibility and enrollment requirements for an individual who applied for or participated in the Ohio Home Care Waiver Program. This rule was replaced with new OAC Rule 5160-46-02.

OAC Rule 5160-46-02, Ohio Home Care Waiver Program: Eligibility and Enrollment, was adopted as a result of five year review and replaces OAC rules 5160-46-02 and 5160-46-07 which were rescinded. This rule sets forth the eligibility and enrollment requirements, and priority categories for enrollment, for an individual who applies for and participates in the Ohio Home Care Waiver. This rule updates Ohio Administrative Code rule cites, the Ohio Department of Medicaid's name and other terminology. It also incorporates Home First criteria used to prioritize assessments for enrollment in the Ohio Home Care Waiver. The rule also identifies the conditions under which an individual can be disenrolled from the waiver.

OAC Rule 5160-46-07, Ohio Home Care Waiver: Enrollment and Waiting List Process, was rescinded as a result of five year review. This rule previously set forth the policies associated with the enrollment process for the Ohio Home Care Waiver Program and the placement and processing of applicants on the Ohio Home Care Waiver waiting list. The policies and practices set forth in this rule were out of date and obsolete. It was replaced with new OAC Rule 5160-46-02.

OAC Rule 5160-50-02, Transitions Carve-Out Waiver: Consumer Eligibility for Enrollment, was rescinded as a result of five year review. It previously set forth the eligibility and enrollment requirements for an individual who participated in the Transitions Carve-Out Waiver Program. This rule was replaced with new OAC Rule 5160-50-02.

OAC Rule 5160-50-02, Transitions Carve-Out Waiver Program: Eligibility and Enrollment, was adopted as a result of five year review and replaced existing OAC rules 5160-50-02 and 5160-50-02.1 which were rescinded. This rule sets forth the eligibility and enrollment requirements for an individual who participates in the Transitions Carve-Out Waiver, including participation in the Ohio Home Care Waiver and/or the HOME Choice (Helping Ohioans Move, Expanding Choice) Program. This rule updates Ohio Administrative Code rule cites, the Ohio Department of Medicaid's name and other terminology. The rule also identifies the conditions under which an individual can be disenrolled from the waiver.

OAC Rule 5160-50-02.1, Transitions Carve-Out Waiver: Eligibility Criteria for Time-Limited Enrollment in HOME Choice ("Helping Ohioans Move, Expanding Choice") Demonstration Program Participants, was rescinded as a result of five year review. This rule previously set forth the Transitions Carve-Out Waiver Program eligibility and enrollment requirements for an individual who was also participating in the HOME Choice Demonstration Program. It was replaced with new OAC rule 5160-50-02.

Instructions:

Remove as Obsolete	Insert Replacement
<u>5160-46-02</u> (effective 7/1/2006)	<u>5160-46-02</u> (effective 12/01/2014)
<u>5160-46-07</u> (effective 2/8/2009)	
<u>5160-50-02</u> (effective 7/1/2006)	<u>5160-50-02</u> (effective 12/01/2014)
<u>5160-50-02.1</u> (effective 7/1/2008)	

Web Pages:

ODM uses the Ohio Department of Job and Family Services' "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Long Term Care Services and Supports Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Medicaid
 Bureau of Long Term Care Services and Supports
 P.O. Box 182709
 Columbus, Ohio 43218-2709
 (614) 466-6742

LTCSSSTL 14-10 (PASRR Rules)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 14-10

October 30, 2014

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health and Addiction Services
Providers, ODM-Administered Home and Community-Based Services
Case Managers and Administrators, CareStar and CareSource
Statewide Provider Oversight Contractor, Public Consulting Group Inc. (PCG)
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Chairperson, Ohio Olmstead Task Force
President/CEO, Ohio Council for Home Care and Hospice
President/CEO, Midwest Care Alliance
Vice-President, SEIU District 1199, WV/KY/OH

FROM: John B. McCarthy, Director

SUBJECT: Preadmission Screening and Resident Review (PASRR) Rules

The Ohio Department of Medicaid (ODM) has amended rule 5160-3-15 of the Administrative Code and also rescinded and filed as new rule 5160-3-15.1 of the Administrative Code pertaining to the preadmission screening and resident review (PASRR) process:

- [5160-3-15](#), entitled "Preadmission screening and resident review (PASRR) definitions."
- [5160-3-15.1](#), entitled "Preadmission screening requirements for individuals seeking admission to nursing facilities."

These rules have been changed in order to modify the hospital exemption policy. Amended Substitute H.B. No. 59, which took effect September 29, 2013, created restrictions on the utilization of the hospital exemption for individuals who are being directly admitted to a nursing facility from a hospital that is either of the following:

1. A hospital that the Ohio Department of Mental Health and Addiction Services (OhioMHAS) maintains, operates, manages, and governs under section 5119.14 of the Revised Code for the care and treatment of mentally ill persons; or
2. A free-standing hospital, or unit of a hospital, licensed by OhioMHAS under section 5119.33 of the Revised Code.

The following individuals seeking a nursing facility admission will be subject to a preadmission screening, in accordance with rule 5160-3-15 of the Administrative Code and will no longer be permitted a hospital exemption from the preadmission screening process:

- Individuals who are being discharged from a hospital or unit as described in paragraphs 1 and 2 above; or
- Individuals who are being discharged from out-of-state psychiatric hospital or psychiatric unit within an out-of-state hospital.

Other changes to rule 5160-3-15 include:

- Changed state agency name references and rule number references to reflect agency name and statutory and Administrative Code numbering changes.
- Added to the list of professionals who may conduct a face-to-face assessment in paragraph (B)(2)(a).
- Modified the definition of "significant change of condition" in paragraph (B)(32).
- Added a date after which hospitals will be required to submit a hospital exemption request electronically through the system approved by ODM in paragraph (B)(8).

Other changes to rule 5160-3-15.1 include:

- Changed state agency name references and rule number references to reflect agency name and statutory and Administrative Code numbering changes.
- Added a date after which hospitals will be required to submit a hospital exemption request electronically through the system approved by ODM in paragraph (H)(1).

Remove as Obsolete	Insert Replacement
5160-3-15 (effective 12/1/2009)	<u>5160-3-15</u> (effective 11/16/2014)
516-3-15.1 (effective 12/1/2009)	<u>5160-3-15.1</u> (effective 11/16/2014)

Web Pages:

ODM maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Long Term Care Services and Supports Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Medicaid
Bureau of Long Term Care Services and Supports
P.O. Box 182709
Columbus, Ohio 43218-2709
BLTCSS@medicaid.ohio.gov
(614) 466-6742

LTCSSSTL 14-09 (Amendment of PASSPORT Waiver Program Rules)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 14-09

June 25, 2014

TO: All Interested Parties
FROM: John B. McCarthy, Director
SUBJECT: Amendment of Pre-Admission Screening System Providing Options Today (PASSPORT) waiver program rules

The Ohio Department of Medicaid will amend the Ohio Administrative Code (OAC) rules dealing with pre-admission screening system providing options and resources today (PASSPORT) waiver program.

Rule [5160-1-06.1](#) entitled **Home and community-based services waivers: PASSPORT**, is being proposed for amendment to update reimbursement policy in the PASSPORT program.

Rule [5160-31-05](#) entitled **PASSPORT HCBS waiver program covered services**, sets forth services covered by the pre-admission screening system providing options and resources today (PASSPORT) home and community based services (HCBS) waiver program. It is being proposed for amendment to add home care attendant, out-home- respite, and waiver nursing services to PASSPORT waiver.

Rule [5160-31-07](#) entitled **PASSPORT HCBS waiver program rate setting**, sets forth the methods used to determine provider rates for the PASSPORT HCBS waiver program. It is being proposed for amendment to add home care attendant, out-home-respite, and waiver nursing services to PASSPORT waiver program.

Instructions:

Remove as Obsolete	Insert Replacement
5160-1-06.1 (effective 03/01/2014)	5160-1-06.1 (effective 07/01/2014)
5160-31-05 (effective 03/01/2014)	5160-31-05 (effective 07/01/2014)
5160-31-07 (effective 03/01/2014)	5160-31-07 (effective 07/01/2014)

Web Pages:

The Ohio Department of Medicaid presently uses the Ohio Department of Job and Family Service's "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Long-Term Care Services and Supports Transmittal Letter" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Medicaid

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTCSS@medicaid.ohio.gov

(614) 466-6742

LTCSSSTL 14-08 (Amendment of Medicaid Mental Health and Alcohol and Drug Treatment Service Program Rules)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 14-08

June 25, 2014

TO: All Interested Parties
FROM: John B. McCarthy, Director
SUBJECT: Amendment of Medicaid mental health and alcohol and drug treatment service program rules

The Ohio Department of Medicaid will amend the Ohio Administrative Code (OAC) rules dealing with mental health and alcohol and drug treatment services. Specifically, the revisions impact phase one of the health home program and implement phase two. They will become effective on July 1, 2014.

Rule [5160-27-02](#) entitled **Coverage and limitations of medicaid community mental health services**. This rule sets forth the Medicaid covered Ohio Department of Mental Health and Addiction Services administered mental health services and related limitations. The change to the rule is new language to define new eligibility criteria and implement the "grandfathering" of current health home enrollees that don't meet the new criteria. Also added is a policy that health home providers must disenroll clients within three business days of a request by the client or client's parent or guardian.

Rule [5160-27-05](#) entitled **Reimbursement for community mental health medicaid services**. This rule sets forth the reimbursement policies for Medicaid covered Ohio Department of Mental Health and Addiction Services administered mental health services. The rule is being amended to describe the reimbursement rates for phase two providers and clarify billing for individuals in a health home and MyCare Ohio. Revisions to the appendix to the rule will add the health home base rates.

Instructions:

Remove as Obsolete	Insert Replacement
5160-27-02 (effective 09/29/2011)	5160-27-02 (effective 7/1/2014)
5160-27-05 (effective 09/29/2011)	5160-27-05 (effective 7/1/2014)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Long-Term Care Services and Supports Transmittal Letter" (in the "Table of Contents" dropdown).

Questions about this LTCSSSTL should be addressed to:

Ohio Office of Medical Assistance

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTCSS@jfs.ohio.gov

(614) 466-6742

LTCSSSTL 14-07 (ODM-Administered Waiver Programs: Obsolete Rules)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 14-07

June 25, 2014

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health and Addiction Services
Providers, ODM-Administered Home and Community-Based Services
Case Managers and Administrators, CareStar and CareSource
Statewide Provider Oversight Contractor, Public Consulting Group Inc. (PCG)
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Chairperson, Ohio Olmstead Task Force
President/CEO, Ohio Council for Home Care and Hospice
President/CEO, Midwest Care Alliance
Vice-President, SEIU District 1199, WV/KY/OH

FROM: John B. McCarthy, Director

SUBJECT: ODM-administered Waiver Programs: Obsolete Rules

Attached please find three rules governing Ohio Department of Medicaid (ODM) -administered waivers that were recently rescinded.

Rule 5160-45-15, entitled "Provisions for transferring consumers receiving core-plus benefit package services to ODJFS-administered waivers" was rescinded in order to streamline the rules found in Division 5160 of the Administrative Code, and because it is obsolete and no longer serves a functional purpose. This rule provided the process for how eligible individuals enrolled on the former core-plus benefit were transitioned to ODM-administered waivers when the core-plus benefit was terminated in 2006.

Rule 5160-46-05, entitled "Ohio home care waiver program: calculation of the individual cost cap" sets forth the former policy and procedures related to the calculation of the individual cost cap for individuals enrolled in the Ohio Home Care Waiver. It has been rescinded because the purpose of, and process for, establishing an individual cost cap for an individual enrolling or enrolled in the Ohio Home Care Waiver are obsolete. The individual cost cap is now used to calculate both waiver and non-waiver costs and to assist with service planning. It is now calculated by Ohio Medicaid's case management information system based on the individual's unique service needs and it is adjusted by the designated case management agency as needs change. At no time are services based solely on the individual's cost cap.

Rule 5160-50-05, entitled "Transitions carve-out waiver program: calculation of the individual cost cap" sets forth the former policy and procedures related to the calculation of the individual cost cap for individuals enrolled in the Transitions Carve-Out Waiver. It has been rescinded because the purpose of, and process for, establishing an individual cost cap for an individual enrolling or enrolled in the Transitions Carve-Out Waiver are obsolete. The individual cost cap is now used to calculate both waiver and non-waiver costs and to assist with service planning. It is now calculated by Ohio Medicaid's case management information system based on the individual's unique service needs and it is adjusted by the designated case management agency as needs change. At no time are services based solely on the individual's cost cap.

Instructions:

Remove as Obsolete
5160-45-15 (effective 7/1/2006)
5160-46-05 (effective 2/15/2007)
5160-50-05 (effective 2/15/2007)

Web Pages:

ODM maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Long Term Care Services and Supports Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Medicaid

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

(614) 466-6742

LTCSSSTL 14-06 (Home and Community Based and Level-One Rules)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 14-06

June 19, 2014

TO: Ohio Association of County Boards
Ohio Developmental Disabilities Council
Ohio Provider Resource Association
Department of Developmental Disabilities (DODD)
Ohio Legal Rights Service
Advocacy and Protective Services

FROM: John B. McCarthy, Director
Office of Medical Assistance

SUBJECT: Home and Community Based and Level-One Rules

The Department of Medicaid (ODM) rules 5160-41-18 and 5160-41-19 of the Ohio Administrative Code are being proposed for rescission and adoption under the same number. The rules set forth the payment standards governing reimbursement for home and community based services (HCBS) administered by the Ohio Department of Developmental Disabilities (DODD).

5160-41-18 Individual options waiver-payment standards. The purpose of this rule is to establish the payment standards for the Individual Options home and community-based services (HCBS) waiver for services provided to individuals enrolled in a HCBS program, as a component of the medicaid program and as administered by the Department of Developmental Disabilities (DODD) in accordance with sections 5166.02 and 5166.23 of the Revised Code. This rule is being proposed for rescission and adoption under the same number.

5160-41-19 Level one waiver- payment standards.

The purpose of this rule is to establish the payment standards for the Level One home and community-based services (HCBS) waiver for services provided to individuals enrolled in a HCBS program, as a component of the medicaid program and as administered by the Department of Developmental Disabilities (DODD) in accordance with sections 5166.02 and 5166.23 of the Revised Code. This rule is being proposed for rescission and adoption under the same number.

Instructions:

Remove and File as Obsolete	Insert /Replacement
5160-41-18 (effective 03/19/2012)	<u>5160-41-18</u> (effective 07/01/2014)
5160-41-19 (effective 09/01/2013)	<u>5160-41-19</u> (effective 07/01/2014)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

At the "electronic manuals" web page, this LTCSSSTL and rules may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Community Access."

- (3) From the drop-down menu entitled "Table of Contents" at the top of the page, scroll to and select the desired LTCSSTL 14-06.
- (4) Scroll through the LTCSSTL 14-06 to the desired rule number highlighted in blue and select the rule number.

Questions:

Questions about this LTCSSTL should be addressed to:

Department of Medicaid

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTCSS@medicaid.ohio.gov

LTCSSSTL 14-05 (Amendment of [PASSPORT] Waiver Program Rule)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 14-05

June 19, 2014

TO: All Interested Parties
FROM: John B. McCarthy, Director
SUBJECT: Amendment of Pre-Admission Screening System Providing Options Today (PASSPORT) waiver program rule

The Ohio Department of Medicaid will amend the Ohio Administrative Code (OAC) rule dealing with pre-admission screening system providing options and resources today (PASSPORT) waiver program.

Rule [5160-31-06](#) entitled **Provider conditions of participation for the PASSPORT HCBS waiver program**, is being proposed for amendment to update references to the Ohio Revised Code and the Ohio Administrative Code resulting from the creation of the Ohio Department of Medicaid and the subsequent renumbering of the statutes and rules governing the Medicaid program. Other changes to the rule include the revising language requiring providers to first obtain certification to furnish PASSPORT services from ODA before obtaining a Medicaid provider agreement to provide PASSPORT waiver services.

Instructions:

Remove as Obsolete	Insert Replacement
5160-31-06 (effective 03/17/2011)	5160-31-06 (effective 07/01/2014)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Long-Term Care Services and Supports Transmittal Letter" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Medicaid

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTCSS@medicaid.ohio.gov

(614) 466-6742

LTCSSSTL 14-04 (HCPCS Updates to Administrative Rules 5160-1-60, 5160-2-21, 5160-4-22, 5160-21-02.3, and 5160-35-04)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 14-04

[Medicaid Handbook Transmittal Letter \(MHTL\) No. 3334-14-01](#)

[Hospital Handbook Transmittal Letter \(HHTL\) No. 3352-14-04](#)

March 28, 2014

TO: Eligible Non-Institutional Providers

Eligible Hospital Providers

Eligible Medicaid School Program Providers

Chief Executive Officers, Managed Care Plans

Directors, County Departments of Job and Family Services

Other Interested Parties

FROM: John B. McCarthy, Director of Medicaid

SUBJECT: HCPCS Updates to Administrative Rules 5160-1-60, 5160-2-21, 5160-4-22, 5160-21-02.3, and 5160-35-04

The federal Centers for Medicare and Medicaid Services, in conjunction with the American Medical Association and other professional groups, updates the Healthcare Common Procedure Coding System (HCPCS) annually. To the extent that HCPCS codes or descriptions are incorporated into the Ohio Administrative Code (OAC) governing the Medicaid program, changes made to HCPCS necessitate corresponding changes in OAC rules. Codes must be added, deleted, or revised, and maximum payment amounts and coverage policies must be established for new codes.

Changes are being made to the following rules, effective for dates of service January 1, 2014, or thereafter:

Rule [5160-1-60](#), "Medicaid reimbursement," sets forth payment policies for services furnished by professional providers.

Changes: In the appendix to this rule, new HCPCS codes are added, obsolete HCPCS codes are marked as discontinued, definitions are revised, and maximum payment amounts are established for new codes. No change is being made to the rule body itself.

Rule [5160-2-21](#), "Policies for outpatient hospital services," sets forth policies and payment rates for outpatient services delivered by hospitals that are subject to prospective payment based on diagnosis related groups (DRG).

Changes: In the appendices to this rule, new covered HCPCS codes are added, obsolete HCPCS codes are removed, and the fee schedules associated with the codes are updated. No change is being made to the rule body itself.

Rule [5160-4-22](#), "Surgical services," sets forth coverage and payment policies for surgical services delivered by physician providers.

Changes: In the appendix to this rule, new HCPCS codes are added, obsolete HCPCS codes are struck, definitions are revised, and updates are made to the schedule of surgical procedures that are subject to multiple-procedure, bilateral-procedure, or assistant-at-surgery fee adjustments. Within the body of this rule, references to the Ohio Department of Medicaid or to other Medicaid rules are modified to comport with the new agency name and designation in the Ohio Administrative Code.

Rule [5160-21-02.3](#), "Limited family planning benefit," sets forth payment policies for services that are covered under this benefit.

Changes: In the appendix to this rule, one new HCPCS code is added. Within the body of this rule, references to other Medicaid rules are modified to comport with the new agency designation in the Ohio Administrative Code.

Rule [5160-35-04](#), "Reimbursement for services provided by medicaid school program (MSP) providers," sets forth payment policies for services that are covered under this program.

Changes: In the appendix to this rule, four new HCPCS codes are added to replace one obsolete HCPCS code that is struck, and maximum payment amounts are established for the new codes. Within the body of this rule, references to the Ohio Department of Medicaid or to other Medicaid rules are modified to comport with the new agency name and designation in the Ohio Administrative Code, and citations of federal law are updated.

Access to Rules and Related Material

Information about the services and programs of the Ohio Department of Medicaid (ODM) may be accessed through the main ODM web page, <http://www.medicaid.ohio.gov/>.

Some information about provider payment is listed by provider type on the 'Fee Schedule and Rates' web page, which may be accessed through the main ODM web page (Providers > Fee Schedule and Rates).

The Ohio Department of Job and Family Services (ODJFS) maintains an "electronic manuals" web page of ODJFS and Medicaid rules, manuals, transmittal letters, forms, and handbooks. This "eManuals" web page may be accessed through the main ODM web page (Resources > Publications > eManuals) or directly at <http://emanuals.odjfs.state.oh.us/emanuals/>.

From the "eManuals" page, providers may view documents online by following these steps:

- (1) Select the 'Medicaid - Provider' collection.
- (2) Select the appropriate service provider type or handbook.
- (3) Select the desired document type.
- (4) Select the desired item from the 'Table of Contents' pull-down menu.

Current Medicaid maximum payment amounts for many professional services are listed in rule 5160-1-60 (formerly 5101:3-1-60) or in Appendix DD to that rule. Providers may view this information by following these steps:

- (1) Select the 'Medicaid - Provider' collection.
- (2) Select 'General Information for Medicaid Providers'.
- (3) Select 'General Information for Medicaid Providers (Rules)'.
- (4) Select the rule number and title from the 'Table of Contents' pull-down menu.
- (5) Scroll down and select the link to Appendix DD.

The Legal/Policy Central web site includes a calendar of documents that have recently been published, <http://www.odjfs.state.oh.us/lpc/calendar/>. It also displays a listing of ODJFS and Medicaid manual transmittal letters, <http://www.odjfs.state.oh.us/lpc/mtl/>, categorized by letter number and subject, with links to PDF copies of the documents.

To receive automatic electronic notification when new Medicaid transmittal letters are published, interested parties may sign up at <http://medicaid.ohio.gov/HOME/ODMEmailListSignup.aspx>.

Additional Information

Questions pertaining to this letter should be addressed to the Ohio Department of Medicaid.

Hospital services policy:

Bureau of Health Plan Policy, Hospital Services
P.O. Box 182709
Columbus, OH 43218-2709

(800) 686-1516

hospital_policy@medicaid.ohio.gov

Medicaid School Program policy:

Bureau of Long-Term Care Services and Support

P.O. Box 182709

Columbus, OH 43218-2709

bltcss@medicaid.ohio.gov

Other provider policy:

Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

(800) 686-1516

LTCSSSTL 14-03 (ODM-Administered Waiver Programs: Incident Management and Provider Monitoring and Oversight Rule Changes)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 14-03

March 20, 2014

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health and Addiction Services
Providers, ODM-Administered Home and Community-Based Services
Case Managers and Administrators, CareStar and CareSource
Statewide Provider Oversight Contractor, Public Consulting Group Inc. (PCG)
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Chairperson, Ohio Olmstead Task Force
President/CEO, Ohio Council for Home Care and Hospice
President/CEO, Midwest Care Alliance
Vice-President, SEIU District 1199, WV/KY/OH

FROM: John B. McCarthy, Director

SUBJECT: ODM-administered Waiver Programs: Incident Management and provider Monitoring and Oversight Rule Changes

The Ohio Department of Medicaid (ODM) recently created new Ohio Administrative Code (OAC) rules governing Ohio Department of Medicaid (ODM)-administered waiver service providers and ODM-administered waiver contractors. Specifically, new OAC rule [5160-45-05](#) governing incident management replaces the OAC rule 5160-45-05 that previously bore the same number. New OAC rule [5160-45-09](#) governing program compliance, monitoring and oversight replaces the OAC rule 5160-45-09 that previously bore that rule number.

Pursuant to proposed OAC rule 5160-45-05, ODM shall operate an incident management system that includes responsibilities for reporting, responding to, investigating and remediating incidents. The rule sets forth the standards and procedures for operating that system, and it applies to ODM, its designees, individuals and providers. ODM has the authority to designate other agencies or entities to perform one or more of the incident management functions set forth in the rule. Among other things, OAC rule 5160-45-05 establishes :

- That ODM and its designees must assure the health and welfare of individuals enrolled on an ODM-administered waiver. Further, ODM, its designees and providers are responsible for ensuring that individuals are protected from abuse, neglect, exploitation and other threats to their health, safety and well-being.
- That individuals shall receive a handbook at the time of waiver enrollment and at reassessment that includes information about how to report abuse, neglect, exploitation and other incidents.
- Those activities that are considered an incident and/or an alert in the ODM-administered waiver program.

- Incident reporter responsibilities including identification of those incidents that must be reported immediately.
- Case manager responsibilities upon learning of an incident, including ensuring the individual's health and welfare.
- ODM and its designee's responsibilities including incident investigation and follow-up.

ODM is responsible for the ongoing monitoring and oversight of all ODM-administered waiver service providers and all ODM-administered waiver contractors in order to assure providers' and contractors' compliance with ODM-administered waiver program requirements. OAC rule 5160-45-09 establishes:

- Guidelines for monitoring and oversight to be conducted by ODM and its designees, including the State's provider oversight contractor.
- Requirements with which providers and contractors must comply as part of the monitoring and oversight process.
- ODM sanctioning/enforcement authority.

Instructions:

Remove as Obsolete	Insert Replacement
5160-45-05 (effective 9/19/2009)	<u>5160-45-05</u> (effective 04/01/2014)
5160-45-09 (effective 8/13/2007)	<u>5160-45-09</u> (effective 04/01/2014)

Web Pages:

ODM maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans – Provider" (right column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Long Term Care Services and Supports Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Medicaid

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTCSS@medicaid.ohio.gov

(614) 466-6742

LTCSSSTL 14-02 (Amendment (PASSPORT) and (HCBS) waiver program rules)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 14-02

February 19, 2014

TO: All Interested Parties

FROM: John B. McCarthy, Director

SUBJECT: Amendment of Pre-Admission Screening System Providing Options Today (PASSPORT) and Choices Home and Community Based Services (HCBS) waiver program rules

The Ohio Department of Medicaid will amend the Ohio Administrative Code (OAC) rules dealing with pre-admission screening system providing options and resources today (PASSPORT) and Choices home and community-based services waivers (HCBS) programs.

Rule [5160-1-06.1](#) entitled **Home and community-based services waivers: PASSPORT**, is being proposed for amendment to add services and rates to the PASSPORT waiver. These rates are to be effective on March 1, 2014. The rule is also proposed for amendment to update Ohio Administrative Code citations.

Rule [5160-31-02](#) entitled **PASSPORT HCBS waiver program definitions**, is being proposed for amendment to update references to the Ohio Revised Code and the Ohio Administrative Code resulting from the creation of the Ohio Department of Medicaid and the subsequent renumbering of the statutes and rules governing the Medicaid program. Other changes to the rule include the addition of new definitions and revisions to the terminology used throughout this rule chapter

Rule [5160-31-03](#) entitled **Eligibility for enrollment in the PASSPORT HCBS waiver program**, is being proposed for amendment to update references to the Ohio Revised Code and the Ohio Administrative Code resulting from the creation of the Ohio Department of Medicaid and the subsequent renumbering of the statutes and rules governing the Medicaid program. Other changes to the rule include revisions to the terminology used throughout this rule chapter.

Rule [5160-31-04](#) entitled **Enrollment process for the pre-admission screening system providing options and resources today (PASSPORT) HCBS waiver program**, is being proposed for amendment to update references to the Ohio Revised Code and the Ohio Administrative Code resulting from the creation of the Ohio Department of Medicaid and the subsequent renumbering of the statutes and rules governing the Medicaid program. Other changes to the rule include revisions to the terminology used throughout this rule chapter.

Rule [5160-31-05](#) entitled **PASSPORT HCBS waiver program covered services**, is being proposed for amendment to update references to the Ohio Revised Code and the Ohio Administrative Code resulting from the creation of the Ohio Department of Medicaid and the subsequent renumbering of the statutes and rules governing the Medicaid program. Other changes to the rule include revisions to terminology, the addition of new services to PASSPORT and reordering the list of approved PASSPORT services, and adding language pertaining to the availability of participant-directed services.

Rule [5160-31-07](#) entitled **PASSPORT HCBS waiver program rate setting**, is being proposed for rescission and a new rule 5160-31-07 will take its place that makes revisions to the rate setting language to improve readability. This new rule includes updates to Ohio Revised Code and the Ohio Administrative Code references that resulting from the creation of the Ohio Department of Medicaid and the subsequent renumbering of the statutes and rules governing the Medicaid program. Other changes to the rule include revisions to terminology, the addition of new services to PASSPORT, and adding language pertaining to the availability of participant-directed services.

Rule [5160-32-06](#) entitled **Enrollment process for choices home and community based services (HCBS) waiver program**, is being proposed for amendment to add language indicating that effective March 1, 2014 the Choices program will be closed to new enrollments.

Instructions:

Remove as Obsolete	Insert Replacement
5160-1-06.1 (effective 10/01/2013)	5160-1-06.1 (effective 03/01/2014)
5160-31-02 (effective 09/29/2011)	5160-31-02 (effective 03/06/2014)
5160-31-03 (effective 03/17/2011)	5160-31-03 (effective 03/01/2014)
5160-31-04 (effective 09/29/2011)	5160-31-04 (effective 03/06/2014)
5160-31-05 (effective 03/17/2011)	5160-31-05 (effective 03/01/2014)
5160-31-07 (effective 09/29/2011)	5160-31-07 (effective 03/01/2014)
5160-32-06 (effective 09/29/2011)	5160-32-06 (effective 03/01/2014)

Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Long-Term Care Services and Supports Transmittal Letter" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Medicaid

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTCSS@medicaid.ohio.gov

(614) 466-6742

LTCSSSTL 14-01 (New Prior Authorization Process Affecting Home Health Services for Individuals Age 21 and Over)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 14-01

[Medical Assistance Letter \(MAL\) 590](#)

January 15, 2014

TO: Interested Home Health Stakeholders

FROM: John B. McCarthy, Director

SUBJECT: New Prior Authorization Process Affecting Home Health Services for Individuals Age 21 and Over

The following applies only to Medicaid fee-for-service enrollees. It does not apply to individuals enrolled on Medicaid managed care plans.

Due to recent guidance from the Centers for Medicare and Medicaid Services (CMS), the Ohio Department of Medicaid (ODM) will now provide for a prior authorization review of home health services for individuals age 21 and over whose physician has determined that **medical necessity exists for more home health services than what is currently available.**

The new prior authorization process is effective immediately.

If you are a Medicare-certified home health care agency seeking prior authorization for more home health services than what is currently available, see the chart below for the entity responsible for the medical-necessity review:

Enrollment Type		Entity Responsible for Medical Necessity Review for Prior Authorization	Special Billing Instructions
Fee-For-Service		Permedion *	Bill with the appropriate prior authorization number
Sister-Agency Administered Waivers	Assisted Living, Choices, PASSPORT, Individual Options, Level One, Self-Empowered Life Funding (SELF) and Transitions Developmental Disabilities (TDD) waivers	Permedion *	Bill with the appropriate prior authorization number
ODM-Administered Waivers	Ohio Home Care and Transitions Carve-Out waivers	Appropriate ODM waiver case management agency	Bill with the new U7 modifier

* A request form with instructions for completion can be found on Permedion's website at www.hmspermedion.com/oh-medicaid. Please fax the completed form to the fax number on the form.

LTCSSSTL 13-10 (OHC, Transitions DD and Transitions Carve-Out Waiver Programs: Criminal Records Checks Involving Agency Providers)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 13-10

December 18, 2013

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health and Addiction Services
Providers, ODM-Administered Home and Community-Based Services
Case Managers and Administrators, CareStar and CareSource
Statewide Provider Oversight Contractor, Public Consulting Group Inc. (PCG)
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Chairperson, Ohio Olmstead Task Force
President/CEO, Ohio Council for Home Care and Hospice
President/CEO, Midwest Care Alliance
Vice-President, SEIU District 1199, WV/KY/OH

FROM: John B. McCarthy, Director

SUBJECT: Ohio Home Care Waiver, Transitions DD Waiver and Transitions Carve-Out Waiver Programs: Criminal Records Checks Involving Agency Providers

Pursuant to Amended Substitute H.B. 59 of the 130th General Assembly, the Ohio Department of Medicaid (ODM) amended Ohio Administrative Code (OAC) rule 5101:3-45-07 governing criminal record checks for agency providers of Ohio Home Care, Transitions DD and Transitions Carve-Out Waiver services. This rule is effective January 1, 2014.

OAC Rule 5101:3-45-07, Ohio Home Care Waiver, Transitions DD Waiver and Transitions Carve-Out Waiver Programs: Criminal Records Checks Involving Agency Providers

OAC rule [5101:3-45-07](#) is being amended to:

- Make the results of the criminal records check available to the individual who receives, or may receive, waiver services from the person who is the subject of the criminal records check. This language was added to the budget bill in order to be consistent with statute, administrative policy and practice regarding independent providers of Ohio Home Care, Transitions DD and Transitions Carve-Out Waiver services.
- Reflect the establishment of the Ohio Department of Medicaid.

Instructions:

Remove as Obsolete	Insert Replacement
5101:3-45-07 (effective 1/1/13)	5101:3-45-07 (effective 1/1/2014)

Web Pages:

ODM maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Long Term Care Services and Supports Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSTL should be addressed to:

Ohio Department of Medicaid

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTCSS@medicaid.ohio.gov

(614) 466-6742

LTCSSSTL 13-09 (Amendment of Medicaid Mental Health and Alcohol and Drug Treatment Service Program Rule)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 13-09

November 18, 2013

TO: All Interested Parties
FROM: John B. McCarthy, Director
SUBJECT: Amendment of Medicaid mental health and alcohol and drug treatment service program rule

The Ohio Department of Medicaid will amend the Ohio Administrative Code (OAC) rule dealing with mental health and alcohol and drug treatment services.

Rule 5101:3-30-04 entitled **Reimbursement for community medicaid alcohol and other drug treatment services**. This rule sets forth the reimbursement methodology for Medicaid covered Ohio Department of Mental Health and Addiction Services alcohol and drug treatment services. The rule is being amended to add an appendix listing the current rates for these services.

Instructions:

Remove as Obsolete	Insert Replacement
5101:3-30-04 (effective 09/29/2011)	5101:3-30-04 (effective 11/10/2013)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Long-Term Care Services and Supports Transmittal Letter" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Medicaid

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTCSS@jfs.ohio.gov

LTCSSSTL 13-08 (Changes to Hospital Exemption Policy Due to Am. Sub. H.B. No. 59)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 13-08

October 23, 2013

TO: All Interested Parties
FROM: John B. McCarthy, Director
SUBJECT: Changes to Hospital Exemption policy due to Am. Sub. H.B. No. 59

The Ohio Department of Medicaid (ODM) is in the process of amending Ohio Administrative Code (OAC) rules pertaining to the preadmission screening and resident review (PASRR) process in order to modify the hospital exemption policy. The changes to the hospital exemption policy are required in order to implement statutory changes made by Am. Sub. H.B. No. 59, which becomes effective September 29, 2013. The proposed PASRR rule amendments are scheduled to take effect on February 1, 2014. ODM is issuing this transmittal to communicate the statutory changes to the hospital exemption policy that take effect before the PASRR rule amendments will become effective.

Section 5119.40 of the Revised Code requires that a preadmission screening (PAS) be completed for certain individuals who previously were eligible for a hospital exemption from this process. This new PAS requirement applies to individuals who are being transferred or directly admitted to a nursing facility from a hospital that is either of the following:

1. A hospital that the Ohio Department of Mental Health and Addiction Services (OhioMHAS) maintains, operates, manages, and governs under section 5119.14 of the Revised Code for the care and treatment of mentally ill persons; or
2. A free-standing hospital, or unit of a hospital, licensed by OhioMHAS under section 5119.33 of the Revised Code.

Therefore, individuals who are being discharged from a hospital or unit as described above, who are seeking nursing facility admission, will be subject to a PAS and will no longer be permitted a hospital exemption from the PAS process.

The PASRR rules that will be amended are:

- Rule 5101:3-3-14, entitled Preadmission screening (PAS) and resident review (RR) definitions.
- Rule 5101:3-3-15.1, entitled Preadmission screening (PAS) requirements for individuals seeking admission to nursing facilities (NFs).

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Community Access" (right column).
- (3) Select "Long-Term Care Services and Supports Transmittal Letter" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Medicaid

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTCSS@medicaid.ohio.gov

LTCSSSTL 13-07 (Amendment of PASSPORT, Assisted Living, Choices HCBS Waiver Program Rules)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 13-07

September 20, 2013

TO: All Interested Parties
FROM: John B. McCarthy, Director
SUBJECT: Amendment of Pre-Admission Screening System Providing Options Today (PASSPORT), Assisted Living, Choices Home and Community Based Services (HCBS) waiver program rules

The Ohio Department of Medicaid will amend the Ohio Administrative Code (OAC) rules dealing with pre-admission screening system providing options and resources today (PASSPORT), Assisted Living, and Choices home and community-based services waivers (HCBS) program. They will be effective on September 27, 2013. These rules are being amended to implement language in HB 59 (130th GA) and to support non-institutional home and community based services.

Rule [5101:3-1-06.1](#) entitled **Home and community-based services waivers: PASSPORT**. This rule sets forth PASSPORT HCBS waiver services and program eligibility criteria. This rule is being amended to increase rates for PASSPORT waiver providers and to establish the effective date of those rates.

Rule [5101:3-1-06.4](#) entitled **Home and community-based services waivers: Choices**. This rule sets forth Choices HCBS waiver services and program eligibility criteria. This rule is being amended to increase rates for Choices waiver providers and to establish the effective date of those rates.

Rule [5101:3-1-06.5](#) entitled **Home and community-based services waivers: Assisted Living**.

This rule sets forth assisted living HCBS waiver services and program eligibility criteria. This rule is being amended to increase rates for providers of assisted living services and to establish the effective date of those rates.

Instructions:

Remove as Obsolete	Insert Replacement
5101:3-1-06.1 (effective 07/01/2013)	5101:3-1-06.1 (effective 9/27/2013)
5101:3-1-06.4 (effective 07/01/2013)	5101:3-1-06.4 (effective 9/27/2013)
5101:3-1-06.5 (effective 07/01/2013)	5101:3-1-06.5 (effective 9/27/2013)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Long-Term Care Services and Supports Transmittal Letter" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Medicaid

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTCSS@jfs.ohio.gov

(614) 466-6742

LTCSSSTL 13-06 (Level One Waiver Rules)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 13-06

August 15, 2013

TO: Ohio Association of County Boards
Ohio Developmental Disabilities Council
Ohio Provider Resource Association
Department of Developmental Disabilities (DODD)
Ohio Legal Rights Service
Advocacy and Protective Services

FROM: John B. McCarthy, Director
Office of Medical Assistance

SUBJECT: Level One Waiver Rules

The Ohio Department of Medicaid (ODM) rules 5101:3-41-19 and 5101:3-42-01 of the Ohio Administrative Code are being proposed for amendment. Rule 5101:3-41-19 sets forth the payment standards governing reimbursement for home and community-based services provided by certified or licensed waiver providers to individuals enrolled in the Level One waiver program. Rule 5101:3-42-01 establishes the Level One waiver as a component of the Medicaid Home and Community-Based Services program (HCBS) pursuant to sections 5111.85 and 5111.87 of the Revised Code.

Rule 5101:3-41-19 Level one waiver-payment standards.

The purpose of this rule is to set forth the payment standards governing reimbursement for home and community-based services provided by certified or licensed waiver providers to individuals enrolled in the Level One waiver program.

Rule 5101:3-42-01 Medicaid home and community-based services program - level one waiver. This rule establishes the Level One waiver as a component of the Medicaid Home and Community-Based Services program (HCBS) pursuant to sections 5111.85 and 5111.87 of the Revised Code.

Instructions:

Remove and File as Obsolete	Insert /Replacement
5101:3-41-19 (effective 03/19/2012)	<u>5101:3-41-19</u> (effective 09/01/2013)
5101:3-42-01 (effective 09/15/2011)	<u>5101:3-42-01</u> (effective 09/01/2013)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

At the "electronic manuals" web page, this LTCSSSTL and rules may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Community Access."
- (3) From the drop-down menu entitled "Table of Contents" at the top of the page, scroll to and select the desired LTCSSSTL 13-06.
- (4) Scroll through the LTCSSSTL 13-06 to the desired rule number highlighted in blue and select the rule number.

Questions:

Questions about this LTCSSTL should be addressed to:

Ohio Department of Medicaid

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTCSS@medicaid.ohio.gov

LTCSSSTL 13-05 (Amendment of Pre-Admission Screening System Providing Options Today (PASSPORT), Assisted Living, Choices Home and Community Based Services (HCBS) waiver program rules)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 13-05

July 5, 2013

TO: All Interested Parties
FROM: John B. McCarthy, Director
SUBJECT: Amendment of Pre-Admission Screening System Providing Options Today (PASSPORT), Assisted Living, Choices Home and Community Based Services (HCBS) waiver program rules

The Ohio Office of Medical Assistance will amend the Ohio Administrative Code (OAC) rules dealing with pre-admission screening system providing options and resources today (PASSPORT), Assisted Living, and Choices home and community-based services waivers (HCBS) program. They will be effective on 7/1/13. These rules are being amended to implement language in HB 59 (130th GA) and to support non-institutional home and community based services.

Rule [5101:3-1-06.1](#) entitled **Home and community-based services waivers: PASSPORT**. This rule sets forth PASSPORT HCBS waiver services and program eligibility criteria. This rule is being amended to increase rates for PASSPORT waiver providers and to establish the effective date of those rates.

Rule [5101:3-1-06.4](#) entitled **Home and community-based services waivers: Choices**. This rule sets forth Choices HCBS waiver services and program eligibility criteria. This rule is being amended to increase rates for Choices waiver providers and to establish the effective date of those rates.

Rule [5101:3-1-06.5](#) entitled **Home and community-based services waivers: Assisted Living**.

This rule sets forth assisted living HCBS waiver services and program eligibility criteria. This rule is being amended to increase rates for providers of assisted living services and to establish the effective date of those rates.

Instructions:

Remove as Obsolete	Insert Replacement
5101:3-1-06.1 (effective 09/29/2011)	5101:3-1-06.1 (effective 7/01/2013)
5101:3-1-06.4 (effective 09/29/2011)	5101:3-1-06.4 (effective 7/01/2013)
5101:3-1-06.5 (effective 09/29/2011)	5101:3-1-06.5 (effective 7/01/2013)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Long-Term Care Services and Supports Transmittal Letter" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:
Ohio Office of Medical Assistance
Bureau of Long Term Care Services and Supports

P.O. Box 182709
Columbus, Ohio 43218-2709
BLTCSS@jfs.ohio.gov
(614) 466-6742

LTCSSSTL 13-04 (Medicaid School Program (MSP) Reimbursement Rule)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 13-04

March 20, 2013

TO: All Interested Parties
FROM: John B. McCarthy, Director
Office of Medical Assistance
SUBJECT: Medicaid School Program (MSP) Reimbursement Rule

The Office of Medical Assistance (OMA) has amended Ohio Administrative Code (OAC) rule [5101:3-35-04](#). The rule sets forth the provisions for claiming to receive Medicaid reimbursement for the provision of services by Medicaid School Program (MSP) providers. No changes are being made to the rule body. However, the appendix to this rule is being amended to add new Healthcare Common Procedure Coding System (HCPCS) codes, delete obsolete HCPCS codes, and update reimbursement amounts associated with the codes.

Instructions:

Remove and File as Obsolete	Insert /Replacement
5101:3-35-04 (effective 10/15/2009)	5101:3-35-04 (effective 03/28/2013)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

At the "electronic manuals" web page, this LTCSSSTL may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Community Access."
- (3) Select "Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) "
- (3) Click on the down arrow next to the "Table of Contents" drop-down menu at the top of the page
- (4) Scroll to LTCSSSTL xx-xx and select the desired transmittal letter

Questions:

Questions about this LTCSSSTL should be addressed to:

Office of Medical Assistance

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTCSS@jfs.ohio.gov

LTCSSSTL 13-03 (Prior Authorization - Home and Community-Based Service Rule)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 13-03

January 4, 2012

TO: Ohio Association of County Boards
Ohio Developmental Disabilities Council
Ohio Provider Resource Association
Department of Developmental Disabilities (DODD)
Ohio Legal Rights Service
Advocacy and Protective Services

FROM: John B. McCarthy, Director
Office of Medical Assistance

SUBJECT: Prior Authorization - Home and Community-Based Service Rule

The Office of Medical Assistance (OMA) rule [5101:3-41-12](#) of the Ohio Administrative Code is being enacted to replace rescinded rule 5101:3-41-12 of the Ohio Administrative Code. The rule authorizes the process for the prior authorization of waiver services when an individual's funding level exceeds the funding range determined by the Ohio developmental disabilities profile (ODDP) for individuals enrolled in the individual options waiver.

Rule 5101:3-41-12 Prior authorization requirements for waiver services administered by the Ohio department of mental retardation and developmental disabilities. This rule is to establish standards and procedures for prior authorization of waiver services when the individual funding level exceeds the funding range determined by the Ohio developmental disabilities profile (ODDP) for medicaid waiver services administered pursuant to section 5111.871 of the Revised Code. The procedures set forth in this rule shall not apply to services administered as part of the "Level One" waiver authorized by rule 5101:3-42-01 of the Administrative Code. This rule is being proposed for rescission.

Rule 5101:3-41-12 Home and community-based services waivers - request for prior authorization for individuals enrolled in the individual options waiver. This rule is to authorize the process for the prior authorization of waiver services when an individual's funding level exceeds the funding range determined by the Ohio developmental disabilities profile (ODDP) for individuals enrolled in the individual options waiver, as is a component of the Medicaid program, and as is administered by the Ohio Department of Developmental Disabilities (DODD). This rule is being proposed for adoption.

Instructions:

Remove and File as Obsolete	Insert /Replacement
5101:3-41-12 (effective 07/01/2005)	5101:3-41-12 (effective 01/17/2013)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

At the "electronic manuals" web page, this LTCSSSTL and rules may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Community Access."
- (3) From the drop-down menu entitled "Table of Contents" at the top of the page, scroll to and select the desired LTCSSSTL 13-03.

- (4) Scroll through the LTCSSSTL 13-03 to the desired rule number highlighted in blue and select the rule number.

Questions:

Questions about this LTCSSSTL should be addressed to:

Office of Medical Assistance

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTCSS@jfs.ohio.gov

LTCSSSTL 13-02 (Transitions Developmental Disabilities- Home and Community Based Rules)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 13-02

January 4, 2012

TO: Ohio Association of County Boards
Ohio Developmental Disabilities Council
Ohio Provider Resource Association
Department of Developmental Disabilities (DODD)
Ohio Legal Rights Service
Advocacy and Protective Services

FROM: John B. McCarthy, Director
Office of Medical Assistance

SUBJECT: Transitions Developmental Disabilities- Home and Community Based Rules

The Office of Medical Assistance (OMA) rules 5101:3-47-02, 5101:3-47-02.1, 5101:3-47-04, 5101:3-47-05 and 5101:3-47-06 of the Ohio Administrative Code are being rescinded. Proposed rules 5101:3-41-21 and 5101:3-41-22 are being adopted. The rules in Chapter 5101:3-47 of the OAC establish the service requirements, provider qualifications, and the administrative responsibilities of the waiver program. Rules 5101:3-41-21 and 5101:3-41-22 set forth the payment and program standards of the Transitions Developmental Disabilities waiver, a component of the Medicaid program administered by the Ohio Department of Developmental Disabilities (DODD).

Rule 5101:3-41-21 Medicaid home and community-based services program-transitions developmental disabilities waiver. The purpose of this rule is to authorize rules governing the transitions developmental disabilities waiver, a component of the medicaid home and community-based services program pursuant to sections 5111.85 and 5111.87 of the Revised Code.

Rule 5101:3-41-22 Transitions developmental disabilities - payment standards. This rule sets forth the definitions of terms used for billing and calculating rates of the Transitions Developmental Disabilities waiver.

Rule 5101:3-47-02 Transitions MR/DD waiver consumer eligibility for enrollment.

The purpose of this rule is to define how individuals become eligible and maintain eligibility for the Transitions Developmental Disabilities waiver.

Rule 5101:3-47-02.1 Transitions MR/DD waiver: eligibility criteria for time-limited Enrollment of HOME choice (Helping Ohioans Move, Expanding Choice) demonstration program participants. The purpose of this rule is to set forth the eligibility criteria when an individual is enrolled on the Home choice program.

Rule 5101:3-47-04 Transitions DD waiver: definitions of the covered services and provider requirements and specifications. The purpose of this rule is to set forth the definitions of services covered by the Transitions Developmental and Disabilities waiver and provider requirements and specifications for the delivery of Transitions Developmental Disabilities waiver services.

Rule 5101:3-47-05 Transitions MR/DD waiver program: calculation of individual cost cap. The purpose of this rule is to set forth the calculation of the individual cost cap for individuals enrolled on the Transitions Developmental Disabilities waiver program.

Rule 5101:3-47-06 Transitions DD waiver program: reimbursement rates and billing procedures. The purpose of this rule is to define the terms used for billing and calculating rates for services under the Transitions Developmental Disabilities waiver program.

Instructions:

Remove and File as Obsolete	Insert /Replacement
5101:3-47-02 (effective 07/01/2006)	5101:3-41-21 (effective 01/01/2013)
5101:3-47-02.1 (effective 07/01/2006)	5101:3-41-22 (effective 01/01/2013)
5101:3-47-04 (effective 07/01/2010)	
5101:3-47-05 (effective 02/15/2007)	
5101:3-47-06 (effective 10/01/2011)	

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

At the "electronic manuals" web page, this LTCSSSTL and rules may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Community Access."
- (3) From the drop-down menu entitled "Table of Contents" at the top of the page, scroll to and select the desired LTCSSSTL 13-02.
- (4) Scroll through the LTCSSSTL 13-02 to the desired rule number highlighted in blue and select the rule number.

Questions:

Questions about this LTCSSSTL should be addressed to:

Office of Medical Assistance
 Bureau of Long Term Care Services and Supports
 P.O. Box 182709
 Columbus, Ohio 43218-2709
BLTCSS@jfs.ohio.gov

LTCSSSTL 13-01 (Office of Medical Assistance-Administered Waiver Program: Criminal Records Checks Involving Agency and Independent Providers, and Exclusionary Periods for Disqualifying Offenses, Certificates and Pardons)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 13-01

January 2, 2013

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health
Providers, OMA-Administered Home and Community-Based Services
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Chairperson, Ohio Olmstead Task Force
President/CEO, Ohio Council for Home Care and Hospice
President/CEO, Midwest Care Alliance
Vice-President, SEIU District 1199, WV/KY/OH

FROM: John B. McCarthy, Director

SUBJECT: Office of Medical Assistance-administered Waiver Program: Criminal Records Checks Involving Agency and Independent Providers, and Exclusionary Periods for Disqualifying Offenses, Certificates and Pardons

Pursuant to Amended Substitute H.B. 487 of the 129th General Assembly, the Office of Medical Assistance (OMA) adopted new Ohio Administrative Code (OAC) rules governing criminal record checks for agency and independent providers of Ohio Home Care, Transitions DD and Transitions Carve-Out Waiver services. Part of an interagency effort coordinated by the Governor's Office of Health Transformation, these rules are effective January 1, 2013.

OAC Rule [5101:3-45-07](#), Ohio Home Care Waiver, Transitions DD Waiver and Transitions Carve-Out Waiver Programs: Criminal Records Checks Involving Agency Providers

OAC Rule 5101:3-45-07 was rescinded and replaced with a new OAC Rule 5101:3-45-07. Like the rule it replaced, the new rule sets forth the criminal records check requirements for agency providers of HCBS under the Ohio Home Care, Transitions DD and Transitions Carve-Out Waiver Programs. The rule:

- Establishes key definitions including, but not limited to: "applicant," "chief administrator," "community-based long term care agency," "disqualifying offense," "employee," "home and community-based services Medicaid waiver component" and "waiver agency."
- Establishes a required review of various free databases for disqualifying information regarding an applicant or employee prior to conducting a criminal record check of an applicant or employee.
- Exempts from database reviews and criminal record checks those individuals who are subject to criminal record check requirements in accordance with section 3701.881 or section 173.394 of the Revised Code.

- Phases-in of required criminal records rechecks every five years. Employees hired prior to January 1, 2008 will be rechecked within 30 days of the anniversary of their date of hire, and employees hired on or after January 1, 2008 will be rechecked within 30 days of the five-year anniversary of their date of hire.
- Requires a fee to be paid by the waiver agency, which may be passed on to the applicant or employee.
- Allows for an individual's conditional employment for a period of 60 days while the waiver agency awaits the results of the criminal records check. The rule requires the waiver agency to terminate an individual if the results are not received within 60 days of the request or, if the results disclose a disqualifying offense and the waiver agency does not choose to employ the individual after the exclusionary periods set forth in OAC Rule 5101:3-45-11 have elapsed.
- Establishes that a waiver agency may continue to employ an individual who has been convicted of, or pleaded guilty to, a Tier IV disqualifying offense only if that individual was hired prior to January 1, 2013 and the conviction or guilty plea was prior to January 1, 2013. The waiver agency must consider the nature and seriousness of the offense(s) and attest, in writing prior to April 1, 2013, that it has weighed the character and fitness of the employee through the employee's work performance. The written attestation must be maintained in the employee's personnel records.
- Establishes recordkeeping requirements pertaining to the criminal records check.
- Sets forth to whom the records check may be disclosed.

OAC Rule 5101:3-45-08, Ohio Home Care Waiver, Transitions DD Waiver and Transitions Carve-Out Waiver Programs: Criminal Records Checks Involving Independent Providers

OAC Rule 5101:3-45-08 was rescinded and replaced with a new OAC Rule 5101:3-45-08. Like the rule it replaced, the new rule sets forth the criminal records check requirements for independent providers of HCBS under the Ohio Home Care, Transitions DD and Transitions Carve-Out Waiver Programs. The rule:

- Establishes key definitions including, but not limited to: "anniversary date," "applicant," "disqualifying offense," "effective date of provider agreement," "home and community-based services Medicaid waiver component" and "independent provider."
- Requires criminal records rechecks annually for all independent providers.
- Requires a fee to be paid by the independent provider.
- Establishes recordkeeping requirements pertaining to the criminal records check.
- Sets forth to whom the records check may be disclosed.

(Please note that the database check for independent providers is already required as part of the provider enrollment process set forth in OAC Rule 5101:3-45-04.)

OAC Rule 5101:3-45-11, Ohio Home Care Waiver, Transitions DD Waiver and Transitions Carve-Out Waiver Programs: Exclusionary Periods for Disqualifying Offenses; Certificates; and Pardons

The personal character standards set forth in OAC Rules 5101:3-45-07 and 5101:3-45-08 have been replaced by a new rule, OAC Rule 5101:3-45-11, which sets forth a tiered system of exclusionary periods for disqualifying offenses. The periods range from five years to permanent exclusion depending upon the type and number of offenses. The rule also sets forth policy regarding pardons, and under which certain individuals can obtain a Certificate of Qualification for Employment issued by a court of common pleas with competent jurisdiction pursuant to Section 2953.25 of the Revised Code; or a Certificate of Achievement and Employability in an HCBS-related field, issued by the Ohio Department of Rehabilitation and Corrections pursuant to Section 2961.22 of the Revised Code.

Instructions:

Remove as Obsolete

Insert Replacement

5101:3-45-07 (effective 12/10/09)	5101:3-45-07 (effective 1/1/2013)
5101:3-45-08 (effective 12/10/09)	5101:3-45-08 (effective 1/1/2013)
	5101:3-45-11 (effective 1/1/2013)

Web Pages:

OMA maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Long Term Care Services and Supports Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSTL should be addressed to:

Office of Medical Assistance

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTCSS@jfs.ohio.gov

(614) 466-6742

LTCSSSTL 12-08 (Medicaid Covered Behavioral Health Services Rules)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 12-08

October 2, 2012

TO: Director, Ohio Department of Mental Health
Directors, County Departments of Job and Family Services
Director, Ohio Department of Alcohol and Drug Addiction Services

FROM: John B. McCarthy, Director
Office of Medical Assistance

SUBJECT: Medicaid covered behavioral health services rules

The Ohio Department of Job and Family Services (ODJFS) rules [5101:3-27-02](#), [5101:3-27-05](#), [5101:3-30-02](#), and [5101:3-30-04](#) of the Ohio Administrative Code are being amended to include revisions related to the provision, by eligible behavioral health providers, of specific medications which will be reimbursable by Medicaid. In addition rules 5101:3-27-02 and 5101:3-27-05 include revisions concerning the health home services project. All revisions are set to become effective October 1, 2012.

Rule [5101:3-27-02](#) entitled Coverage and limitation of Medicaid community mental health services, has been amended for final filing to include new language and an appendix listing medications that may be rendered by eligible mental health providers and reimbursed by Medicaid. Additional revisions describe health home services as defined by the Ohio Department of Mental Health and covered by Medicaid when rendered by eligible providers.

Rule [5101:3-27-05](#) entitled Reimbursement for community mental health Medicaid services, has been amended to describe the reimbursement methodology for the medications listed in the appendix to rule 5101:3-27-02. In addition, revisions describe the reimbursement methodology for health home services.

Rule [5101: 3-30-02](#) entitled Coverage and limitation policies for alcohol and other drug treatment services, has been rescinded and proposed new to update the rule to reflect current rule terminology and rule references. Inclusion of a new appendix lists specific drugs that can be rendered by substance abuse treatment providers and reimbursed by Medicaid.

Rule [5101: 3-30-04](#) entitled Reimbursement for community Medicaid alcohol and other drug treatment services, has been amended to describe the reimbursement methodology for the medications listed in the appendix to rule 5101:3-30-02.

Instructions:

Remove as Obsolete	Insert Replacement
5101:3-27-02 (effective 01/30/2012)	5101:3-27-02 (effective 10/01/2012)
5101:3-27-05 (effective 09/29/2011)	5101:3-27-05 (effective 10/01/2012)
5101:3-30-02 (effective 09/30/1991)	5101:3-30-02 (effective 10/01/2012)
5101:3-30-04 (effective 01/30/2012)	5101:3-30-04 (effective 10/01/2012)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Community Access" (left column).
- (3) Select "Long-Term Care Service and Supports Transmittal Letters" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTSS@jfs.ohio.gov

(614) 466-6742

LTCSSSTL 12-07 (Home and Community-Based Service Rule)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 12-07

August 29, 2012

TO: Ohio Association of County Boards
Ohio Developmental Disabilities Council
Ohio Provider Resource Association
Department of Developmental Disabilities (DODD)
Ohio Legal Rights Service
Advocacy and Protective Services

FROM: Michael B. Colbert, Director

SUBJECT: Home and Community-based service rule

The Ohio Department of Job and Family Services (ODJFS) rule 5101:3-41-15 of the Ohio Administrative Code is being enacted to replace rescinded rule 5101:3-41-15 of the Ohio Administrative Code. The rule establishes the payment standards governing reimbursement for various home and community-based services administered by the Ohio Department of Developmental Disabilities (DODD).

Rule 5101:3-41-15 Home and community based waiver services - reimbursement for adult day support, vocational habilitation, supported employment- enclave, supported employment-community, supported employment adaptive equipment and non-medical transportation to access one or more of these services administered by the Ohio department of mental retardation and developmental disabilities. This rule establishes the payment standards governing reimbursement for adult day support, vocational habilitation, supported employment-enclave, supported employment - community, supported employment adaptive equipment and non-medical transportation to access one or more of these services as components of the Medicaid program and as administered by the Ohio Department of Developmental Disabilities (DODD) in accordance with sections 5111.85 and 5111.873 of the Revised Code.

This rule is being proposed for rescission.

Rule 5101:3-41-15 Home and community based waiver services-reimbursement for adult day services as administered by the department of developmental disabilities. This rule establishes the payment standards governing reimbursement for adult day support, vocational habilitation, supported employment-enclave, supported employment- community, supported employment adapted equipment and non-medical transportation to access one or more of these services as components of the Medicaid program and as administered by the Ohio Department of Developmental Disabilities (DODD) in accordance with sections 5111.85 and 5111.873 of the Revised Code. This rule is replacing the rescinded rule of the same number.

Instructions:

Remove and File as Obsolete	Insert /Replacement
5101:3-41-15 (effective 07/01/2007)	<u>5101:3-41-15</u> (effective 09/15/2012)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

At the "electronic manuals" web page, this LTCSSSTL and rules may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Community Access."

- (3) From the drop-down menu entitled "Table of Contents" at the top of the page, scroll to and select the desired LTCSSTL 12-07.
- (4) Scroll through the LTCSSTL 12-07 to the desired rule number highlighted in blue and select the rule number.

Questions:

Questions about this LTCSSTL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTCSS@jfs.ohio.gov

LTCSSSTL 12-06 (Medicaid Covered Behavioral Health Services Rules)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 12-06

June 27, 2012

TO: Director, Ohio Department of Mental Health
Directors, County Departments of Job and Family Services
Director, Ohio Department of Alcohol and Drug Addiction Services

FROM: Michael B. Colbert, Director

SUBJECT: Medicaid covered behavioral health services rules

The Ohio Department of Job and Family Services (ODJFS) rules [5101:3-27-01](#) and [5101: 3-30-01](#) of the Ohio Administrative Code are being amended to include revisions related to the ODMH/ODADAS claims integration project set to become effective July 1, 2012. These two rules, along with [5101:3-30-03](#) are being amended to include necessary revisions to update the rules.

Rule [5101:3-27-01](#) entitled Eligible providers for community mental health services, is being proposed for amendment to limit the requirement that providers must contract with a community mental health board to only those services rendered prior to July 1, 2012. Additional amendments are included to update the rule as needed.

Rule [5101:3-30-01](#) entitled Eligible provider for alcohol and other drug treatment services, is being proposed for amendment to limit the requirement that providers must contract with a community alcohol and other drug treatment board to only those services rendered prior to July 1, 2012. Additional amendments are included to update the rule as needed.

Rule [5101:3-30-03](#) entitled Billable services, is being proposed for amendment to delete language which is located in other rules and to include new references as needed.

Instructions:

Remove as Obsolete	Insert Replacement
5101:3-27-01 (03/15/1993)	5101:3-27-01 (effective 07/01/2012)
5101:3-30-01 (08/01/1993)	5101:3-30-01 (effective 07/01/2012)
5101:3-30-03 (09/30/1991)	5101:3-30-03 (effective 07/01/2012)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Community Access" (left column).
- (3) Select "Long-Term Care Service and Supports Transmittal Letters" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Job and Family Services
Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTSS@jfs.ohio.gov

(614) 466-6742

LTCSSSTL 12-04 (Self-Empowered Life Funding {SELF} Waiver)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 12-04

June 21, 2012

TO: Ohio Association of County Boards
Ohio Developmental Disabilities Council
Ohio Provider Resource Association
Department of Developmental Disabilities (DODD)
Ohio Legal Rights Service
Advocacy and Protective Services

FROM: Michael B. Colbert, Director

SUBJECT: Self-Empowered Life Funding (SELF) waiver

The Ohio Department of Job and Family Services (ODJFS) rules [5101:3-41-17](#) and [5101:3-41-20](#) of the Ohio Administrative Code are being enacted for adoption. The rules establish the SELF waiver as a component of the Medicaid program and sets forth the payment standards for waiver services administered by the Ohio Department of Developmental Disabilities (DODD).

Rule 5101:3-41-17 Medicaid home and community-based services program - self-empowered life funding waiver. The purpose of this rule is to establish the Self-Empowered Life Funding waiver as a component of the Medicaid Home and Community-Based Services program pursuant to sections 5111.85 and 5111.87 of the Revised Code.

Rule 5101:3-41-20 Self-empowered life funding - payment standards as administered by the department of developmental disabilities. The purpose of this rule is to establish the payment standards governing reimbursement for Home and Community-Based Services (HCBS) provided by certified or licensed waiver providers to individuals enrolled in the Self-Empowered Life Funding waiver program as a component of the Medicaid program and as administered by the Department of Developmental Disabilities (DODD) in accordance with sections 5111.85 and 5111.873 of the Revised Code.

Instructions:

Insert
5101:3-41-17 (effective 07/01/2012)
5101:3-41-20 (effective 07/01/2012)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

At the "electronic manuals" web page, this LTCSSSTL and rules may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Community Access."
- (3) From the drop-down menu entitled "Table of Contents" at the top of the page, scroll to and select the desired LTCSSSTL 12-04.
- (4) Scroll through the LTCSSSTL 12-04 to the desired rule number highlighted in blue and select the rule number.

Questions:

Questions about this LTCSSTL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTCSS@jfs.ohio.gov

LTCSSSTL 12-03 (Level of Care Rules)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 12-03

March 22, 2012

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health
Director, Ohio Department of Alcohol and Drug Addiction Services
Providers, ODJFS-administered Home and Community-Based Services
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Ohio Legal Rights Service
Director, Brain Injury Association of Ohio
Directors, Members, HOME Choice Planning and Advisory Group
Chairperson, Ohio Olmstead Task Force
Administrators, Nursing Facilities
Administrators and Discharge Planners, Hospitals
President and CEO, Ohio Council for Home Care and Hospice
President and CEO, Midwest Care Alliance
Vice-President, SEIU District 1199, WV/KY/OH

FROM: Michael B. Colbert, Director

SUBJECT: Level of care rules

The Ohio Department of Job and Family Services (ODJFS) is proposing to rescind and replace rules [5101:3-3-05](#), [5101:3-3-06](#), [5101:3-3-08](#), and [5101:3-3-15](#) of the Ohio Administrative Code with new rules describing the definitions, criteria, and processes related to the determination of an individual's level of care for purposes of Medicaid payment for long-term services and supports.

These rules are one component of a larger project of long-term services and supports system balancing to be accomplished through the Money Follows the Person (MFP) Front Door Project. The Front Door Project is a four-phase project that is guided by a Front Door Stakeholder Group. The following rules are included in phase two of the project, which encompasses the updating and re-writing of rules to provide short-term system balance related specifically to an individual's level of care. Additional changes are expected in later phases of the Front Door Project.

The following is a description of the rule changes:

Rules to be rescinded:

Rule 5101:3-3-05, "Skilled level of care (SLOC)," describes the criteria used to determine whether an individual who is seeking Medicaid payment for long-term care services needs a skilled level of care. It is being proposed for rescission and will be replaced by new rule 5101:3-3-08.

Rule 5101:3-3-06, "Intermediate level of care (ILOC)," describes the criteria used to determine whether an individual who is seeking Medicaid payment for long-term care services needs an intermediate level of care. It is being proposed for rescission and will be replaced by new rule 5101:3-3-08.

Rule 5101:3-3-08, "Protective level of care," describes the criteria used to determine whether an individual who is seeking Medicaid payment for long-term care services needs a protective level of care. It is being proposed for rescission and will be replaced by new rule 5101:3-3-06.

Rule 5101:3-3-15, "In-person assessments and level of care review process for medicaid covered long term care services," describes the in-person assessment process and level of care review process for individuals who are seeking Medicaid payment for long-term care services. It is being proposed for rescission and will be replaced by a new rule with the same rule number.

Rules to be adopted:

Rule [5101:3-3-05](#), "Level of care definitions," is a new rule that contains the definitions related to level of care from current rules 5101:3-3-05, 5101:3-3-06, 5101:3-3-07, 5101:3-3-08, 5101:3-3-15, and 5101:3-3-15.3. This one definition rule now contains all of the definitions used in the process of making a determination of an individual's level of care.

Rule [5101:3-3-06](#), "Criteria for the protective level of care," is a new rule that will replace current rule 5101:3-3-08, "Protective level of care" and describes the criteria for an individual to meet the protective level of care.

Rule [5101:3-3-08](#), "Criteria for nursing facility-based level of care," is a new rule that will replace current rules 5101:3-3-05, "Skilled level of care (SLOC)" and 5101:3-3-06, "Intermediate level of care (ILOC)" and describes the criteria for an individual to meet the nursing facility (NF)-based level of care.

Rule [5101:3-3-15](#), "Process and timeframes for a level of care determination for nursing facility-based level of care programs," is a new rule that will replace current rule 5101:3-3-15, "In-person assessments and level of care review process for Medicaid covered long term care services" and describes the processes and timeframes for a level of care determination for a NF-based level of care program.

Instructions:

Remove as Obsolete	Insert Replacement
5101:3-3-05 (effective 7/1/2008)	5101:3-3-05 (effective 3/19/2012)
5101:3-3-06 (effective 7/1/2008)	5101:3-3-06 (effective 3/19/2012)
5101:3-3-08 (effective 7/1/2008)	5101:3-3-08 (effective 3/19/2012)
5101:3-3-15 (effective 7/1/2008)	5101:3-3-15 (effective 3/19/2012)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Community Access" (left column).
- (3) Select "Long-Term Care Service and Supports Transmittal Letters" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Job and Family Services
Bureau of Long Term Care Services and Supports
P.O. Box 182709
Columbus, Ohio 43218-2709
BLTSS@jfs.ohio.gov
(614) 466-6742

LTCSSSTL 12-02 (Medicaid Covered Behavioral Health Services Rules)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 12-02

January 17, 2012

TO: Director, Ohio Department of Mental Health
Director, Ohio Department of Alcohol and Drug Addiction Services
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Medicaid covered behavioral health services rules

The Ohio Department of Job and Family Services (ODJFS) rule 5101:3-27-02 of the Ohio Administrative Code is being enacted to replace the rescinded rule 5101:3-27-02 of the Ohio Administrative Code. ODJFS rule 5101:3-30-04 of the Ohio Administrative Code is being amended.

Rule [5101:3-27-02](#) entitled Coverage and limitations of Medicaid community mental health services, is being adopted to implement annual service limits on all Medicaid covered community mental health services with the exception of crisis intervention. In addition, prior authorization (PA) will apply to two services, community psychiatric supportive treatment (CPST) and partial hospitalization. Currently, there are no limits or PA requirements on the services.

Rule [5101:3-30-04](#) entitled Reimbursement for community Medicaid alcohol and other drug treatment services is being amended to implement weekly service limits on four Medicaid covered services and to implement a new reimbursement methodology for one service, case management. Case management services provided to a client in excess of 1.5 units (ninety minutes) per day by the same provider will be reimbursed at fifty percent of the standard rate or the billed amount whichever is less. Currently, there are no limits or reduced reimbursement methodologies on the services.

Instructions:

Remove as Obsolete	Insert Replacement
5101:3-27-02 (effective 11/01/2011)	5101:3-27-02 (effective 01/30/2012)
5101:3-30-04 (effective 11/01/2011)	5101:3-30-04 (effective 01/30/2012)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Community Access" (left column).
- (3) Select "Long-Term Care Service and Supports Transmittal Letters" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Job and Family Services
Bureau of Long Term Care Services and Supports
P.O. Box 182709

Columbus, Ohio 43218-2709

BLTSS@jfs.ohio.gov

(614) 466-6742

LTCSSSTL 12-01 (Home and Community-Based Waiver Services Rules)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 12-01

March 19, 2012

TO: Ohio Association of County Boards
Ohio Developmental Disabilities Council
Ohio Provider Resource Association
Department of Developmental Disabilities (DODD)
Ohio Legal Rights Service
Advocacy and Protective Services

FROM: Michael B. Colbert, Director

SUBJECT: Home and Community-Based Waiver Services Rules

The Ohio Department of Job and Family Services (ODJFS) rule 5101:3-41-11 of the Ohio Administrative Code is being enacted for adoption to replace the rescinded rule 5101:3-41-11 of the Ohio Administrative Code. ODJFS rules 5101:3-41-18 and 5101:3-41-19 are being enacted for adoption. The rules set forth the payment standards for waiver services administered by the Department of Developmental Disabilities (DODD).

Rule 5101:3-41-11 Home and community-based waiver services administered by the Ohio department of developmental disabilities. This rule establishes the payment standards governing reimbursement for home and community-based services (HCBS) provided by certified or licensed waiver providers to individuals enrolled in a HCBS program as a component of the Medicaid program and as administered by the Department of Developmental Disabilities (DODD) in accordance with sections 5111.85 and 5111.873 of the Revised Code.

Rule 5101:3-41-18 Individual options waiver-payment standards. This rule establishes the payment standards for the Individual Options waiver home and community-based services (HCBS) provided by certified or licensed waiver providers to individuals enrolled in a HCBS program as a component of the Medicaid program and as administered by the Department of Developmental Disabilities (DODD) in accordance with sections 5111.85 and 5111.873 of the Revised Code.

Rule 5101:3-41-19 Medicaid home and community-based services program - level one waiver. This rule establishes the payment standards governing reimbursement for the Level One waiver home and community-based services (HCBS) provided by certified or licensed waiver providers to individuals enrolled in a HCBS program as a component of the Medicaid program and as administered by the Department of Developmental Disabilities (DODD) in accordance with sections 5111.85 and 5111.873 of the Revised Code.

Instructions:

Remove and File as Obsolete	Insert /Replacement
5101:3-41-11 (effective 07/15/2011)	<u>5101:3-41-11</u> (effective 03/19/2012)
	<u>5101:3-41-18</u> (effective 03/19/2012)
	<u>5101:3-41-19</u> (effective 03/19/2012)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

At the "electronic manuals" web page, this LTCSSTL and rules may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Community Access."
- (3) From the drop-down menu entitled "Table of Contents" at the top of the page, scroll to and select the desired LTCSSTL 12-01.
- (4) Scroll through the LTCSSTL 12-01 to the desired rule number highlighted in blue and select the rule number.

Questions:

Questions about this LTCSSTL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTCSS@jfs.ohio.gov

LTCSSSTL 11-16 (Medicaid Covered Behavioral Health Services Rules)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 11-16

November 14, 2011

TO: Director, Ohio Department of Mental Health
Directors, County Departments of Job and Family Services
Director, Ohio Department of Alcohol and Drug Addiction Services

FROM: Michael B. Colbert, Director

SUBJECT: Medicaid covered behavioral health services rules

The Ohio Department of Job and Family Services (ODJFS) rule 5101:3-27-02 of the Ohio Administrative Code is being enacted to replace the rescinded rule 5101:3-27-02 of the Ohio Administrative Code. ODJFS rule 5101:3-30-04 of the Ohio Administrative Code is being amended. These rules will become effective on an emergency basis November 1, 2011.

Rule [5101:3-27-02](#) entitled Coverage and limitations of Medicaid community mental health services, is being proposed for revision to implement annual service limits on all Medicaid covered community mental health services with the exception of crisis intervention. In addition, prior authorization (PA) will apply to two services, community psychiatric supportive treatment (CPST) and partial hospitalization. Currently, there are no limits or PA requirements on the services.

Rule [5101:3-30-04](#) entitled Reimbursement for community Medicaid alcohol and other drug treatment services is being proposed for revision to implement weekly services limits on four Medicaid covered services and to implement a new reimbursement methodology for one service, case management. Case management services provided to a client in excess of 1.5 units (ninety minutes) per day by the same provider will be reimbursed at fifty percent of the standard rate or the billed amount whichever is less. Currently, there are no limits or reduced reimbursement methodologies on the services.

Instructions:

Remove as Obsolete	Insert Replacement
5101:3-27-02 (effective 07/01/2008)	5101:3-27-02 (effective 11/01/2011)
5101:3-30-04 (effective 10/04/2010)	5101:3-30-04 (effective 11/01/2011)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Community Access" (left column).
- (3) Select "Long-Term Care Service and Supports Transmittal Letters" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTSS@jfs.ohio.gov

(614) 466-6742

LTCSSSTL 11-15 (Providing Speech Therapy in the Medicaid School Program through Interactive Audio-Visual Technologies)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 11-15

October 19, 2011

TO: Eligible Providers of the Medicaid School Program
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Providing Speech Therapy in the Medicaid School Program through Interactive Audio-Visual Technologies

This letter provides clarification of coverage of speech therapy provided by Speech-Language Pathologists through the Medicaid School Program (MSP) through interactive audio-visual technologies, commonly referred to as telehealth. Effective August 2, 2011, MSP speech therapy telehealth can be billed using Current Procedural Terminology code 92507, defined by the American Medical Association as: Treatment of speech language, voice, communication, and/or auditory procession disorder, individual; this code needs to be billed using the telehealth modifier "GT" to indicate the service was provided "via interactive audio and video telecommunication system" (e.g., 92507 GT). The purpose of this modifier is tracking and reporting only; no additional reimbursement is associated with providing speech therapy through telehealth.

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page of the department's rules manuals. The URL is as follows: <http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column)
- (2) Select "Community Access" (left column).
- (3) Select "Long-Term Care Service and Supports Transmittal Letters" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Job and Family Services
Bureau of Long Term Care Services and Supports
P.O. Box 182709
Columbus, Ohio 43218-2709
BLTCSS@jfs.ohio.gov
(614) 466-6742

LTCSSSTL 11-14 (Reimbursement for Community Mental Health Medicaid Services)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 11-14

September 28, 2011

TO: Director, Ohio Department of Mental Health Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Reimbursement for community mental health Medicaid services

The Ohio Department of Job and Family Services (ODJFS) shall be proposing an amendment to rule 5101:3-27-05 of the Administrative Code. This rule will become effective on September 29, 2011.

Rule [5101:3-27-05](#), entitled Reimbursement for community mental health medicaid services. This rule is being amended to implement a tiered reimbursement rate methodology for one service, community psychiatric supportive treatment. The rule sets forth the reimbursement methodology and rates for Medicaid mental health services administered by the Ohio Department of Mental Health.

Instructions:

Remove as Obsolete	Insert Replacement
5101:3-27-05 (effective 07/01/2011)	5101:3-27-05 (effective 09/29/2011)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Community Access" (left column).
- (3) Select "Long-Term Care Service and Supports Transmittal Letters" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Job and Family Services
Bureau of Long Term Care Services and Supports
P.O. Box 182709
Columbus, Ohio 43218-2709
BLTCSS@jfs.ohio.gov
(614) 466-6742

LTCSSSTL 11-13 (Amendment of PASSPORT HCBS, Assisted Living Medicaid Waiver Program, and Choices Program Rules)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 11-13

September 30, 2011

TO: All Interested Parties

FROM: Michael B. Colbert, Director

SUBJECT: Amendment of Pre-admission screening system providing options today (PASSPORT) home and community based services (HCBS), Assisted Living Medicaid waiver program, and Choices program rules

The Ohio Department of Job and Family Services (ODJFS) has amended Ohio Administrative Code (OAC) rules dealing with pre-admission screening system providing options and resources today (PASSPORT), home and community-based services waivers (HCBS) program, Assisted Living, and Choices program. They will be effective on 09/29/11. These rules were amended to implement language in HB 153 (129th GA).

- [5101:3-31-02](#), entitled **Passport program definitions**. This rule was amended to clarify and update language. This rule sets forth the definitions used in preadmission screening system providing options and resources today (PASSPORT).
- [5101:3-31-04](#), entitled **Enrollment process for pre-admission screening system providing options and resources today (PASSPORT)**. This rule was amended to clarify and update language. This rule sets forth the enrollment process for the PASSPORT waiver program.
- [5101:3-32-02](#), entitled **Definitions for the choices home and community-based (HCBS) waiver program**. This rule was amended and sets forth the definitions used in the choices HCBS waiver program.
- [5101:3-32-03](#) entitled **Eligibility for enrollment for the choices program**. This rule was amended and describes the criteria that must be met for a consumer to be eligible for enrollment in the choices program.
- [5101:3-32-04](#) entitled **Provider conditions of participation for the choices HCBS waiver program**. This rule was amended and sets forth the conditions of participation under which providers are able to participate in the choices HCBS waiver program.
- [5101:3-32-05](#) entitled **Choices HCBS waiver covered services**. This rule was amended and sets forth services covered by the choices home and community based services waiver program.
- [5101:3-32-06](#) entitled **Enrollment process for choices HCBS waiver program**. This rule was amended and describes the enrollment process for choices HCBS waiver program.
- [5101:3-33-02](#) entitled **Definitions for the Assisted Living home and community based services waiver (HCBS) program**. This rule was amended and sets forth the definitions used in the Assisted Living HCBS waiver program.
- [5101:3-33-03](#) entitled **Eligibility for the Assisted Living HCBS Waiver Program**. This rule was amended and outlines the eligibility criteria for the Assisted Living waiver.
- [5101:3-33-04](#) entitled **Enrollment Process for Assisted Living HCBS Waiver Program**. This rule was amended and describes the enrollment process for consumers entering the Assisted Living waiver.
- [5101:3-33-05](#) entitled **Provider conditions of participation for the assisted living home and community based services (HCBS) waiver program**. This rule was amended and sets forth the conditions under which providers are able to participate in the assisted living HCBS waiver program.

- [5101:3-33-06](#) entitled **Covered services for the assisted living services home and community based services (HCBS) waiver program**. This rule was amended and sets forth the services covered by the assisted living (HCBS) waiver program.
- [5101:3-33-07](#) entitled **Assisted living home and community based services (HCBS) waiver rate setting**. This rule was amended and describes the methods used to determine waiver provider rates in the Assisted Living waiver.

Instructions:

Remove as Obsolete	Insert Replacement
5101:3-31-02 (effective 03/17/2011)	5101:3-31-02 (effective 09/29/2011)
5101:3-31-04 (effective 03/17/2011)	5101:3-31-04 (effective 09/29/2011)
5101:3-32-02 (effective 07/01/2006)	5101:3-32-02 (effective 09/29/2011)
5101:3-32-03 (effective 10/01/2007)	5101:3-32-03 (effective 09/29/2011)
5101:3-32-04 (effective 07/01/2007)	5101:3-32-04 (effective 09/29/2011)
5101:3-32-05 (effective 07/01/2006)	5101:3-32-05 (effective 09/29/2011)
5101:3-32-06 (effective 07/01/2006)	5101:3-32-06 (effective 09/29/2011)
5101:3-33-02 (effective 12/31/2009)	5101:3-33-02 (effective 09/29/2011)
5101:3-33-03 (effective 07/01/2006)	5101:3-33-03 (effective 09/29/2011)
5101:3-33-04 (effective 09/19/2009)	5101:3-33-04 (effective 09/29/2011)
5101:3-33-05 (effective 07/01/2006)	5101:3-33-05 (effective 09/29/2011)
5101:3-33-06 (effective 07/01/2006)	5101:3-33-06 (effective 09/29/2011)
5101:3-33-07 (effective 09/19/2009)	5101:3-33-07 (effective 09/29/2011)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Community Access" (left column).
- (3) Select "Long-Term Care Services and Supports Transmittal Letter" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Job and Family Services
 Bureau of Long Term Care Services and Supports
 P.O. Box 182709

Columbus, Ohio 43218-2709

BLTCSS@jfs.ohio.gov

(614) 466-6742

LTCSSSTL 11-12 (Amendment of PASSPORT HCBS, Assisted Living Medicaid Waiver Program, Choices, PACE Rules)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 11-12

September 30, 2011

TO: All Interested Parties

FROM: Michael B. Colbert, Director

SUBJECT: Amendment of Pre-admission screening system providing options today (PASSPORT) home and community based services (HCBS), Assisted Living Medicaid waiver program, Choices, Program of all inclusive care for the elderly program (PACE) rules

The Ohio Department of Job and Family Services (ODJFS) has amended Ohio Administrative Code (OAC) rules dealing with pre-admission screening system providing options and resources today (PASSPORT), home and community-based services waivers (HCBS) program, Assisted Living, Choices, and PACE program. They will be effective on 09/29/11. These rules were amended to implement language in HB 153 (129th GA).

Rule [5101:3-1-06.1](#) entitled **Home and community-based services waivers: PASSPORT**. This rule was amended to reduce the maximum reimbursement rate for services provided through the PASSPORT Medicaid waiver program.

Rule [5101:3-1-06.4](#) entitled **Home and community-based services waivers: Choices**. This rule was amended to reduce the maximum reimbursement rate for services provided through the Choices Medicaid waiver program.

Rule [5101:3-1-06.5](#) entitled **Home and community-based services waivers: Assisted Living**. This rule was amended to reduce the maximum reimbursement rate for services provided through the Assisted Living Medicaid waiver program.

Rule [5101:3-31-07](#) entitled **PASSPORT HCBS waiver program rate setting**. This rule was amended to change how the state reimburses providers who are serving more than one consumer at the same time.

Rule [5101:3-32-07](#) entitled **Choices HCBS waiver program rate setting**. This rule was amended to change how the state reimburses providers who are serving more than one consumer at the same time.

Rule [5101:3-36-01](#) entitled **Program of all inclusive care for the elderly (PACE) definitions and acronyms**. This rule was amended to define the terms used in rules governing in the program of all-inclusive care for the elderly (PACE).

Rule [5101:3-36-02](#) entitled **Program of all inclusive care for the elderly (PACE) program administration**. This rule was amended and sets forth that the day to day administration of the PACE program shall be carried out by Ohio department of aging (ODA).

Rule [5101:3-36-06](#) entitled **Program of all inclusive care for the elderly (PACE) organization reimbursement**. This rule was amended and sets forth the reimbursement standards for the PACE program. This rule takes the existing practice for reimbursement and generally describes that standard in rule.

Instructions:

Remove as Obsolete	Insert Replacement
5101:3-1-06.1 (effective 07/01/2011)	5101:3-1-06.1 (effective 09/29/2011)
5101:3-1-06.4 (effective 07/01/2011)	5101:3-1-06.4 (effective 09/29/2011)
5101:3-1-06.5 (effective 07/01/2011)	5101:3-1-06.5 (effective 09/29/2011)
5101:3-31-07 (effective 07/01/2011)	5101:3-31-07 (effective 09/29/2011)

5101:3-32-07 (effective 07/01/2011)	5101:3-32-07 (effective 09/29/2011)
5101:3-36-01 (effective 07/01/2011)	5101:3-36-01 (effective 09/29/2011)
5101:3-36-02 (effective 07/01/2011)	5101:3-36-02 (effective 09/29/2011)
5101:3-36-06 (effective 07/01/2011)	5101:3-36-06 (effective 09/29/2011)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Long-Term Care Services and Supports Transmittal Letter" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTCSS@jfs.ohio.gov

(614) 466-6742

LTCSSSTL 11-11 (Policy Changes Governing the Non-Medicaid-Funded Ohio Access Success Project)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 11-11

September 27, 2011

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health
Director, Ohio Department of Alcohol and Drug Addiction Services
Providers, ODJFS-administered Home and Community-Based Services
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Director, Brain Injury Association of Ohio
Directors, Members, HOME Choice Planning and Advisory Group
Chairperson, Ohio Olmstead Task Force
President and CEO, Ohio Council for Home Care and Hospice
President and CEO, Midwest Care Alliance
Vice-President, SEIU District 1199, WV/KY/OH

FROM: Michael B. Colbert, Director

SUBJECT: Policy Changes Governing the Non-Medicaid-funded Ohio Access Success Project

The Ohio Department of Job and Family Services (ODJFS) has amended rule 5101:3-49-01 of the Administrative Code (OAC) governing the non-Medicaid-funded Ohio Access Success Project to address changes brought about by Am. Sub. H.B. 153 of the 129th General Assembly and as a result of the five-year rule review process required by Section 119.032 (C) of the Revised Code.

OAC rule [5101:3-49-01](#) (Non-Medicaid-funded Ohio Access Success Project) sets forth the application process, eligibility requirements and benefit limitations for the non-Medicaid-funded Ohio Access Success Project. Changes include, but are not limited to, the following:

- The definition of "individual" has been amended to clarify that the individual is a Medicaid recipient who is residing in a NF and is seeking non-Medicaid Ohio Access Success Project benefits.
- Among other things, to be eligible for the benefit,
 - An individual no longer requires a nursing facility or ICF-MR level of care in order to qualify for the benefit.
 - The individual has to be a Medicaid recipient of Medicaid-funded NF services at the time of application.
 - The individual must be able to remain in the community as a result of receiving the benefit.

- The individual must receive a determination from ODJFS or its designee that the individual's projected cost of services shall not exceed eighty percent of the state average monthly Medicaid cost of care for a Medicaid recipient residing in a NF. (The methodology for calculating the projected monthly services costs for the individual in the community is being moved within the rule.)
- The description of goods and services has been amended to be consistent with Revised Code statute. Good and services include, but are not limited to, rental deposits, utility deposits, moving expenses, home modifications, debts and other expenses not covered by the Medicaid program to facilitate the securing of residence in a community setting.
- Language has been amended to clarify that no participant may receive more than \$2,000.00 worth of benefits under the non-Medicaid-funded Ohio Access Success Project.

Instructions:

Remove and File as Obsolete	Insert Replacement
5101:3-49-01 (effective 12/10/2009)	5101:3-49-01 (effective 10/01/2011)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (left column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Long Term Care Services and Supports Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Additional information about the HOME Choice Demonstration Program can be found at:

<http://jfs.ohio.gov/ohp/consumers/HOMEchoice.stm>.

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Job and Family Services
 Bureau of Long Term Care Services and Supports
 P.O. Box 182709 Columbus, Ohio 43218-2709

<http://jfs.ohio.gov/ohp/consumers/HOMEchoice.stm>

(614) 466-6742

LTCSSSTL 11-10 (Rate Reductions to Medicaid Nursing and Aide Services)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 11-10

September 27, 2011

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health
Director, Ohio Department of Alcohol and Drug Addiction Services
Providers, ODJFS-administered Home and Community-Based Waiver Services
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Director, Brain Injury Association of Ohio
Directors, Members, HOME Choice Planning and Advisory Group
Chairperson, Ohio Olmstead Task Force
President and CEO, Ohio Council for Home Care and Hospice
President and CEO, Midwest Care Alliance
Vice-President, SEIU District 1199, WV/KY/OH

FROM: Michael B. Colbert, Director

SUBJECT: Rate Reductions to Medicaid Nursing and Aide Services

Pursuant to Revised Code Section 5111.0213 of Amended Substitute House Bill 153, 129th General Assembly, the Ohio Department of Job and Family Services (ODJFS) has amended Rules [5101:3-12-05](#) and [5101:3-12-06](#) of the Administrative Code (OAC), and rescinded and replaced their appendices. ODJFS has also amended Rules [5101:3-46-06](#), [5101:3-46-06.1](#), [5101:3-47-06](#), [5101:3-50-06](#) and [5101:3-50-06.1](#) of the Administrative Code.

Effective with date of service October 1, 2011, the **base rate** for up to the first hour of state plan home health nursing and private duty nursing, and ODJFS-administered waiver nursing will be reduced by five percent. The **base rate** for up to the first hour of state plan home health aide, and ODJFS-administered waiver personal care aide and home care attendant will be reduced by three percent. And, the **base rates** paid to non-agency providers of nursing and aide services will be reduced by another 20 percent.

Therefore, the new base rates are as follows:

- The base rate for the first hour of nursing services will be reduced from \$54.95 to \$52.20 for agency providers, while the base rate for non-agency nurses will be reduced from \$54.95 to \$41.76.
- The base rate paid to agency providers of state plan home health and ODJFS-administered waiver personal care aide services will be reduced from \$23.98 to \$23.26, while the base rate paid to non-agency ODJFS-administered personal care aides will be reduced from \$23.98 to \$18.61. (Only Medicare-certified home health agencies are permitted to provide state plan home health services.)

- The base rate for ODJFS-administered waiver home care attendant services will be reduced from \$33.36 to \$25.89. (Agency providers are not permitted to provide ODJFS-administered waiver home care attendant services.)

There will be no reductions to the unit rates paid for each additional 15-minutes of nursing or aide services rendered after the first hour.

OAC rules 5101:3-12-05 and 5101:3-12-06 have also been amended to add definitions for "base rate" and "unit rate", and to clarify information regarding claims submission. OAC rules 5101:3-46-06.1 and 5101:3-50-06.1 have also been amended in conjunction with Medicaid Information Technology System (MITS) implementation.

Instructions:

Remove as Obsolete	Insert Replacement
5101:3-12-05 (effective 1/1/2010)	<u>5101:3-12-05</u> (effective 10/1/2011)
5101:3-12-06 (effective 1/1/2010)	<u>5101:3-12-06</u> (effective 10/1/2011)
5101:3-46-06 (effective 4/1/2011)	<u>5101:3-46-06</u> (effective 10/1/2011)
5101:3-46-06.1 (effective 7/1/2010)	<u>5101:3-46-06.1</u> (effective 10/1/2011)
5101:3-47-06 (effective 4/1/2011)	<u>5101:3-47-06</u> (effective 10/1/2011)
5101:3-50-06 (effective 4/1/2011)	<u>5101:3-50-06</u> (effective 10/1/2011)
5101:3-50-06.1 (effective 7/1/2010)	<u>5101:3-50-06.1</u> (effective 10/1/2011)

Web Pages:

ODJFS maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Long Term Care Services and Supports Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Job and Family Services
Bureau of Long-Term Care Services and Supports
P.O. Box 182709

Columbus, Ohio 43218-2709

<http://jfs.ohio.gov/ohp>

(614) 466-6742

LTCSSSTL 11-09 (Home and Community Based Waiver Services Rules)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 11-09

September 2, 2011

TO: Ohio Association of County Boards
Ohio Developmental Disabilities Council
Ohio Provider Resource Association
Department of Developmental Disabilities (DODD)
Ohio Legal Rights Service
Advocacy and Protective Services

FROM: Michael B. Colbert, Director

SUBJECT: Home and community based waiver services rules

The Ohio Department of Job and Family Services (ODJFS) rules 5101:3-41-08 and 5101:3-42-01 of the Ohio Administrative Code is being amended. ODJFS rule 5101:3-41-05 of the Ohio Administrative Code is being enacted to replace the rescinded rule 5101:3-41-05 of the Ohio Administrative Code. The rules set forth the requirements of a county board of developmental disabilities to establish and maintain a waiting list for home and community-based services, sets forth the requirements the Ohio Department of Developmental Disabilities (DODD) must meet to assure free choice of provider and establishes the level one waiver as a component of the Medicaid home and community-based services program pursuant to sections 5111.87 and 5111.85 of the Revised Code.

Rule 5101:3-41-05, Waiting lists for home and community-based services administered by the Ohio department of developmental disabilities. This rule sets forth the requirements of a county board of developmental disabilities to establish and maintain a waiting list for home and community-based services. This rule is being filed consistent with the requirements of the Revised Code Section 119.032 review.

Rule 5101:3-41-08 Free choice of provider requirements for Medicaid home and community-based services programs administered by the Ohio Department of Developmental Disabilities. This rule sets forth the requirements the Ohio Department of Developmental Disabilities (DODD) must meet to assure free choice of provider. This rule is being filed consistent with the requirements of the Revised Code Section 119.032 review.

Rule 5101:3-42-01 Medicaid home and community-based services program - level one waiver. This rule establishes the level one waiver as a component of the Medicaid home and community-based services program pursuant to sections 5111.87 and 5111.85 of the Revised Code. This rule is being filed consistent with the requirements of the Revised Code Section 119.032 review.

Instructions:

Remove and File as Obsolete	Insert /Replacement
5101:3-41-05 (effective 05/09/2002)	<u>5101:3-41-05</u> (effective 09/15/2011)
5101:3-41-08 (effective 07/01/2005)	<u>5101:3-41-08</u> (effective 09/15/2011)
5101:3-42-01 (effective 01/01/2007)	<u>5101:3-42-01</u> (effective 09/15/2011)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

At the "electronic manuals" web page, this LTCSSTL and rules may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Community Access."
- (3) From the drop-down menu entitled "Table of Contents" at the top of the page, scroll to and select the desired LTCSSTL 11-09.
- (4) Scroll through the LTCSSTL 11-09 to the desired rule number highlighted in blue and select the rule number.

Questions:

Questions about this LTCSSTL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTCSS@jfs.ohio.gov

LTCSSSTL 11-08 (Amendment of HOME Choice (Money Follows the Person) Demonstration Program Rules)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 11-08

July 28, 2011

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health
Director, Ohio Department of Alcohol and Drug Addiction Services
Providers, ODJFS-administered Home and Community-Based Services
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Director, Brain Injury Association of Ohio
Directors, Members, HOME Choice Planning and Advisory Group
Chairperson, Ohio Olmstead Task Force
President and CEO, Ohio Council for Home Care and Hospice
President and CEO, Midwest Care Alliance
Vice-President, SEIU District 1199, WV/KY/OH

FROM: Michael B. Colbert, Director

SUBJECT: Amendment of HOME Choice (Money Follows the Person) Demonstration Program Rules

The Ohio Department of Job and Family Services (ODJFS) has amended rules 5101:3-51-02, 5101:3-51-04 and 5101:3-51-06 of the Administrative Code to clarify policy governing the HOME Choice (Money Follows the Person) Demonstration Program. They became effective on 08/01/2011.

OAC rule [5101:3-51-02](#) [HOME Choice ("Helping Ohioans Move, Expanding Choice") Demonstration Program: Individual Eligibility for Services and Participant Hearing Rights] was amended for the purpose of clarifying that if, at anytime, it is determined that the health and welfare of an individual participating in the pre- or post-transition phase of the HOME Choice Demonstration Program cannot be assured, that individual may be denied further participation in or disenrolled from the program. In such instances, the individual shall be afforded notice and hearing rights.

OAC rule [5101:3-51-04](#) [HOME Choice ("Helping Ohioans Move, Expanding Choice") Demonstration Program: Definitions of the Covered Services and Program Service Limitations, Provider Qualifications and Specifications] was amended to add availability of a maximum of \$500 for pre-transition transportation expenses associated with visits to available housing and to local agencies for the purpose of establishing benefits, etc.

OAC rule [5101:3-51-06](#) [HOME Choice ("Helping Ohioans Move, Expanding Choice") Demonstration Program: Reimbursement Rates and Billing Procedures] was amended to modify the maximum rate and usage amounts for community transitions services upon the addition of pre-transition transportation expenses to a service.

Instructions:

Remove as Obsolete	Insert Replacement
5101:3-51-02 (effective 09/09/2010)	<u>5101:3-51-02</u> (effective 08/01/2011)
5101:3-51-04 (effective 09/09/2010)	<u>5101:3-51-04</u> (effective 08/01/2011)
5101:3-51-06 (effective 09/09/2010)	<u>5101:3-51-06</u> (effective 08/01/2011)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Long-Term Care Services and Supports Transmittal Letter" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Additional information about the HOME Choice Demonstration Program can be found at:

<http://jfs.ohio.gov/ohp/consumers/HOMEChoice.stm>

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTCSS@jfs.ohio.gov

(614) 466-6742

LTCSSSTL 11-07 (Reimbursement for Community Mental Health Medicaid Services)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 11-07

July 13, 2011

TO: Director, Ohio Department of Mental Health
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Reimbursement for community mental health Medicaid services

The Ohio Department of Job and Family Services (ODJFS) shall be proposing an amendment to rule 5101:3-27-05 of the Administrative Code. This rule will become effective on an emergency basis July 1, 2011.

Rule 5101:3-27-05, entitled **Reimbursement for community mental health medicaid services**. This rule is being amended to implement a tiered reimbursement rate methodology for one service, community psychiatric supportive treatment. The rule sets forth the reimbursement methodology and rates for Medicaid mental health services administered by the Ohio Department of Mental Health.

Instructions:

Remove as Obsolete	Insert Replacement
5101:3-27-05 (effective 10/14/2010)	<u>5101:3-27-05</u> (effective 07/01/2011)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Community Access" (left column).
- (3) Select "Long-Term Care Service and Supports Transmittal Letters" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Job and Family Services
Bureau of Long Term Care Services and Supports
P.O. Box 182709
Columbus, Ohio 43218-2709
BLTCSS@jfs.ohio.gov
(614) 466-6742

LTCSSSTL 11-06 (Amendment of PASSPORT, HCBS, Assisted Living Medicaid Waiver Program, Choices, PACE rules)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 11-06

July 13, 2011

TO: All Interested Parties

FROM: Michael B. Colbert, Director

SUBJECT: Amendment of Pre-admission screening system providing options today (PASSPORT) home and community based services (HCBS), Assisted Living Medicaid waiver program, Choices, Program of all inclusive care for the elderly program (PACE) rules

The Ohio Department of Job and Family Services (ODJFS) has amended Ohio Administrative Code (OAC) rules dealing with pre-admission screening system providing options and resources today (PASSPORT), home and community-based services waivers (HCBS) program, Assisted Living, Choices, and PACE program. They became effective on emergency basis 07/01/11. These rules were amended to implement language in HB 153 (129th GA).

Rule [5101:3-1-06.1](#) entitled **Home and community-based services waivers: PASSPORT**. This rule was amended to reduce the maximum reimbursement rate for services provided through the PASSPORT Medicaid waiver program.

Rule [5101:3-1-06.4](#) entitled **Home and community-based services waivers: Choices**. This rule was amended to reduce the maximum reimbursement rate for services provided through the Choices Medicaid waiver program.

Rule [5101:3-1-06.5](#) entitled **Home and community-based services waivers: Assisted Living**. This rule was amended to reduce the maximum reimbursement rate for services provided through the Assisted Living Medicaid waiver program.

Rule [5101:3-31-07](#) entitled **PASSPORT HCBS waiver program rate setting**. This rule was amended to change how the state reimburses providers who are serving more than one consumer at the same time.

Rule [5101:3-32-07](#) entitled Choices **HCBS waiver program rate setting**. This rule was amended to change how the state reimburses providers who are serving more than one consumer at the same time.

Rule [5101:3-36-01](#) entitled **Program of all inclusive care for the elderly (PACE) definitions and acronyms**. This rule was amended to define the terms used in rules governing the program of all-inclusive care for the elderly (PACE).

Rule [5101:3-36-02](#) entitled **Program of all inclusive care for the elderly (PACE) program administration**. This rule was amended and sets forth that the day to day administration of the PACE program shall be carried out by the Ohio department of aging (ODA).

Rule [5101:3-36-06](#) entitled **Program of all inclusive care for the elderly (PACE) organization reimbursement**. This rule was amended and sets forth the reimbursement standards for the PACE program. This rule takes the existing practice for reimbursement and generally describes that standard in rule.

Instructions:

Remove as Obsolete	Insert Replacement
5101:3-1-06.1 (effective 03/17/2011)	5101:3-1-06.1 (effective 07/01/2011)
5101:3-1-06.4 (effective 09/30/2008)	5101:3-1-06.4 (effective 07/01/2011)
5101:3-1-06.5 (effective 07/01/2006)	5101:3-1-06.5 (effective 07/01/2011)
5101:3-31-07 (effective 03/17/2011)	5101:3-31-07 (effective 07/01/2011)

5101:3-32-07 (effective 07/01/2007)	5101:3-32-07 (effective 07/01/2011)
5101:3-36-01 (effective 03/28/2009)	5101:3-36-01 (effective 07/01/2011)
5101:3-36-02 (effective 03/28/2009)	5101:3-36-02 (effective 07/01/2011)
5101:3-36-06 (effective 03/28/2009)	5101:3-36-06 (effective 07/01/2011)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Community Access" (left column).
- (3) Select "Long-Term Care Services and Supports Transmittal Letter" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Job and Family Services
Bureau of Long Term Care Services and Supports
P.O. Box 182709
Columbus, Ohio 43218-2709
BLTCSS@jfs.ohio.gov
(614) 466-6742

LTCSSSTL 11-04 (Home and Community Based Waiver Services Rules)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 11-04

June 30, 2011

TO: Ohio Association of County Boards
Ohio Developmental Disabilities Council
Ohio Provider Resource Association
Department of Developmental Disabilities (DODD)
Ohio Legal Rights Service
Advocacy and Protective Services

FROM: Michael B. Colbert, Director

SUBJECT: Home and community based waiver services rules

The Ohio Department of Job and Family Services (ODJFS) rules [5101:3-41-11](#) and [5101:3-40-01](#) of the Ohio Administrative Code (OAC) are being proposed for amendment. The rules establish the payment standards governing reimbursement for home and community-based services (HCBS) and establish the individual options waiver as a component of the medicaid home and community-based services program pursuant to sections 5111.85, 5111.87 and 5111.873 of the Revised Code.

OAC Rule [5101:3-40-01](#): Medicaid home and community-based services program-individual options waiver.

OAC Rule [5101:3-41-11](#): Home and community-based waiver services -reimbursement for waiver services administered by the department of development disabilities.

Instructions:

Remove and File as Obsolete	Insert /Replacement
5101:3-40-01 (effective 03/20/2008)	5101:3-40-01 (effective 07/15/2011)
5101:3-41-11 (effective 07/01/2010)	5101:3-41-11 (effective 07/15/2011)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

At the "electronic manuals" web page, this LTCSSSTL and rules may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Community Access."
- (3) From the drop-down menu entitled "Table of Contents" at the top of the page, scroll to and select the desired LTCSSSTL 11-04.
- (4) Scroll through the LTCSSSTL 11-04 to the desired rule number highlighted in blue and select the rule number.

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Job and Family Services
Bureau of Long Term Care Services and Supports
P.O. Box 182709

Columbus, Ohio 43218-2709

BLTCSS@jfs.ohio.gov

LTCSSSTL 11-03 (Medicaid Coverage of Targeted Case Management Services Provided to Individuals with Mental Retardation or Developmental Disabilities)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 11-03

July 1, 2011

TO: Ohio Association of County Boards
Ohio Developmental Disabilities Council
Ohio Provider Resource Association
Department of Developmental Disabilities (DODD)
Ohio Legal Rights Service
Advocacy and Protective Services

FROM: Michael B. Colbert, Director

SUBJECT: Medicaid coverage of targeted case management services provided to individuals with mental retardation or developmental disabilities

The Ohio Department of Job and Family Services (ODJFS) rule [5101:3-48-01](#) of Administrative Code (OAC), Medicaid coverage of targeted case management services provided to individuals with mental retardation or developmental disabilities is being amended. This rule sets forth Medicaid payment specifications for targeted case management services.

OAC rule 5101:3-48-01, Medicaid coverage of targeted case management services provided to individuals with mental retardation or developmental disabilities. This rule specifies the conditions for Medicaid payment of targeted case management (TCM), which is comprised of those activities described in section 5126.15 of the Revised Code and in rule 5123:2-1-11 of the Administrative Code.

Instructions:

Remove and File as Obsolete	Insert /Replacement
5101:3-48-01 (effective 10/04/2006)	5101:3-48-01 (effective 07/01/2011)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

At the "electronic manuals" web page, this LTCSSSTL and rules may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Community Access."
- (3) From the drop-down menu entitled "Table of Contents" at the top of the page, scroll to and select the desired LTCSSSTL 11-03
- (4) Scroll through the LTCSSSTL to the desired rule number highlighted in blue and select the rule number.

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Job and Family Services
Bureau of Long Term Care Services and Supports
P.O. Box 182709

Columbus, Ohio 43218-2709

BLTCSS@jfs.ohio.gov

(614) 466-6742

LTCSSSTL 11-02 (NEW Hospital Exemption Notification System)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 11-02

May 18, 2011

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health
Administrators, Nursing Facilities
Administrators and Discharge Planners, Hospitals
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Director, Brain Injury Association of Ohio
Directors, Members, HOME Choice Planning and Advisory Group
Chairperson, Ohio Olmstead Task Force

FROM: Michael B. Colbert, Director

SUBJECT: NEW Hospital Exemption Notification System

DATE: April 29, 2011

Preadmission Screening/Resident Review (PASRR) is a mandate of the OBRA 1987 Nursing Home Reform Act. PASRR provisions are contained in section 1919(e)(7) of the Social Security Act. The regulations prohibit a Nursing Facility (NF) from accepting a new applicant (or retaining residents) with Serious Mental Illness (SMI) or Developmental Disabilities (DD) unless the individual requires the level of services provided by a NF. The federal intent of PASRR is to prevent long-term NF placement of individuals with SMI and/or DD.

Some individuals may meet the criteria to be admitted to a NF under the Hospital (convalescent) Exemption provision. These are individuals seeking admission to a NF directly from a hospital after receiving acute inpatient care at the hospital and; who require the level of services provided by a NF for the condition which was treated in the hospital and; whose physician has provided written certification, signed and dated no later than the date of discharge from the hospital, stating that the individual is likely to require the level of services provided by a NF for less than thirty days.

OAC 5101:3-3-15.1 (G)(1) specifies: "The discharging hospital must complete the hospital (convalescent) exemption from preadmission screening notification form (JFS 07000) (11/09). The form must be signed and dated by the attending physician no later than the date of discharge from the hospital certifying that all of the hospital (convalescent) exemption criteria as defined in paragraph (B)(9) of rule [5101:3-3-14](#) of the Administrative Code have been met."

The JFS 07000 is now available using a secure web-based application. The application is called HENS (Hospital Exemption Notification System) and will send the form electronically to the appropriate entities that are required to receive it. When the form is created in HENS, the requirement to obtain the physician's signature and date on the actual form itself is not applicable and is not required. In lieu of this, the hospital staff person creating the form in HENS must attest that the documentation substantiating the required certification exists and has been signed and dated by the physician. The documentation must be maintained

by the hospital, and be furnished at the request of ODJFS or its designee. The Physician's Signature line on the JFS 07000 created in HENS will state, 'Signature on File'.

This is to inform all parties that the form received via HENS shall be considered to meet the requirement for completing and sending the form, including the physician's signed and dated certification, as set forth in OAC 5101:3-3-15.1

Any party in receipt of the JFS 07000 that was created in HENS does **NOT** also need the physician's certification documentation from the hospital for proof that the PASRR requirements were met. The responsibility to request and audit the hospital documentation as determined necessary to verify the submitter's attestations is the responsibility of ODJFS or its designee.

The NF must ensure that the date of the physician's certification on the form is no later than the date of discharge from the hospital before admitting the person to the NF. The NF retains the responsibility to furnish the form as proof that the PASRR requirements have been met. HENS provides the NF with the ability to either save the form as a PDF or to print it. When the NF can furnish the JFS 07000 that was created in HENS with the physician's certification date being no later than the date of discharge from the hospital, the NF will be considered to be in compliance with ensuring that the PASRR requirements for meeting the hospital exemption have been met. The form furnished in either the printed or electronic format is acceptable proof.

LTCSSSTL 11-01 (Policy Changes Governing ODJFS-administered Waiver Service Providers)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 11-01

March 29, 2011

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health
Director, Ohio Department of Alcohol and Drug Addiction Services
Providers, ODJFS-administered Home and Community-Based Services
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Director, Brain Injury Association of Ohio
Directors, Members, HOME Choice Planning and Advisory Group
Chairperson, Ohio Olmstead Task Force
Director, Ohio Council for Home Care
Director, Ohio Home Care Organization
Vice-President, SEIU District 1199, WV/KY/OH

FROM: Michael B. Colbert, Director

SUBJECT: Policy Changes Governing ODJFS-administered Waiver Service Providers

The Ohio Department of Job and Family Services (ODJFS) has amended four Administrative Code rules governing ODJFS-administered waivers in preparation for the forthcoming implementation of the Ohio Department of Job and Family Services (ODJFS) Medicaid Information Technology System (MITS).

- Rule [5101:3-45-04](#) (Provider Enrollment Process) of the Administrative Code has been amended to state that the waiver provider application shall be completed and submitted in accordance with the requirements set forth in Chapter 5101:3-1 of the Administrative Code.
- Rules [5101:3-46-06](#), [5101:3-47-06](#) and [5101:3-50-06](#) (Reimbursement Rates and Billing Procedures) of the Administrative Code have been amended to state that claims shall be submitted to, and reimbursement shall be provided by, ODJFS in accordance with Chapter 5101:3-1 of the Administrative Code.

No other changes are being made to these rules at this time.

Instructions:

Remove and File as Obsolete	Insert Replacement
5101:3-45-04 (effective 07/01/2009)	5101:3-45-04 (effective 04/01/2011)
5101:3-46-06 (effective 01/01/2010)	5101:3-46-06 (effective 04/01/2011)

5101:3-47-06 (effective 01/01/2010)	5101:3-47-06 (effective 04/01/2011)
5101:3-50-06 (effective 01/01/2010)	5101:3-50-06 (effective 04/01/2011)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Long-Term Care Services and Supports Transmittal Letter" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Job and Family Services
Bureau of Long Term Care Services and Supports
P.O. Box 182709
Columbus, Ohio 43218-2709
BLTCSS@jfs.ohio.gov
(614) 466-6742

LTCSSSTL 10-02 (PASRR and Level of Care: "Most Common Scenarios" Chart)

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 10-02

December 3, 2010

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health
Administrators, Nursing Facilities
Administrators and Discharge Planners, Hospitals
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Director, Brain Injury Association of Ohio
Directors, Members, HOME Choice Planning and Advisory Group
Chairperson, Ohio Olmstead Task Force

FROM: Douglas E. Lumpkin, Director

SUBJECT: Preadmission Screening/Resident Review (PASRR) and Level of Care: "Most Common Scenarios" Chart

PASRR is a mandate of the OBRA 1987 Nursing Home Reform Act. PASRR provisions are contained in section 1919(e)(7) of the Social Security Act. The regulations prohibit a nursing facility (NF) from accepting a new applicant (or retaining residents) with mental illness (SMI) or developmental disabilities (DD) unless the individual requires the level of services provided by a NF. The federal intent of PASRR is to prevent long term nursing home placement of individuals with serious mental illness (SMI) and/or developmental disabilities (DD).

PASRR requirements are located within Ohio Administrative Code (OAC) rules 5101:3-3-14, 5101:3-3-15.1, and 5101:3-3-15.2. These OAC rules were modified and effective on December 1, 2009.

The rules, forms, training materials, and frequently asked questions may be found at <http://mentalhealth.ohio.gov/what-we-do/protect-and-monitor/pre-admission-screening-and-resident-review/webinar-materials.shtml>.

In an attempt to provide further guidance to local systems, ODJFS in partnership with the Ohio Departments of Aging, Mental Health and Developmental Disabilities, developed the attached "Common Scenarios" chart. This chart provides guidance to local systems on when to request a hospital exemption, preadmission screen, resident review or a level of care. If you have any questions about the chart or need additional guidance related to the newly effective PASRR rules, please contact us at:

Ohio Department of Job and Family Services
Bureau of Long Term Care Services and Supports
P.O. Box 182709 - 5th Floor
Columbus, Ohio 43218-2709
BLTCSS@jfs.ohio.gov

(614) 466-6742

[Common Scenarios Chart](#)

LTCSSSTL 10-01 (JFS 03622 "PASRR Form" and JFS 07000 "Hospital (Convalescent) Exemption From Preadmission Screening Notification Form")

Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 10-01

January 4, 2011

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health
Administrators, Nursing Facilities
Administrators and Discharge Planners, Hospitals
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Director, Brain Injury Association of Ohio
Directors, Members, HOME Choice Planning and Advisory Group
Chairperson, Ohio Olmstead Task Force

FROM: Douglas E. Lumpkin, Director

SUBJECT: JFS 03622 "Preadmission Screening/Resident Review (PASRR) Form" and JFS 07000 "Hospital (Convalescent) Exemption From Preadmission Screening Notification Form"

Preadmission Screening/Resident Review (PASRR) is a mandate of the OBRA 1987 Nursing Home Reform Act. PASRR provisions are contained in section 1919(e)(7) of the Social Security Act. The regulations prohibit a nursing facility (NF) from accepting a new applicant (or retaining residents) with mental illness (SMI) or developmental disabilities (DD) unless the individual requires the level of services provided by an NF. The federal intent of PASRR is to prevent long term nursing home placement of individuals with serious mental illness (SMI) and/or developmental disabilities (DD).

Attached are forms [JFS 03622](#), "Preadmission Screening/Resident Review Identification Screen" and [JFS 07000](#), "Hospital (Convalescent) Exemption from Preadmission Screening Notification." These revised forms reflect modifications made based on feedback provided to the PASSRR Interagency Team from each of their respective agencies.

Instructions:

Obsolete	Insert
JFS 03622 (effective 11/2009)	JFS 03622 (effective 11/2010)
JFS 07000 (effective 2/2010)	JFS 07000 (effective 11/2010)

Web Pages:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks.

The URL is <http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed by selecting the "Forms Central" link (top right column).

Questions about this LTCSSSTL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Long Term Care Services and Supports

P.O. Box 182709 - 5th Floor

Columbus, Ohio 43218-2709

BLTCSS@jfs.ohio.gov

(614) 466-6742