Ohio Administrative Code

Rule 5123-9-30 Home and community-based services waivers - homemaker/ personal care under the individual options and level one waivers.

Effective: January 1, 2024

(A) Purpose

This rule defines homemaker/personal care and sets forth provider qualifications, requirements for service delivery and documentation of services, and payment standards for the service.

(B) Definitions

For the purposes of this rule, the following definitions apply:

(1) "Acute care hospital" means a hospital that provides inpatient medical care and other related services for surgery, acute medical conditions, or injuries (usually for a short-term illness or condition).

(2) "Adult day support" has the same meaning as in rule 5123-9-17 of the Administrative Code.

(3) "Agency provider" means an entity that directly employs at least one person in addition to a director of operations for the purpose of providing services for which the entity is certified in accordance with rule 5123-2-08 of the Administrative Code.

(4) "County board" means a county board of developmental disabilities.

(5) "Department" means the Ohio department of developmental disabilities.

(6) "Developmental center" means a department-operated intermediate care facility for individuals with intellectual disabilities.

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

delivery time. Minutes of service delivery time accrued throughout a day will be added together for the purpose of calculating the number of fifteen-minute billing units for the day.

(8) "Funding range" means one of the dollar ranges contained in appendix A to rule 5123-9-06 of the Administrative Code to which individuals enrolled in the individual options waiver have been assigned for the purpose of funding services. The funding range applicable to an individual is determined by the score derived from the Ohio developmental disabilities profile that has been completed by a county board employee qualified to administer the tool.

(9) "Group employment support" has the same meaning as in rule 5123-9-16 of the Administrative Code.

(10) "Group size" means the number of individuals who are sharing services, regardless of the funding source for those services.

(11) "Homemaker/personal care" means the coordinated provision of a variety of services, supports, and supervision necessary to ensure the health and welfare of an individual who lives in the community. Homemaker/personal care advances the individual's independence within the individual's home and community and helps the individual meet daily living needs. Examples of supports that may be provided as homemaker/personal care include:

(a) Self-advocacy training to assist in the expression of personal preferences, self-representation, self-protection from and reporting of abuse, neglect, and exploitation, asserting individual rights, and making increasingly responsible choices.

(b) Self-direction, including the identification of and response to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements and life activities.

(c) Daily living skills including training in and providing assistance with routine household tasks, meal preparation, personal care, self-administration of medication, and other areas of day-to-day living including proper use of adaptive and assistive devices, appliances, home safety, first aid, and communication skills such as using the telephone.

(d) Implementation of recommended therapeutic interventions under the direction of a professional or extension of therapeutic services, which consist of reinforcing physical, occupational, speech, and other therapeutic programs for the purpose of increasing the overall effective functioning of the individual.

(e) Implementation of behavioral support strategies including training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially-appropriate behaviors, or extension of therapeutic services for the purpose of increasing the overall effective functioning of the individual.

(f) Medical and health care services that are integral to meeting the daily needs of the individual such as routine administration of medication or tending to the needs of individuals who are ill or require attention to their medical needs on an ongoing basis.

(g) Emergency response training including development of responses in case of emergencies, prevention planning, and training in the use of equipment or technologies used to access emergency response systems.

(h) Community access services that explore community services available to all people, natural supports available to the individual, and develop methods to access additional services, supports, and activities needed by the individual to be integrated in and have full access to the community.

(i) When provided in conjunction with other components of homemaker/personal care, assistance with personal finances which may include training, planning, and decision-making regarding the individual's personal finances.

(12) "Independent provider" means a self-employed person who provides services for which the person is certified in accordance with rule 5123-2-09 of the Administrative Code and does not employ, either directly or through contract, anyone else to provide the services.

(13) "Individual" means a person with a developmental disability or for purposes of giving, refusing to give, or withdrawing consent for services, the person's guardian in accordance with section

5126.043 of the Revised Code or other person authorized to give consent.

(14) "Individual employment support" has the same meaning as in rule 5123-9-15 of the Administrative Code.

(15) "Individual service plan" means the written description of services, supports, and activities to be provided to an individual.

(16) "Intermediate care facility for individuals with intellectual disabilities" has the same meaning as in section 5124.01 of the Revised Code.

(17) "Money management" has the same meaning as in rule 5123-9-20 of the Administrative Code.

(18) "Non-medical transportation" has the same meaning as in rule 5123-9-18 of the Administrative Code.

(19) "Ohio developmental disabilities profile" means the standardized instrument utilized by the department to assess the relative needs and circumstances of an individual compared to others. The individual's responses are scored and the individual is linked to a funding range, which enables similarly situated individuals to access comparable waiver services paid in accordance with rules adopted by the department.

(20) "On-site/on-call" means a rate authorized when no need for supervision or supports is anticipated because the individual is expected to be asleep for a continuous period of no less than five hours, and a provider must be present and readily available to provide homemaker/personal care if an unanticipated need arises but is not required to remain awake. This rate and service may only be authorized in the residence of the individual or at another location in the community selected by the individual other than the residence of the provider of the service.

(21) "Residential respite" has the same meaning as in rule 5123-9-34 of the Administrative Code.

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

maintained contemporaneously with the delivery of services, and kept in a manner as to fully disclose the nature and extent of services delivered that includes the items delineated in paragraph (E) of this rule to validate payment for medicaid services.

(23) "Shared living" has the same meaning as in rule 5123-9-33 of the Administrative Code.

(24) "Team" means the group of persons chosen by an individual with the core responsibility to support the individual in directing development of the individual service plan. The team includes the individual's guardian or adult whom the individual has identified, as applicable, the service and support administrator, direct support professionals, providers, licensed or certified professionals, and any other persons chosen by the individual to help the individual consider possibilities and make decisions.

(25) "Vocational habilitation" has the same meaning as in rule 5123-9-14 of the Administrative Code.

(26) "Waiver eligibility span" means the twelve-month period following either an individual's initial waiver enrollment date or a subsequent eligibility re-determination date.

(C) Provider qualifications

(1) Homemaker/personal care will be provided by an independent provider or an agency provider that meets the requirements of this rule and that has a medicaid provider agreement with the Ohio department of medicaid.

(2) Homemaker/personal care will not be provided by a county board or a regional council of governments formed under section 5126.13 of the Revised Code by two or more county boards.

(3) An applicant seeking approval to provide homemaker/personal care will complete and submit an application and adhere to the requirements of as applicable, rule 5123-2-08 or 5123-2-09 of the Administrative Code.

(4) Providers licensed under section 5123.19 of the Revised Code seeking to provide

homemaker/personal care will:

(a) Meet all of the requirements set forth in and maintain a license issued under section 5123.19 of the Revised Code.

(b) Maintain a current medicaid provider agreement with the Ohio department of medicaid.

(5) Failure of a certified provider to comply with this rule and as applicable, rule 5123-2-08 or 5123-2-09 of the Administrative Code, may result in denial, suspension, or revocation of the provider's certification.

(6) Failure of a licensed provider to comply with this rule and Chapter 5123-3 of the Administrative Code may result in denial, suspension, or revocation of the provider's license.

(D) Requirements for service delivery

(1) Homemaker/personal care will be provided pursuant to an individual service plan that conforms to the requirements of rule 5123-4-02 of the Administrative Code. Providers will participate in individual service plan development meetings when a request for their participation is made by the individual.

(2) A provider of homemaker/personal care will not also provide money management or shared living to the same individual.

(3) Homemaker/personal care will not be provided to an individual at the same time as residential respite.

(4) Homemaker/personal care services may extend to those times when the individual is not physically present and the provider is performing homemaker activities on behalf of the individual.

(5) Homemaker/personal care services involving direct contact with an individual receiving the services will not be provided at the same time the individual is receiving adult day support, group employment support, individual employment support, or vocational habilitation.

(6) A provider will not bill for homemaker/personal care provided by the driver during the same time non-medical transportation at the per-trip rate is provided.

(7) Homemaker/personal care may be provided to an individual in an acute care hospital to address the individual's intensive personal care, behavioral support/stabilization, or communication needs when the following conditions are met:

(a) Homemaker/personal care is necessary to ensure smooth transition between the acute care hospital and the individual's home and to preserve the individual's functional abilities;

(b) Homemaker/personal care is not a substitute for services the acute care hospital provides or is obligated to provide (e.g., attendant care) through its conditions of participation, federal law, state law, or other applicable requirement;

(c) The person providing homemaker/personal care is awake;

(d) A maximum of sixteen hours of homemaker/personal care per day may be provided to an individual in an acute care hospital;

(e) An individual may receive homemaker/personal care in an acute care hospital on no more than thirty calendar days per waiver eligibility span; and

(f) The cost of homemaker/personal care provided to an individual in an acute care hospital can be accommodated by the individual's budget authorized in the medicaid services system.

(8) A provider of homemaker/personal care will arrange for substitute coverage, when necessary, only from a provider certified or approved by the department and as identified in the individual service plan; notify as applicable, the individual or legally responsible person in the event that substitute coverage is necessary; and notify the person identified in the individual service plan when substitute coverage is not available to allow such person to make other arrangements.

(9) A provider delivering homemaker/personal care in fifteen-minute billing units in accordance with

this rule, excluding on-site/on-call, will utilize electronic visit verification in accordance with rule 5160-1-40 of the Administrative Code.

(10) An agency provider will develop and implement a documented process by which it reviews and manages overtime of staff members who provide homemaker/personal care in a manner that ensures the health and safety of individuals served and staff members and considers the specific needs of individuals served, the abilities of staff members, and patterns of overtime with the goal of reducing overtime.

(E) Documentation of services

Service documentation for homemaker/personal care will include each of the following to validate payment for medicaid services:

(1) Type of service.

(2) Date of service.

(3) Place of service.

(4) Name of individual receiving service.

(5) Medicaid identification number of individual receiving service.

(6) Name of provider.

(7) Provider identifier/contract number.

(8) Written or electronic signature of the person delivering the service or initials of the person delivering the service if a signature and corresponding initials are on file with the provider.

(9) Group size in which the service was provided.

(10) Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided.

(11) Number of units of the delivered service or continuous amount of uninterrupted time during which the service was provided.

(12) Times the delivered service started and stopped.

(F) Payment standards

(1) The billing units, service codes, and payment rates for homemaker/personal care provided January 1, 2024 through June 30, 2024 are contained in appendix A to this rule. The billing units, service codes, and payment rates for homemaker/personal care provided on or after July 1, 2024 are contained in appendix B to this rule. Payment rates are based on the county cost-of-doing-business category. The cost-of-doing-business category for an individual is the category assigned to the county in which the service is actually provided for the preponderance of time. The cost-of-doing-business categories are contained in appendix C to this rule. The department may cause independent providers to be paid a rate that exceeds the payment rates contained in appendix A or appendix B to this rule as necessary to comply with increases to minimum wage pursuant to Section 34a of Article II, Ohio Constitution.

(2) Payment rates for homemaker/personal care are established separately for independent providers and agency providers.

(3) Payment rates for homemaker/personal care will be adjusted to reflect the number of individuals being served and the number of people providing services.

(a) When two individuals are being served by one person, the base rate is one hundred seven per cent of the base rate for one-to-one service. When three individuals are being served by one person, the base rate is one hundred seventeen per cent of the base rate for one-to-one service. When four or more individuals are being served by one person, the base rate is one hundred thirty per cent of the base rate for one-to-one service.

(b) The base rate is divided by the number of individuals being served to determine the rate apportioned to each individual.

(c) When multiple staff members of an agency provider simultaneously provide services to more than one individual, the payment rate is adjusted to reflect the average staff-to-individual ratio at which services are provided. The calculation of rates apportioned to each individual when multiple staff members simultaneously provide services to more than one individual are contained in, as applicable, the "Application of Appendix A to Rule 5123-9-30" or the "Application of Appendix B to Rule 5123-9-30" available at https://dodd.ohio.gov.

(4) Payment rates for routine homemaker/personal care will be adjusted by the behavioral support rate modification to reflect the needs of an individual requiring behavioral support upon determination by the department that the individual meets the criteria set forth in paragraph (F)(4)(a) of this rule. The amount of the behavioral support rate modification applied to each fifteen-minute billing unit of service is contained in as applicable, appendix A or appendix B to this rule.

(a) The department will determine that an individual meets the criteria for the behavioral support rate modification when:

(i) The individual has been assessed within the last twelve months to present a danger to self or others or have the potential to present a danger to self or others; and

(ii) A behavioral support strategy that is a component of the individual service plan has been developed in accordance with the requirements in rules established by the department; and

(iii) The individual either:

(A) Has a response of "yes" to at least four items in question thirty-two of the behavioral domain of the Ohio developmental disabilities profile; or

(B) Requires a structured environment that, if removed, will result in the individual's engagement in behavior destructive to self or others.

(b) The duration of the behavioral support rate modification is limited to the individual's waiver eligibility span, may be determined needed or no longer needed within that waiver eligibility span, and may be renewed annually.

(c) The purpose of the behavioral support rate modification is to provide funding for the implementation of behavioral support strategies by staff who have the level of training necessary to implement the strategies; the department retains the right to verify that staff who implement behavioral support strategies have received training (e.g., specialized training recommended by clinicians or the team or training regarding an individual's behavioral support strategy) that is adequate to meet the needs of the individuals served.

(5) Payment rates for routine homemaker/personal care provided to individuals enrolled in the individual options waiver will be adjusted by the complex care rate modification to reflect the needs of an individual requiring total support from others upon determination by the county board that the individual meets the criteria set forth in paragraph (F)(5)(a) of this rule. The amount of the complex care rate modification applied to each fifteen-minute billing unit of service is contained in as applicable, appendix A or appendix B to this rule.

(a) The county board will determine that an individual meets the criteria for the complex care rate modification based on the individual's responses to specific questions on the Ohio developmental disabilities profile that indicate that the individual:

(i) Must be transferred and moved; and

(ii) Cannot walk, roll from back to stomach, or pull self to a standing position; and

(iii) Requires total support in toileting, taking a shower or bath, dressing/undressing, and eating.

(b) The duration of the complex care rate modification is limited to the individual's waiver eligibility span, may be determined needed or no longer needed within that waiver eligibility span, and may be renewed annually.

(6) Payment rates for routine homemaker/personal care will be adjusted by the medical assistance

rate modification to reflect the needs of an individual requiring medical assistance upon determination by the county board that the individual meets the criteria set forth in paragraph (F)(6)(a) of this rule. The amount of the medical assistance rate modification applied to each fifteen-minute billing unit of service is contained in as applicable, appendix A or appendix B to this rule.

(a) The county board will determine that an individual meets the criteria for the medical assistance rate modification when:

(i) The individual requires the administration of fluid, nutrition, and/or prescribed medication through gastrostomy or jejunostomy tube; and/or requires the administration of insulin through subcutaneous injection, inhalation, or insulin pump; and/or requires the administration of medication for the treatment of metabolic glycemic disorder by subcutaneous injection; or

(ii) The individual requires a nursing procedure or nursing task that a licensed nurse agrees to delegate in accordance with rules in Chapter 4723-13 of the Administrative Code, which is provided in accordance with section 5123.42 of the Revised Code, and when such nursing procedure or nursing task is not the administration of oral prescribed medication, topical prescribed medication, oxygen, or metered dose inhaled medication, or a health-related activity as defined in rule 5123-6-01 of the Administrative Code.

(b) The duration of the medical assistance rate modification is limited to the individual's waiver eligibility span, may be determined needed or no longer needed within that waiver eligibility span, and may be renewed annually.

(7) Payment rates for routine homemaker/personal care will be adjusted by the staff competency rate modification when homemaker/personal care is provided by independent providers or staff of agency providers who meet the criteria set forth in paragraph (F)(7)(a) of this rule and as determined in accordance with, as applicable, paragraph (F)(7)(b) or (F)(7)(c) of this rule. The amount of the staff competency rate modification applied to each fifteen-minute billing unit of service is contained in as applicable, appendix A or appendix B to this rule.

(a) An independent provider or a staff member of an agency provider will be determined eligible for the staff competency rate modification when the independent provider or staff member:

(i) Has successfully completed at least two years of full-time (or equivalent part-time) paid work experience providing direct services to individuals; and

(ii) Either:

(A) Holds a "Professional Advancement Through Training and Education in Human Services" or "DSPaths" certificate of initial proficiency or certificate of advanced proficiency; or

(B) Within the past five years has successfully completed at least sixty hours of competency-based training with proof of successful completion that is available for print, download, or issued to the learner that includes the name of the learner, the course title, the completion date, and the number of hours of training completed. For purposes of this paragraph, "competency-based training" means online or in-person training in topics not otherwise required by rule 5123-2-08, rule 5123-2-09, rule 5123-17-02, Chapter 5123-3, or Chapter 5123-9 of the Administrative Code that:

(i) Is accredited by the "National Alliance for Direct Support Professionals"; or

(ii) Is approved by the department for purposes of the staff competency rate modification.

(b) Eligibility for the staff competency rate modification for an independent provider will be determined by the department when documentation submitted by the independent provider demonstrates that the independent provider meets the criteria set forth in paragraph (F)(7)(a) of this rule.

(c) Eligibility for the staff competency rate modification for a staff member of an agency provider will be determined by the employing agency provider. The employing agency provider will review, verify, and maintain documentation that demonstrates that the staff member meets the criteria set forth in paragraph (F)(7)(a) of this rule.

(d) The cost of a staff competency rate modification is excluded from an individual's waiver budget limitation.

(8) Payment rates for routine homemaker/personal care may be modified to reflect the needs of individuals enrolled in the individual options waiver who formerly resided at developmental centers when the following conditions are met:

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

(b) Homemaker/personal care is identified in the individual service plan as a service to be delivered and the individual begins receiving the service on or after July 1, 2011; and

(c) The director of the department determines that the rate modification is warranted due to time-limited cost increases experienced when individuals move from institutional settings to community-based settings.

(9) Payment rates for routine homemaker/personal care may be modified to reflect the needs of individuals enrolled in the individual options waiver who formerly resided at intermediate care facilities for individuals with intellectual disabilities when the following conditions are met:

(a) The individual was a resident of an intermediate care facility for individuals with intellectual disabilities immediately prior to enrollment in the individual options waiver;

(b) As a result of the individual enrolling in the individual options waiver, the intermediate care facility for individuals with developmental disabilities has reduced its medicaid-certified capacity;

(c) Homemaker/personal care is identified in the individual service plan as a service to be delivered and the individual begins receiving the service on or after April 1, 2013; and

(d) The director of the department determines that the rate modification is warranted due to time-limited cost increases experienced when individuals move from institutional settings to community-based settings.

(10) The amount of the payment rate modifications set forth in paragraphs (F)(8) and (F)(9) of this rule is limited to fifty-two cents for each fifteen-minute billing unit of routine homemaker/personal

care provided to the individual during the first year of the individual's enrollment in the individual options waiver.

(11) The team will use a department-approved tool to assess and document in the individual service plan when on-site/on-call may be appropriate.

(a) In making the assessment, the team will consider:

(i) Medical or psychiatric condition which requires supervision or supports throughout the night;

(ii) Behavioral needs which require supervision or supports throughout the night;

(iii) Sensory or motor function limitations during sleep hours which require supervision or supports throughout the night;

(iv) Special dietary needs, restrictions, or interventions which require supervision or supports throughout the night;

(v) Other safety considerations which require supervision or supports throughout the night;

(vi) Emergency action needed to keep the individual safe; and

(vii) On-site/on-call will be delivered in the residence of the individual or at another location in the community selected by the individual other than the residence of the provider of the service.

(b) A provider will be paid at the on-site/on-call rate for homemaker/personal care contained in as applicable, appendix A or appendix B to this rule when:

(i) Based upon assessed and documented need, the individual service plan indicates the days of the week and the beginning and ending times each day when it is anticipated that an individual will require on-site/on-call; and

(ii) On-site/on-call does not exceed eight hours for the individual in any twenty-four-hour period.

(c) During an authorized on-site/on-call period, a provider will be paid the routine homemaker/personal care rate instead of the on-site/on-call rate for a period of time when an individual receives supervision or supports. In these instances, the provider will document the date and beginning and ending times during which supervision or supports were provided to the individual.

(d) The payment rate modifications set forth in paragraphs (F)(4), (F)(5), (F)(6), (F)(7), (F)(8), and (F)(9) of this rule are not applicable to the on-site/on-call payment rates for homemaker/personal care.

(12) Payment for homemaker/personal care does not include room and board, items of comfort and convenience, or costs for the maintenance, upkeep, and improvement of the home in which homemaker/personal care is provided.