Ohio Administrative Code

Rule 5123-9-32 Home and community-based services waivers - participant-directed homemaker/personal care under the individual options, level one, and self-empowered life funding waivers.

Effective: January 1, 2024

(A) Purpose

This rule defines participant-directed 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) "Agency with choice" means an arrangement available to an individual enrolled in the self-empowered life-funding waiver whereby an agency provider acts as a co-employer with the individual for purposes of provision of participant-directed homemaker/personal care. Under this arrangement, the individual is responsible for recruiting, selecting, training, and supervising the persons providing participant-directed homemaker/personal care. Agency with choice enables the individual to exercise choice and control over services without the burden of carrying out financial matters and other legal responsibilities associated with the employment of workers. The agency

provider is considered the employer of staff and assumes responsibility for:

(a) Employing and paying staff who have been selected by the individual;

(b) Reimbursing allowable services;

(c) Withholding, filing, and paying federal, state, and local income and employment taxes; and

(d) Providing other supports to the individual as described in the individual service plan.

(5) "Co-employer" means an arrangement available to an individual enrolled in the self-empowered life funding waiver whereby either an agency with choice or a financial management services entity under contract with the state functions as the employer of staff recruited by the individual. The individual directs the staff and is considered their co-employer. The agency with choice or financial management services entity conducts all necessary payroll functions and is legally responsible for the employment-related functions and duties for individual-selected staff based on the roles and responsibilities identified in the individual service plan for the two co-employers.

(6) "Common law employee" means a natural person certified by the department to provide participant-directed homemaker/personal care to an individual who is exercising employer authority. A common law employee will not employ, either directly or through contract, anyone else to provide participant-directed homemaker/personal care.

(7) "Common law employer" means an arrangement available to an individual enrolled in the individual options, level one, or self-empowered life funding waiver whereby the individual is the legally responsible employer of persons selected by the individual to furnish supports. The individual hires, supervises, and discharges those persons. The individual is liable for the performance of necessary employment-related tasks and uses a financial management services entity under contract with the state to perform necessary payroll and other employment-related functions as the individual's agent in order to ensure that the employer-related legal obligations are fulfilled.

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

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

(10) "Employer authority" means the individual has the authority to recruit, hire, supervise, and direct the persons who furnish participant-directed homemaker/personal care and functions as either the co-employer or the common law employer of those persons.

(11) "Family" means a person who is related to the individual by blood, marriage, or adoption.

(12) "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.

(13) "Financial management services" means services provided to an individual who directs some or all of the individual's waiver services. When used in conjunction with employer authority, financial management services includes, but is not limited to, operating a payroll service for individual-employed staff and making required payroll withholdings.

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

(15) "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.

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

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

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

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

(20) "Ohio developmental disabilities profile" means the standardized instrument utilized by the department to assess the relative needs and circumstances of an individual compared to other individuals.

(21) "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 participant-directed 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.

(22) "Participant-directed 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 and chooses to exercise employer authority. Participant-directed 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 participant-directed 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 participant-directed homemaker/personal care, assistance with personal finances which may include training, planning, and decision-making regarding the individual's personal finances.

(23) "Provider" means an agency with choice or a common law employee.

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

(25) "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.

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

(27) "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.

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

(29) "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) Participant-directed homemaker/personal care provided to an individual enrolled in the individual options waiver or the level one waiver will be provided by a common law employee.

(2) Participant-directed homemaker/personal care provided to an individual enrolled in the self-empowered life funding waiver will be provided by a common law employee or an agency with choice.

(3) A provider of participant-directed homemaker/personal care will meet the requirements of this rule and have a medicaid provider agreement with the Ohio department of medicaid.

(4) Neither a county board nor a regional council of governments formed under section 5126.13 of the Revised Code by two or more county boards will provide participant-directed

homemaker/personal care.

(5) A provider of participant-directed homemaker/personal care is subject to the requirements of rule 5123-2-08 or 5123-2-09 of the Administrative Code, as applicable, except that:

(a) A common law employee need not hold a high school diploma or certificate of high school equivalence, "American Red Cross" or equivalent certification in first aid, or "American Red Cross" or equivalent certification in cardiopulmonary resuscitation unless specifically required to do so by the individual receiving services; and

(b) A common law employee need not complete the eight hours of annual training described in appendix A to rule 5123-2-09 of the Administrative Code unless specifically required to do so by the individual receiving services, but in any case will annually complete training in accordance with standards established by the department in:

(i) The rights of individuals set forth in section 5123.62 of the Revised Code; and

(ii) Rule 5123-17-02 of the Administrative Code including a review of health and welfare alerts issued by the department since the previous year's training.

(6) A provider of participant-directed homemaker/personal care will not administer medication or perform health-related activities unless the provider meets the applicable requirements of Chapters 4723., 5123., and 5126. of the Revised Code and rules adopted under those chapters.

(7) An applicant seeking certification to provide participant-directed 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.

(8) The individual receiving participant-directed homemaker/personal care will determine training to be completed by the common law employee or staff of the agency with choice as necessary to meet the individual's unique needs.

(9) Failure of a 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.

(D) Requirements for service delivery

(1) The individual receiving participant-directed homemaker/personal care or the individual's guardian or the individual's designee must be willing and able to perform the duties associated with participant direction.

(2) Participant-directed 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.

(3) An individual enrolled in the individual options waiver or the level one waiver may receive participant-directed homemaker/personal care only when living alone or with family.

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

(5) Participant-directed homemaker/personal care will not be provided to an individual at the same time as residential respite.

(6) Participant-directed 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.

(7) Participant-directed homemaker/personal care services may extend to those times when the individual is not physically present and the common law employee is performing homemaker activities on behalf of the individual.

(8) Participant-directed 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) Participant-directed 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) Participant-directed 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 participant-directed homemaker/personal care is awake;

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

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

(f) The cost of participant-directed 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.

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

(10) The ratio of persons providing participant-directed homemaker/personal care to the individuals being served will not exceed one to three.

(11) A provider of participant-directed 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.

(12) A provider delivering participant-directed homemaker/personal care 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.

(E) Documentation of services

(1) Service documentation for participant-directed homemaker/personal care will include each of the following to validate payment for medicaid services:

(a) Type of service.

(b) Date of service.

(c) Place of service.

(d) Name of individual receiving service.

(e) Medicaid identification number of individual receiving service.

(f) Name of provider.

(g) Provider identifier/contract number.

(h) Written or electronic signature of the person delivering the service.

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

(j) 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.

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

(l) Times the delivered service started and stopped.

(2) A common law employee will prepare an accurate timesheet to be verified by the individual receiving participant-directed homemaker/personal care prior to submission to the financial management services entity.

(F) Payment standards

(1) The billing unit, service codes, and payment rates for participant-directed homemaker/personal care provided January 1, 2024 through June 30, 2024 are contained in appendix A to this rule. The billing unit, service codes, and payment rates for participant-directed homemaker/personal care provided on or after July 1, 2024 are contained in appendix B to this rule.

(2) The payment rates for participant-directed homemaker/personal care provided by a common law employee are negotiated by the individual and the common law employee subject to the minimum and maximum payment rates contained in as applicable, appendix A or appendix B to this rule and will be recorded in the individual service plan. An individual who meets the criteria for a rate modification described in paragraph (F)(4), (F)(5), or (F)(6) of this rule may choose to add the applicable rate modification to the negotiated base payment rate.

(3) The payment rates for participant-directed homemaker/personal care are adjusted to reflect the number of individuals being served and the number of persons providing services.

(4) Payment rates for routine participant-directed homemaker/personal care may 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 participant-directed homemaker/personal care may 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)(5)(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.

(6) Payment rates for routine participant-directed homemaker/personal care provided to individuals enrolled in the individual options waiver may 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)(6)(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.

(7) 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 participant-directed 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 participant-directed homemaker/personal care rate instead of the on-site/on-call rate for a period of time when an individual receives supports. In these instances, the provider will document the date and beginning and ending times during which supports were provided to the individual.

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

(8) Payment for participant-directed 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 participant-directed homemaker/personal care is provided.