5123:2-9-30 **[WILL BE RENUMBERED 5123-9-30] Home and community-based services waivers - homemaker/ personal care under the individual options and level one waivers.**

(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

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

(2) "Agency provider" means an entity that directly employs at least one person in addition to the chief executive officer for the purpose of providing services for which the entity must be certified in accordance with rule 5123:2-2-01 of the Administrative Code.

(3) "Community respite" has the same meaning as in rule ~~5123:2-9-22~~ 5123-9-22 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 state-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.

(8) "Funding range" means one of the dollar ranges contained in appendix A to rule 5123:2-9-06 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 5123:2-9-16 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 his or her 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) 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 he or she must be certified in accordance with rule 5123:2-2-01 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, his or her 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 5123:2-9-15 of the Administrative Code.

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

(16) "Informal respite" has the same meaning as in rule 5123:2-9-21 of the Administrative Code.

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

(18) "Money management" has the same meaning as in rule 5123:2-9-20 of the Administrative Code.

(19) "Non-medical transportation" has the same meaning as in rule 5123:2-9-18 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 enrolled in the individual options waiver 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.

(21) "On-site/on-call" means a rate paid when no need for supervision or supports is anticipated and a provider must be on-site and available to provide homemaker/personal care but is not required to remain awake.

(22) "Participant-directed homemaker/personal care" has the same meaning as in rule 5123:2-9-32 of the Administrative Code.

~~(22)~~(23) "Residential respite" has the same meaning as in rule ~~5123:2-9-34~~ 5123-9-34 of the Administrative Code.

~~(23)~~(24) "Service and support administrator" means a person, regardless of title, employed by or under contract with a county board to perform the functions of service and support administration and who holds the appropriate certification in accordance with rule 5123:2-5-02 of the Administrative Code.

~~(24)~~(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 shall include the items delineated in paragraph (E) of this rule to validate payment for medicaid services.

~~(25)~~(26) "Shared living" has the same meaning as in rule 5123:2-9-33 of the Administrative Code.

~~(26)~~(27) "Team" has the same meaning as in rule 5123:2-1-11 of the Administrative Code.

~~(27)~~(28) "Transportation" has the same meaning as in rule 5123:2-9-24 of the Administrative Code.

~~(28)~~(29) "Vocational habilitation" has the same meaning as in rule 5123:2-9-14 of the Administrative Code.

~~(29)~~(30) "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 shall 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 shall 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 shall complete and submit an application through the department's website (http://dodd.ohio.gov~~/~~).

(4) Providers licensed under section 5123.19 of the Revised Code seeking to provide homemaker/personal care shall:

(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.

(c) Provide to the department written assurance to arrange for substitute coverage, if necessary, only from a provider certified or approved by the department and as identified in the individual service plan; notify 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.

(5) Each direct services staff member of an agency provider shall successfully complete on-the-job training specific to each individual he or she serves that includes:

(a) What is important to the individual and what is important for the individual; and

(b) The individual's support needs including, as applicable, behavioral support strategy, management of the individual's funds, and medication administration/delegated nursing.

(6) Each independent provider and each direct services staff member of an agency provider shall annually complete at least eight hours of training, in accordance with standards established by the department.

(a) The training shall enhance the skills and competencies of the independent provider or direct services staff member relevant to his or her job responsibilities and shall include, but is not limited to:

(i) The role and responsibilities of the independent provider or direct services staff member with regard to services including person-centered planning, community integration, self-determination, and self-advocacy.

(ii) The rights of individuals set forth in sections 5123.62 to 5123.64 of the Revised Code.

(iii) The requirements of rule 5123:2-17-02 of the Administrative Code including a review of health and welfare alerts issued by the department since the previous year's training.

(iv) The requirements relative to the independent provider's or direct services staff member's role in providing behavioral support to the individuals he or she serves.

(b) The training may be structured or unstructured and may include, but is not limited to, lectures, seminars, formal coursework, workshops, conferences, demonstrations, visitations or observations of other services/programs, distance and other means of electronic learning, video and audio-visual training, and staff meetings.

(c) The provider shall maintain a written record, which may include an electronic record, of training. This information shall be presented upon request by the Ohio department of medicaid, the department, or the county board. Documentation shall include the name of the person

receiving the training, date of training, training topic, duration of training, instructor's name if applicable, and a brief description of the training.

(7) Failure of a certified provider to comply with this rule and rule 5123:2-2-01 of the Administrative Code may result in denial, suspension, or revocation of the provider's certification.

(8) Failure of a licensed provider to comply with this rule and Chapter 5123:2-3 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 shall be provided pursuant to an individual service plan that conforms to the requirements of rule 5123:2-1-11 of the Administrative Code. Providers shall 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 shall not also provide money management or shared living to the same individual.

(3) Homemaker/personal care shall 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 shall 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 shall not bill for homemaker/personal care provided by the driver during the same time non-medical transportation is provided.

(7) An agency provider shall 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 shall 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 are contained in appendix A 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 B to this rule.

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

(3) Payment rates for homemaker/personal care shall 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 shall be 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 shall be 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 shall be 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 the "Application of Appendix A to Rule ~~5123:2-9-30~~ 5123-9-30" (~~January~~July 1, 2018), which is available at the department's website (http://dodd.ohio.gov~~/ruleslaws/pages/rulesineffect.aspx~~).

(4) Payment rates for routine homemaker/personal care shall 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 ~~the~~ appendix A to this

rule.

(a) The department shall 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 shall be 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 shall 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 ~~the~~ appendix A to this rule.

(a) The county board shall 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 himself or herself 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 shall be 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) Complex care rate modifications are subject to review by the department.~~

(6) Payment rates for routine homemaker/personal care shall 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 ~~the~~ appendix A to this rule.

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

(i) The individual requires routine feeding and/or the administration of prescribed medication through gastrostomy and/or jejunostomy tubes, and/or requires the administration of routine doses of insulin through subcutaneous injections and insulin pumps; or

(ii) The individual requires oxygen administration that a licensed nurse agrees to delegate in accordance with rules in Chapter 4723-13 of

the Administrative Code; or

(iii) 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 procedure or nursing task is not the administration of oral prescribed medication or topical prescribed medication or a health-related activity as defined in rule 5123:2-6-01 of the Administrative Code.

(b) The duration of the medical assistance rate modification shall be 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) Medical assistance rate modifications are subject to review by the department.~~

(7) Payment rates for routine homemaker/personal care shall 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 appendix A to this rule.

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

(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. For purposes of this paragraph, "competency-based training" means online

or in-person training in topics not otherwise required by rule 5123:2-2-01, rule 5123:2-17-02, Chapter 5123:2-3, Chapter 5123:2-9, or Chapter 5123-9 of the Administrative Code that:

(i) Is accredited by the "National Alliance for Direct Support Professionals" and offered through "Relias" or "DirectCourse College of Direct Support";

(ii) Requires the learner to demonstrate proficiency via testing or portfolio development; and

(iii) Offers proof of successful completion that is available for print, download, or issue to the learner that includes the name of the learner, the course title, the completion date, and the number of hours of training completed.

(b) Eligibility for the staff competency rate modification for an independent provider shall be determined by the department when documentation submitted by the independent provider through the department's website (http://dodd.ohio.gov) 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 shall be determined by the employing agency provider. The employing agency provider shall 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.

~~(7)~~(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.

~~(8)~~(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.

~~(9)~~(10) The amount of the payment rate modifications set forth in paragraphs ~~(F)(7) and~~ (F)(8) and (F)(9) of this rule shall be 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.

~~(10)~~(11) The team shall assess and document in the individual service plan when on-site/on-call may be appropriate.

(a) In making the assessment, the team shall 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; and

(vi) Emergency action needed to keep the individual safe.

(b) A provider shall be paid at the on-site/on-call rate for homemaker/personal care contained in appendix A 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) The individual is asleep and requires staff to be available to provide homemaker/personal care; and

(iii) The needs of the individual require staff to be on-site but not to remain awake; and

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

(c) A provider shall be paid the routine homemaker/personal care rate instead of the on-site/on-call rate when an individual receives supervision or supports during the night. In these instances, the provider shall 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), ~~and~~ (F)(8), and (F)(9) of this rule are not applicable to the on-site/on-call payment rates for homemaker/personal care.

~~(11)~~(12) Payment for homemaker/personal care shall not include room and board, items of comfort and convenience, or costs for the maintenance, upkeep, and improvement of the home.

~~(12)~~(13) Under the level one waiver, payment for community respite, homemaker/personal care, informal respite, money management, participant-directed homemaker/personal care, residential respite, and transportation, alone or in combination, shall not exceed five thousand three hundred twenty-five dollars per waiver eligibility span.