Department of Medicaid

Mike DeWine, Governor
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To: ALL CLEARANCE REVIEWERS

From: Icilda Dickerson, Chief, Bureau of Long-Term Services and Supports

Date: August 2, 2021

Subject: **Proposed Draft Changes to OAC Rule 5160-51-10 Helping Ohioans move, expanding choice (HOME choice)**

Attached for your review and comment are the proposed changes to Ohio Administrative Code (OAC) Rule 5160-51-10 Helping Ohioans move, expanding choice (HOME choice). The rule is being proposed for amendment due to a change in the institutional residency period requirement per the Consolidated Appropriations Act, 116 H.R. 133 (Pub. L. 116-260), Division CC, Title II, Section 204 (b)(1)(A). The rule is being amended to align the institutional residency period with the federal regulation. Changes to the rule include the following:

OAC 5160-51-10, entitled "Helping Ohioans move, expanding choice (HOME choice)"

- Period of residency in an institutional setting changed from ninety days to sixty days
- Language clarification, "Needs Assessment" updated to "Assessment"

In addition to updating the rule, the corresponding Home Choice Application, form ODM 10239, is also being proposed for amendment to reflect the change in federal regulation and better align the paper form with the online application. Changes to the form include the following:

ODM 10239, entitled "HOME Choice Application"

- Language referencing period of residency in an institutional setting changed from ninety to sixty days
- Language updated to refine requirements
- Language clarified to verify income
- Waiver references updated to reflect all Ohio HCBS waivers
- Formatting and order changes to align paper form with online application

Thank you in advance for your review.

Attachments

5160-51-10 Helping Ohioans move, expanding choice (HOME choice).

(A) Helping Ohioans move, expanding choice (HOME choice) assists individuals to transition from an institutional setting into a community setting.

(B) Definitions

(1) "Assessment" means an in-person meeting with the HOME choice applicant to determine eligibility for the program, conducted by the Ohio department of medicaid (ODM) or its designee.

~~(1)~~ (2) "Community setting" means a location that meets the home and community-based setting requirements set forth in rule 5160-44-01 of the Administrative Code or for those moving from an intermediate care facility for individuals with intellectual disabilities the requirements set forth in rule 5123:2-9-02 of the Administrative Code.

~~(2)~~ (3) "HOME choice participant" or "participant" means a person who is enrolled in HOME choice.

~~(3)~~ (4) "Institutional setting" means a hospital as described in Chapter 5160-2 of the Administrative Code, a nursing facility as described in Chapter 5160-3 of the Administrative Code, or an intermediate care facility for individuals with intellectual disabilities as described in Chapter 5123:2-7 of the Administrative Code.

~~(4)~~ (4) ~~"Needs assessment" means an in-person meeting with the HOME choice applicant to determine eligibility for the program, conducted by the Ohio department of medicaid (ODM) or its designee.~~

(C) To be eligible for HOME choice, an individual must:

(1) Be enrolled in medicaid in accordance with division 5160:1 of the Administrative Code at the time of HOME choice application and during the entire HOME choice enrollment period;

(2) Currently reside in an institutional setting in Ohio and have resided in an institutional setting in Ohio for a period of not less than ~~ninety~~sixty consecutive days;

(3) Be eighteen years of age or older;

(4) Complete the ODM 10239, "HOME Choice Application" ~~(7/2019)~~(5/2021) which includes:

(a) Agreeing to adhere to the participant responsibilities outlined in the HOME choice application;

(b) Agreeing to move to a community setting in Ohio within one hundred eighty days of enrolling in the program.

(5) Participate in ~~a needs~~an assessment and be determined by ODM to have:

(a) A need for the program. Examples include:

(i) Requiring physical or emotional supports to successfully transition from an institutional setting to a community setting;

(ii) Lacking family or informal supports willing and capable of assisting with any of the following;

(a) Locating, securing or moving into a community setting;

(b) Acquiring household furnishings and supplies;

(c) Restoring credit or obtaining financial resources necessary to obtain or set up a household;

(d) Accessing community resources and supports; or

(e) Arranging necessary home adaptations required for community living.

(b) Health care needs that may be adequately met in a community setting; and

(c) Enough income or means to sustain community living at the time of HOME choice application and during the entire HOME choice enrollment period.

(6) Have not previously transitioned through the HOME choice program after July 1, 2019;

(7) Not be moving to another institutional setting.

(8) Work with a transition coordinator to develop a safe transition plan, and discharge in accordance with that plan.

(9) Not be a foster child, as defined in Chapter 5101:2-1 of the Administrative Code; and

(10) Not be eligible for both:

(a) Targeted case management, as defined in rule 5160-48-01 of the Administrative Code, and

(b) Community transition services, as defined in rule 5123-9-48 of the Administrative Code.

(D) An individual may be enrolled in HOME choice when all the criteria in paragraph (C) of this rule are met. ODM will notify the individual of enrollment in writing. The HOME choice enrollment period begins on the date of the enrollment letter and continues for up to one hundred eighty days pre-transition and up to thirty days post transition.

(E) Services available through HOME choice include activities approved by ODM or it's designee to assist the participant in their transition including:

(1) "Transition coordination" which includes:

(a) Working with facility discharge planners to determine what services and supports the participant will need in the community;

(b) Helping the participant obtain housing;

(c) Linking the participant with community resources;

(d) Coordinating the use of community transition services;

(e) Collaborating with the participant's comprehensive care team and nursing facility or hospital to coordinate services at the time of discharge from the institutional setting, and after the transition into the community setting when applicable.

(2) "Community transition service" as set forth in rule 5160-44-26 of the Administrative Code.

(3) HOME choice services can not duplicate services available to a participant enrolled on a home and

community-based services (HCBS) waiver.

(F) A participant may receive HOME choice services for up to thirty days post transition beginning on the date the participant moves from the institutional setting into the community setting.

(G) If an individual fails to meet any of the requirements set forth in paragraph (C) of this rule before the HOME choice enrollment period, the individual will be denied participation in the program and afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

(H) If an individual fails to meet any of the requirements set forth in paragraph (C) of this rule after the HOME choice enrollment period begins, the individual will be terminated from the program and afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

Ohio Department of Medicaid

HOME CHOICE APPLICATION

Applicant Name *(Last)*	*(First)*	*(MI)*	Date of Birth *(mm/dd/yyyy)*

Social Security Number	Phone Number	Email	Gender ☐ Male ☐ Female

Eligibility Requirements – If you have transitioned through the HOME Choice program after July 2019, you are not eligible to reapply. To qualify for this program, you must be at least 18 years of age, have needs that can safely be met in a home or community-based setting as determined by the Ohio Department of Medicaid or its designee, and meet each of the additional four requirements listed below.

1. You must be currently approved for Ohio Medicaid at the time of application and throughout HOME Choice program involvement. — Medicaid ID Number *(12-digits)*

2. You must have income or a means of support for such ongoing expenses as rent, utilities, food, etc. *(Please verify income and check all that apply)*

☐ Social Security Retirement ☐ Pension ☐ Earned Wages (Employment) ☐ Private Disability Insurance
☐ Social Security Disability Insurance (SSDI) ☐ Supplemental Security Income (SSI) ☐ Veterans Benefits
☐ Workers Compensation ☐ Other *(specify)*

3. You must be legally permitted to leave the institution and relocate to a community setting. ☐ Yes ☐ No
If No, please describe the situation *(e.g. court ordered placement).*

4. You must currently reside in one of the following types of long-term care facilities in Ohio at the time of application for at least 60 consecutive days *(Check only one)* ☐ Nursing Facility ☐ Hospital ☐ Intermediate Care Facility

Name of Current Facility	Date of Facility Admission *(mm/dd/yyyy)*
Street Address	Facility Phone Number

City	County	Zip Code	Facility Fax Number

Facility Social Worker/Point of Contact *(Name)*	Phone Number	Email *(Required)*

If you were in other facilities for care during the past 60 consecutive days, please indicate these below.

Name of Facility	Date of Admission	Discharge Date	Type of Facility

What circumstance led you to be in your current long-term care stay? *(Check only one)*

☐ Physical Disability ☐ Chronic Illness ☐ Surgery ☐ Accident (Motor Vehicle)
☐ Accident *(Other)* ☐ Mental Illness ☐ Short-term Illness ☐ Substance Use
☐ Accident *(Work)*
☐ Other *(specify)*

What type of housing did you live in just before being in long-term care? *(Check only one)*

☐ My own house ☐ Assisted Living ☐ Rented apartment/house ☐ Homeless
☐ Group Home ☐ Incarceration ☐ Friend or relative's home
☐ Other *(specify)*

Have you received any of these specific services in the community? *(Check all that apply)*

☐ Home Nursing ☐ Delivered Meals ☐ Personal Care Aide ☐ Case Management
☐ Voucher/Subsidized Housing ☐ Transportation ☐ Housekeeping ☐ Home Modifications
☐ Training/Employment ☐ Utility Assistance

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Do you plan on transitioning to the community within the next six months? ☐ Yes ☐ No ☐ Not Sure	Anticipated Date
Do you have housing to live in once you leave the facility?	☐ Yes ☐ No ☐ Not Sure
Do you have friends or relatives who can help you transition to the community?	☐ Yes ☐ No ☐ Not Sure
Do you have friends or relatives who can help you after you transition to the community?	☐ Yes ☐ No ☐ Not Sure

Are you a past Medicaid waiver recipient? ☐ Yes ☐ No If Yes, which waiver?
☐ Assisted Living ☐ Level One ☐ MyCare Ohio ☐ Ohio Home Care ☐ PASSPORT ☐ SELF ☐ IO

I understand that participation in the Ohio HOME Choice program is voluntary; therefore, if approved, I understand and agree to the following responsibilities as a participant in the HOME Choice program:
(Each box must be checked to be eligible for program and you must agree with each individual statement.)

- ☐ I agree to participate in the HOME Choice program and understand that information obtained by the Transition Coordination Agency may be shared with others as part of my transition planning.
- ☐ I will actively participate in any assessments and meetings necessary to develop a transition plan that ensures my health and safety in a home or community-based setting.
- ☐ I will provide full and accurate information *(e.g. credit history, law enforcement involvement, rental history, personal history)* to the program's providers so they may plan for and assist me with my transition to a home or community-based setting.
- ☐ If I refuse to participate and cooperate with the Transition Coordination Agency, it may result in my termination from the HOME Choice program.
- ☐ I will forfeit the opportunity to participate in the program if I leave the long-term care facility early against medical advice and/or prior to participating in planning to ensure a safe and orderly discharge to the community.
- ☐ I will lose the opportunity to participate if I fail to meet any of the eligibility requirements.
- ☐ I agree to move into an appropriate residence upon discharge from the long-term care facility.
- ☐ I understand that if I transition to a home or community-based setting with the assistance of this program, I may not reapply for HOME Choice in the future.
- ☐ I understand that the transition coordinator will work with me up to 180 days pre-transition and for 30 days after I transition.

Applicant Signature *(or mark)*	Date *(mm/dd/yyyy)*

If the applicant has a guardian, please have the guardian sign and complete this section.

Guardian Name *(Last)*	*(First)*	*(MI)*	Guardian Type ☐ Person ☐ Estate ☐ Person and Estate
Guardian Street Address	City	State	Zip Code
Guardian Phone	Guardian Email		
Guardian Signature *(if applicable)*	Date *(mm/dd/yyyy)*		
Person Completing Application *(if other than applicant)*	Phone Number	Relationship to Applicant	Email

Referral Source

☐ Self	☐ Guardian	☐ Community Agency	☐ Family
☐ AAA/PSA	☐ Friend	☐ LTC Ombudsman	☐ Managed Care Provider
☐ Nursing Facility	☐ CareStar/CareSource	☐ Hospital	☐ Center for Independent Living
☐ CLS	☐ Other *(specify)*:		

Submit completed form to:

Ohio Department of Medicaid
Office of Health, Innovation & Quality, Clinical Operations Bureau, HOME Choice Section
PO Box 182709 | 4th Floor | Columbus, Ohio 43218-2709
Email: HOME_Choice@medicaid.ohio.gov | Phone: (888) 221-1560 | FAX: (614) 360-3549

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