To: ALL CLEARANCE REVIEWERS

From: Susan Hussein, Policy Administrator, HCBS Policy Section

Bureau of Long-Term Services and Supports, HCBS Policy Section

Date: 8/04/2021

Subject: Proposed Rate Increases for Services in the Ohio Home Care, PASSPORT, and Assisted Living Waiver

The Ohio Department of Medicaid (ODM) is responsible for the administration and oversight of four nursing facility-based level of care home and community-based services (HCBS) waivers: MyCare Ohio, the Ohio Home Care Waiver, PASSPORT, and the Assisted Living Waiver. Day-to-day operations for the PASSPORT and Assisted Living Waiver are performed by the Ohio Department of Aging (ODA).

Attached for your review and comment are the Ohio Administrative Code (OAC) rule changes governing the reimbursement policy for the Ohio Home Care, PASSPORT, and Assisted Living waivers. Increases are being proposed for the maximum reimbursement rates for personal care, home care attendant, waiver nursing, and adult day services under the Ohio Home Care waiver. Increases are also being proposed for the maximum reimbursement rates for personal care, home maker, waiver nursing, and adult day services under the PASSPORT waiver, as well as the assisted living service in the Assisted Living Waiver. Adult Day Service rates are in the process of being established by the Department and are reflected as "TBD" within the associated rule drafts.

The Department will continue to work with stakeholders to finalize home delivered meal rates, to be effective at a later date in another rule package.

OAC 5160-1-06.1, entitled "Home and community-based service waivers: PASSPORT," is the rule that sets forth the covered services and the maximum allowable rates for services furnished under the PASSPORT waiver. This rule will be proposed for amendment to increase the maximum allowable reimbursement for waiver nursing, personal care, homemaker, and adult day services set forth in the Appendix and update rule citations in the Appendix.

OAC 5160-1-06.5, entitled "Home and community-based services (HCBS) waivers: assisted living," is the rule that sets forth the covered services and the maximum allowable rates for services furnished under the assisted living waiver. This rule will be proposed for amendment to increase the maximum allowable reimbursement for the assisted living service set forth in the Appendix.

OAC 5160-46-06, entitled "Ohio home care waiver program: reimbursement rates and billing procedures," is the rule that sets forth the covered services and maximum allowable rates for services furnished under the Ohio home care waiver. This rule will be proposed for amendment to increase the maximum allowable reimbursement for waiver nursing, personal care services, and adult day services, update effective dates for statutory citations, and five-year rule review as well.

OAC 5160-46-06.1, entitled "Ohio home care waiver program: home care attendant services reimbursement rates and billing procedures," is the rule that sets forth the maximum allowable rates for home care attendant services furnished under the Ohio home care waiver. This rule will be proposed for amendment to increase the maximum allowable reimbursement for home care attendant services, add rate and billing code information that was previously omitted from the rule in error update terminology and rule citations, and five-year rule review.

Thank you in advance for your review of these rules.

Attachments

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5160-1-06.1 Home and community-based service waivers: PASSPORT.

(A) The Ohio department of aging (ODA) is responsible for the daily administration of the preadmission screening system providing options and resources today (PASSPORT) medicaid waiver program. ODA shall administer the waiver pursuant to an interagency agreement with the Ohio department of medicaid in accordance with section 5162.35 of the Revised Code.

(B) The PASSPORT waiver provides home and community based services to individuals enrolled in the waiver in accordance with rule 5160-31-04 of the Administrative Code.

(C) The PASSPORT HCBS waiver covered services and eligibility requirements are set forth in Chapter 5160-31 of the Administrative Code.

(D) The maximum allowable payment rates for PASSPORT HCBS waiver program services are listed in appendix A to this rule.

(E) PASSPORT HCBS payment must be provided in accordance with paragraphs (A) to (C) of rule 5160-1-60 of the Administrative Code.

PASSPORT WAIVER RATES

WAIVER	UNIT	BILLING MAXIMUM
Adult Day: enhanced	1 day	~~$49.39~~ TBD
Adult Day: enhanced	½ day	~~$24.70~~ TBD
Adult Day: enhanced	15 minutes	~~$1.55~~ TBD
Adult Day: intensive	1 day	~~$64.84~~ TBD
Adult Day: intensive	½ day	~~$32.41~~ TBD
Adult Day: intensive	15 minutes	~~$2.03~~ TBD
Adult Day Transportation	1 mile	~~$2.22~~ TBD
Adult Day Transportation	Round Trip	~~$20.40~~ TBD
Adult Day Transportation	1 one-way Trip	~~$16.55~~ TBD
Alternative Meals	1 meal	$31.35
Choices Home Care Attendant	15 minutes	$6.25
Community Integration	15 minutes	$3.50
Community Transition	1 completed job or deposit	$2,000
Enhanced Community Living	15 minutes	$5.83
Home Care Attendant	Unit is established in OAC 5160-46-06.1	Billing maximum is established in OAC 5160-46-06.1
Home Delivered Meals: regular	1 meal	$6.50
Home Delivered Meals: therapeutic and kosher	1 meal	$8.68
Home Medical Equipment and Supplies	1 item	$5,224.93

Home Maintenance and Chore	1 completed job	$10,000 per calendar year
Home Modification	1 completed job	$10,000 per calendar year
Homemaker	15 minutes	~~$3.84~~ $4.07
Non-emergency medical Transportation	1 round trip	$1,306.24
Non-emergency medical Transportation	1 one-way trip	$653.11
Non-medical Transportation	1 round trip	$1,306.24
Non-medical Transportation	1 one-way trip	$653.11
Nutritional Consultation	15 minutes	$13.34
Out-of-Home Respite	Unit is established in OAC 5160-46-06	Billing maximum is established in OAC 5160-46-06
Personal Care: agency	15 minutes	~~$4.64~~ $4.92
Personal Care: participant-directed individual provider	15 minutes	~~$3.24~~ $3.44
Personal Emergency Response System: installation	1 completed installation	$32.95
Personal Emergency Response System: ongoing	1 monthly rental	$32.95
Social Work Counseling	15 minutes	$16.26
Waiver Nursing	Unit is established in OAC 5160-46-06	Billing maximum is established in OAC ~~5160-46-06.1~~ 5160-46-06

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5160-1-06.5 Home and community based services (HCBS) waivers: assisted living.

(A) The Ohio department of aging (ODA) is responsible for the daily administration of the assisted living HCBS waiver. ODA will administer this waiver pursuant to an interagency agreement with the Ohio department of medicaid (ODM), in accordance with section 5162.35 of the Revised Code.

(B) The assisted living HCBS waiver is an alternative to nursing facility placement for persons age twenty-one and over who require an intermediate level of care or a skilled level of care as set forth in rule 5160-3-08 of the Administrative Code and are enrolled in the waiver.

(1) The assisted living HCBS waiver's services and program eligibility criteria are set forth in Chapter 5160-33 of the Administrative Code.

(2) The maximum allowable reimbursement rates for assisted living HCBS waiver program services are listed in appendix A to this rule.

(3) Assisted living HCBS reimbursement shall be provided in accordance with rule 5160-1-60 of the Administrative Code.

(4) The billing maximum for the community transition service listed in appendix A to this rule represents the cumulative maximum for the items purchased or deposits made through the community transition service as set forth in rule 173-39-02.17 of the Administrative Code.

ASSISTED LIVING WAIVER RATES

WAIVER SERVICE	UNIT	BILLING MAXIMUM
Assisted Living Service: Tier 1	1 day	~~$51.61~~ $54.76
Assisted Living Service: Tier 2	1 day	~~$61.95~~ $65.73
Assisted Living Service: Tier 3	1 day	~~$72.26~~ $76.67
Community Transition Service	Completed Job Order or Deposit Made	$2000.00

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5160-46-06 Ohio home care waiver program: reimbursement rates and billing procedures.

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

(1) "Base rate," as used in table A, column 3 of paragraph (B) of this rule, means the amount reimbursed by the Ohio department of medicaid (ODM) for the first thirty-five to sixty minutes of service delivered.

(2) "Bid rate," as used in table B, column 3 of paragraph (B) of this rule, means the per job bid rate negotiated between the provider and the individual's case manager.

(3) "Billing unit," as used in table B, column 3 of paragraph (B) of this rule, means a single fixed item, amount of time or measurement (e.g., a meal, a day, or mile, etc.).

(4) "Caretaker relative" has the same meaning as in rule 5160:1-1-01 of the Administrative Code.

(5) "Group rate," as used in paragraph (D)(1) of this rule, means the amount that waiver nursing and personal care aide service providers are reimbursed when the service is provided in a group setting.

(6) "Group setting" means a setting in which:

(a) A personal care aide service provider furnishes the same type of services to two or three individuals at the same address. The services provided in the group setting can be either the same type of ODM-administered waiver service, or a combination of ODM-administered waiver services and similar non-ODM-administered waiver services.

(b) A waiver nursing service provider furnishes the same type of services to either:

(i) Two or three individuals at the same address. The services provided in the group setting can be either the same type of ODM-administered waiver service, or a combination of ODM-administered waiver services and similar non-ODM-administered waiver services.

(ii) Two to four individuals at the same address if all of the individuals receiving ODM-administered waiver nursing services are:

(a) Medically fragile children, and

(b) Siblings, and

(c) Residing together in the home of their caretaker relative. The services provided in the group setting must be ODM-administered waiver nursing services.

(7) "Medicaid maximum rate" means the maximum amount that will be paid by medicaid for the service rendered.

(a) For the billing codes in table B of paragraph (B) of this rule, the medicaid maximum rate is set forth in column (4).

(b) For the billing codes in table A of paragraph (B) of this rule, the medicaid maximum rate is:

(i) The base rate as defined in paragraph (A)(1) of this rule, or

(ii) The base rate as defined in paragraph (A)(1) of this rule plus the unit rate as defined in paragraph (A) (7) of this rule for each additional unit of service delivered, or

(iii) The unit rate as defined in paragraph (A)(7)(b) of this rule.

(8) "Medically fragile child" means an individual who is under eighteen years of age, has intensive health care needs, and is considered blind or disabled under section 1614(a)(2) or (3) of the "Social Security Act," (42 U.S.C. 1382c(a)(2) or (3)) (as in effect on January 1, ~~2018~~2021).

(9) "Modifier," as used in paragraph (D) of this rule, means the additional two-alpha-numeric-digit billing codes that providers are required to use to provide additional information regarding service delivery.

(10) "Unit rate," as used in table A, column 4 of paragraph (B) of this rule, means the amount reimbursed by ODM for each fifteen minutes of service delivered when the visit is:

(a) Greater than sixty minutes in length.

(b) Less than or equal to thirty-four minutes in length. ODM will reimburse a maximum of only one unit if the service is equal to or less than fifteen minutes in length, and a maximum of two units if the service is sixteen through thirty-four minutes in length.

(B) Billing code tables.

Table A

Column 1	Column 2	Column 3	Column 4
Billing code	Service	Base rate	Unit rate
T1002	Waiver nursing services provided by an agency RN	~~$47.40~~$50.29	~~$8.72~~$9.25
T1002	Waiver nursing services provided by a non-agency RN	~~$38.95~~$41.33	~~$7.03~~$7.46
T1002	Waiver nursing services provided by a non-agency RN (overtime)	~~$50.82~~$53.92	~~$10.01~~$10.62
T1003	Waiver nursing services provided by an agency LPN	~~$40.65~~$43.13	~~$7.37~~$7.82
T1003	Waiver nursing services provided by a non-agency LPN	~~$33.20~~$35.23	~~$5.88~~$6.24
T1003	Waiver nursing	~~$43.00~~$45.62	~~$8.33~~$8.84

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Table A

	services provided by a non-agency LPN (overtime)		
T1019	Personal care aide services provided by an agency personal care aide	~~$23.88~~$25.34	~~$3.97~~$4.21
T1019	Personal care aide services provided by a non-agency personal care aide	~~$19.25~~$20.42	$3.24 ~~$3.05~~
T1019	Personal care aide services provided by a non-agency personal care aide (overtime)	~~$23.33~~$24.75	$4.56 ~~$4.30~~

Table B

Column 1	Column 2	Column 3	Column 4
Billing code	Service	Billing unit	Medicaid maximum rate
H0045	Out-of-home respite services	Per day	$199.82
S0215	Supplemental transportation services	Per mile	$0.38
S5101	Adult day health center services	Per half day	TBD ~~$32.48~~
S5102	Adult day health	Per	~~$64.94~~TBD

Table B

	center services	day	
S5160	Personal emergency response systems	Per installation and testing	$32.95
S5161	Personal emergency response systems	Per monthly fee	$32.95
S5165	Home modification services	Per item	Amount prior-authorized on the person-centered services plan, not to exceed $10,000 in a twelve-month calendar year
T2029	Supplemental adaptive and assistive device services	Per item	Amount prior-authorized on the person-centered services plan, not to exceed $10,000 in a twelve-month calendar year
S5170	Home delivered meal services - standard meal	Per meal	$6.50
S5170	Home delivered meal services - therapeutic or kosher meal	Per meal	$8.68
S5135	Community integration	Per	$3.50

Table B

	services	fifteen-minute unit	
T2038	Community transition services	Per job	$2,000 per waiver enrollment
S5121	Home maintenance and chore services	Per job	Amount prior-authorized on the person-centered services plan, not to exceed $10,000 in a twelve-month calendar year

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

(D) Required modifiers.

(1) The "HQ" modifier must be used when a provider submits a claim for billing code T1002, T1003 or T1019 if the service was delivered in a group setting. Reimbursement as a group rate shall be the lesser of the provider's billed charge or seventy-five per cent of the medicaid maximum.

(2) The "TU" modifier must be used when a provider submits a claim for billing code T1002, T1003 or T1019 and the entire claim is being billed as overtime.

(3) The "UA" modifier must be used when a provider submits a claim for billing code T1002, T1003 or T1019 and only a portion of the claim is being billed as overtime.

(4) The "U1" modifier must be used when a provider submits a claim for billing code T1002 and the individual enrolled on the Ohio home care waiver is receiving infusion therapy.

(5) The "U2" modifier must be used when the same provider submits a claim for billing code T1002, T1003 or T1019 for a second visit to an individual enrolled on the Ohio home care waiver for the same date of service.

(6) The "U3" modifier must be used when the same provider submits a claim for billing code T1002, T1003 or T1019 for three or more visits to an individual enrolled on the Ohio home care waiver for the same date of service.

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

(8) The "U6" modifier must be used when a provider submits a claim for billing code S5170 for a therapeutic or kosher home delivered meal.

(E) Claims shall be submitted to, and reimbursement shall be provided by, ODM in accordance with Chapter 5160-1 of the Administrative Code.

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5160-46-06.1 Ohio home care waiver program: home care attendant services reimbursement rates and billing procedures.

(A) Definitions of terms used for billing and calculating home care attendant services (HCAS) rates.

(1) "Base rate," as set forth in column 3 of tables A and B of this rule, means the amount reimbursed by Ohio medicaid for the first thirty-five to sixty minutes of assistance with self-administration of medications and the performance of nursing tasks provided during a single visit.

(2) "Continuous nursing" means nursing services (waiver nursing and/or private duty nursing) that are more than four hours in length and during which personal care aide service tasks as described in paragraph ~~(B)~~(A)(1) of rule 5160-46-04 of the Administrative Code may be provided incidental to nursing services.

(3) "Group rate" means the amount that HCAS providers shall be reimbursed when the service is provided in a group setting.

(4) "Group setting" means a situation in which an HCAS provider furnishes HCAS in accordance with rule ~~5160-46-04.1~~5160-44-27 of the Administrative Code, and as authorized by the Ohio department of medicaid (ODM), to two or three individuals who reside at the same address.

(5) "HCAS visit" is a visit during which HCAS is provided in accordance with rule ~~5160-46-04.1~~5160-44-27 of the Administrative Code. An HCAS visit shall not exceed twelve hours or forty-eight units in duration.

(6) "Intermittent nursing" means nursing services (waiver nursing and/or home health nursing) that are four hours or less in length.

(7) "Medicaid maximum rate" means the maximum amount that shall be paid by the Ohio medicaid program for the service rendered. The base rate in column 3 and the unit rate in column 4 of table A of this rule, and the base rate in column 3 and the unit rates in column 5 of table B of this rule represent the medicaid maximum rates for HCAS.

(8) "Modifier," as set forth in column 4 of table A of this rule and column 4 of table B of this rule, means the additional two-alpha-numeric-digit billing code as set forth in paragraph (G) of this rule that HCAS providers shall use to provide additional information regarding service delivery.

(9) "Unit rate," as set forth in column ~~4~~ 5 of table A of this rule and column 5 of table B of this rule, means the amount reimbursed by Ohio medicaid for each fifteen minutes of HCAS delivered when the visit is:

(a) Greater than sixty minutes in length.

(b) Less than or equal to thirty-four minutes in length. Ohio medicaid will reimburse a maximum of only one unit if HCAS is equal to or less than fifteen minutes in length, and a maximum of two units if the service is sixteen through thirty-four minutes in length.

(B) Providers shall bill for reimbursement using table A when HCAS is provided in lieu of continuous nursing as described in paragraph (A)(2) of this rule. Personal care aide tasks are included in the unit rate.

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Table A

Column 1	Column 2	Column 3	Column 4	Column 45
Billing code	Home care attendant service description	Base rate	Modifier	Unit rate
S5125	Assistance with self-administration of medications and/or the performance of nursing tasks (HCAS/N)	~~$25.95~~$27.53	N/A	~~$4.43~~$4.70 per fifteen minute unit of HCAS/N delivered during visit
S5125	HCAS/N (overtime)	$35.11	TU or UA	$6.60

(C) Providers shall bill for reimbursement using table B when HCAS is provided in lieu of intermittent nursing as described in paragraph (A)(6) of this rule. The first four units of HCAS shall be billed for at the base rate. Beginning with the fifth unit of HCAS, assistance with self-administration of medications and the performance of nursing tasks (HCAS/N) shall be billed at the HCAS/N unit rate; and personal care aide service tasks (HCAS/PC) shall be billed at the HCAS/PC unit rate using the U8 modifier. There is no base rate for HCAS/PC. The HCAS/PC service can only be rendered in conjunction with an HCAS/N service.

Table B

Column 1	Column 2	Column 3	Column 4	Column 5
Billing code	Home care attendant service description	Base rate	Modifier	Unit rate
S5125	HCAS/N	~~$25.95~~$27.53	N/A	~~$4.43~~$4.70 per fifteen minute unit of HCAS/N delivered during the visit
S5125	HCAS/PC	N/A	U8	~~$2.95~~$3.24 per fifteen minute of HCAS/PC delivered during the visit
S5125	HCAS/N (overtime)	$35.11	TU or UA	$6.60

Table B

S5125	HCAS/PC (overtime)	~~$33.09~~N/A	either TU or UA, and U8	~~$4.16~~$4.56

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

(E) When HCAS/N and HCAS/PC are provided during an uninterrupted period of time, the visit shall be considered a single HCAS visit. An HCAS provider is entitled to only one base rate during an HCAS visit.

(F) HCAS providers shall be limited to a maximum of twelve hours or forty-eight units of HCAS during a twenty-four-hour period, regardless of the number of individuals enrolled on an ODM-administered waiver who are served.

(G) Required modifiers.

(1) The "HQ" modifier must be used when a provider submits a claim if HCAS was delivered in a group setting. Reimbursement at a group rate shall be the lesser of the provider's billed charge or seventy-five per cent of the medicaid maximum rate.

(2) The "TU" modifier must be used when a provider submits a claim for billing code S5125 and the entire ~~claim~~ visit is being billed as overtime.

(3) The "UA" modifier must be used when a provider submits a claim for billing code S5125 and only a portion of the ~~claim~~ visit is being billed as overtime.

(4) The "U2" modifier must be used when a provider submits a claim for a second HCAS visit to an individual enrolled on the Ohio home care waiver for the same date of service.

(5) The "U3" modifier must be used when the same provider submits a claim for three or more HCAS visits to an individual enrolled on the Ohio home care waiver for the same date of service.

(6) The "U8" modifier must be used when a provider submits a claim for an HCAS visit that is in lieu of intermittent nursing as described in paragraph (A)(6) of this rule, and for units of service that are HCAS/PC.

(H) Claims shall be submitted to, and reimbursement shall be provided by, the ODM in accordance with Chapter 5160-1 of the Administrative Code.