
# Department of Medicaid

# Access Rule Update

October 23, 2024

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Ohio Department of Medicaid

# UPCOMING REQUIREMENTS IMPACTING HCBS

| Rule requirement | Applicability date | Compliance requirement | Reporting requirement | Ohio Home Care | PASSPORT | Assisted Living | MyCare |
|---|---|---|---|---|---|---|---|
| HCBS Quality Measure Set | September 1, 2026<br>July 9, 2028 | X | X | X | X | X | X |
| Grievance System | July 9, 2026 | X | | X | X | X | |
| Payment Rate Transparency | July 1, 2026 | X | | X | X | X | |
| Payment Rate Disclosure | July 1, 2026 | X | | X | X | X | |
| Interested Parties Advisory Group | July 9, 2026 | X | | X | X | X | |

# HCBS QUALITY MEASURE SET (QMS)

Applicability date: July 9, 2028

- HCBS QMS was initially released by CMS in July 2022 and is intended to promote consistent use of nationally standardized quality measures in HCBS
- Includes measures developed by CMS and other entities
- Data sources include:
  - Experience of care surveys
  - Assessment and case management system records
  - Claims and encounter data
- Individuals under 18 years excluded from measure calculations
- Reporting to CMS will be at the state level, not program level

# HCBS QUALITY MEASURE SET

Applicability date: July 9, 2028

- The State:
  - Must report mandatory measures biannually, subject to a measure phase-in schedule
  - May optionally report on voluntary measures and/or apply data stratification methods not yet required
  - Must establish performance targets for all mandatory measures, subject to CMS review and approval
  - Must develop quality improvement strategies that it will pursue to achieve the performance targets for all mandatory measures
- The HCBS Quality Measure Set is subject to:
  - Biannual measure selection changes, subject to public comment
  - Annual technical updates and corrections
  - Data stratification requirements

**Data stratification factors**

Race
Ethnicity
Sex
Age
Rural/urban status
Disability
Language

**Percent of measures stratified**

25% by 2028
50% by 2030
100% by 2032

# HCBS QUALITY MEASURE SET FOR MFP STATES

Applicability: September 1, 2026

- MFP grant recipient states must:
  - Report on a set of mandatory measures beginning in the fall of 2026, utilizing 2025 measurement year data
  - Establish statewide performance targets for all mandatory measures
  - Develop quality improvement strategies related to two mandatory measures
- Data stratification is not required at this stage
- ODM has identified gaps and is working to revise operational guidance and requirements to align with federal requirements

# HCBS QUALITY MEASURE SET FOR MFP STATES

Applicability: September 1, 2026

| Data source | Mandatory measures |
|---|---|
| Experience of Care Survey | NCI-AD: Percentage of people who are as active in their community as they would like to be |
| | NCI-AD: Percentage of people whose service plan reflects their preferences and choices |
| | NCI-AD: Percentage of people who feel safe around their support staff |
| | NCI-AD: Percentage of people who have transportation to get to medical appointments when they need to |
| | NCI-AD: Percentage of people who have transportation when they want to do things outside of their home |
| Assessment/Case Management Record | LTSS/MLTSS-1: Comprehensive Assessment and Update |
| | LTSS/MLTSS-2: Comprehensive Care Plan and Update |
| Claims/Encounter Data | LTSS/MLTSS-6: LTSS Admission to a Facility from the Community |
| | LTSS/MLTSS-7: LTSS Minimizing Facility Length of Stay |
| | LTSS/MLTSS-8: LTSS Successful Transition After Long-Term Facility Stay |

# GRIEVANCE SYSTEM FOR FFS HCBS

Applicability date: July 9, 2026

- The State must establish procedures under which a beneficiary or authorized representative may file a grievance related to the State's or a provider's performance of person-centered planning and settings requirements
- The grievance process must:
  - Ensure no punitive or retaliatory action is threatened or taken against a beneficiary who files a grievance or who has a grievance filed on their behalf
  - Allow another individual or entity to file a grievance on the beneficiary's behalf, with the written consent from the beneficiary or authorized representative
  - Provide the beneficiary with reasonable assistance in completing forms and procedural steps, including providing language/translation service at no cost and ensuring grievances are appropriately filed with the grievance system
  - Provide the beneficiary with their case file and an opportunity to provide additional information in advance of the resolution timeframe

# GRIEVANCE SYSTEM FOR FFS HCBS

Applicability date: July 9, 2026

- The State must additionally:
  - Base grievance processes on written policies and procedures
  - Provide information about the grievance system to beneficiaries and providers
  - Acknowledge receipt of each grievance
  - Resolve grievances as expeditiously as the beneficiary's health condition requires, within 90 calendar days of receipt (option to extend by up to 14 calendar days in some cases)
  - Provide oral or written notification of resolution or delay to beneficiaries
- ODM is developing a single statewide grievance system to meet this requirement

# PAYMENT RATE TRANSPARENCY

Applicability date: July 1, 2026, then subsequently updated within 30 days of a payment rate change

- The State must publish all Medicaid fee-for-service schedule payment rates on a website that is accessible to the general public and easily reached from a link on the State Medicaid agency's website
- Rates must be organized in such as a way that a member of the general public can readily determine the amount that Medicaid would pay for a given service
- When applicable, the State must publish the Medicaid fee-for-service bundled payment rate and identify each constituent service included within the rate and how much of the bundled payment is allocated to each constituent service under the State's methodology
- The State must separately identify payment rates by population (pediatric and adult), provider type, and geographical location, as applicable
- The date the payment rates were last updated must be included

# PAYMENT RATE DISCLOSURE

Applicability date: July 1, 2026, then updated at least every 2 years

- The State agency must develop and publish the average hourly Medicaid fee-for-service payment rates for each of the categories of services below:
  - Personal care
  - Home health aide
  - Homemaker
  - Habilitation
- The State must separately identify the rates for payments made to individual providers and provider agencies, by population (pediatric and adult), provider type, and geographical location, and whether the payment rate includes facility-related costs, as applicable
- The published analysis must identify the number of Medicaid-paid claims and the number of beneficiaries who received each service within a calendar year

# INTERESTED PARTIES ADVISORY GROUP

Applicability date: July 9, 2026

- The State agency must establish an advisory group for interested parties to advise and consult on provider rates for direct care workers providing the following services:
  - Homemaker
  - Home health aide
  - Personal care
  - Habilitation
- The group must include direct care workers, beneficiaries, beneficiaries' authorized representatives, and other interested parties as determined by the State
- The group will advise and consult with the Medicaid agency on current and proposed payment rates, HCBS payment adequacy data, and access to care metrics to ensure rate sufficiency

# LOOKING AHEAD

| Rule provision | Applicability date(s) | Compliance requirement | Reporting requirement | Ohio Home Care | PASSPORT | Assisted Living | MyCare |
|---|---|---|---|---|---|---|---|
| Website Transparency | July 9, 2027 | X | | X | X | X | X |
| Incident Management System | July 9, 2027<br>July 9, 2029 | X | X | X | X | X | X |
| Person-Centered Service Plan Update | July 9, 2027 | X | X | X | X | X | X |
| Access to Homemaker, Home Health Aide, Personal Care, and Habilitation Services | July 9, 2027 | | X | X | X | X | X |
| HCBS Payment Adequacy | July 9, 2028<br>July 9, 2030 | X | X | X | X | X | X |

# Self-Direction Expansion

October 23, 2024

Ohio Department of Medicaid

# Self-Direction Overview

- Self-direction empowers Ohioans served by the Ohio Home Care, MyCare, and PASSPORT waivers to have more choice and control over the long-term services and support needed to live at home. People involved in self-direction make decisions about the type of care they receive, the way certain services are delivered, and the caregivers who provide them services.
- As of October 1, 2024, the option to self-direct services was added to the Ohio Home Care Waiver.
- As of November 15, 2024, self-directed services available under the MyCare waiver were expanded.
- The benefits of self-direction include:

Choice and control

Personalized care

Empowerment

Access to a need-based budget

Flexibility

Family involvement

# Service Delivery Options

All waiver services are authorized based on assessed need. This includes:

- The type of service
- The amount of service

Once the service needs are identified, individuals have a choice on how to meet those needs. Options for service delivery include:

| | |
|---|---|
| **Provider-Managed** | An agency or independent provider arranges, manages, and supplies waiver services. |
| **Self-Directed** | The individual or their representative arranges and manages waiver services using the allowed waiver budget. |

# Overview of Self-Directed Services

| Ohio Home Care and MyCare Waiver | MyCare Waiver Only |
| --- | --- |
| • Home Care Attendant<br>• Home Modifications<br>• Personal Care Aide<br>• Self-Directed Goods and Services<br>• Waiver Nursing | • Alternative Meals<br>• Choices Home Care Attendant<br>• Home Medical Equipment and Supplies |

Descriptions for each self-directed service can be found at the following link: Service Description Document.

# Self-Directed Goods and Services

Self-directed goods and services is a service offered through the MyCare Waiver and Ohio Home Care Waiver. It helps people be more independent and involved in their communities. The service allows individuals to pay for services, equipment, or supplies that they need but cannot access through Medicaid, waivers, or other sources. Individuals will have $2,500 available for this service each 365 days.

# Self-Directed Goods and Services Decision Flow

Does this item or service cover an assessed need?

No

Yes

**Does the item or service do at least <u>one</u> of the following:**

- Increase the individual's independence, safety and ability to remain engaged in the community;
- Decrease the individual's need for other Medicaid services; OR
- Cover the costs of services, equipment, or supplies that are not available through other sources?

No

Yes

**Are the funds being used for any <u>one</u> of the following:**

- Experimental treatments;
- For entertainment or recreational use only;
- Rent, utilities, or internet service; OR
- An item or service that is prohibited by federal or state statues and regulations?

Yes

The item or service **cannot** be covered.

No

The item or service **can** be covered.

Ohio Department of Medicaid

# Budget Worksheet Overview

- The purpose of the budget worksheet is to help individuals see the amount of money available to them for each self-direction service option in their person-centered service plan.
- The worksheet helps the individual plan out the hourly wages and hours for their caregiver(s) and helps them understand if they are over or under budget.
- The budget is calculated per week; however, it will still calculate the total amount available in the budget per month and year.
- As numbers are inputted into the document, the calculations will auto-populate.
    - Care managers will insert total approved weekly caregiver hours as listed in the person-centered service plan.
    - Individuals will allocate hours, overtime hours, and agreed upon wages in the document.
- Each waiver will have a budget worksheet that includes the different service options available under each.

| LEGEND | | | |
|---|---|---|---|
| Blue: Information for care manager to insert | Purple: Information for self-directing individual or representative to insert | Green: Total amount allocated is under or equal to the available budget | Red: Total amount allocated is over the available budget |

# Budget Summary

The "Budget Summary" tab will update automatically with any information inserted on the self-direction service option tabs. It provides an overview of the "Total Budget Available" and the "Total Service Amount Allocated" for each service. There will be a different budget summary table for services that are budget authority only and for services that are both budget and employer authority.

| | The table below summarizes the budget available compared to the total allocated amount for self-direction services (excluding budget authority only services). As the individiual fills out the worksheet, this information will autopopulate. | | | | | | |
|---|---|---|---|---|---|---|---|
| | Total Budget Available | | | Total Allocated Amount | | | |
| Self-Direction Waiver Services | Weekly | Monthly | Yearly | Weekly | Monthly | Yearly | Over or Under Budget |
| Home Care Attendant: Nursing | $ 500.00 | $ 2,166.67 | $ 26,000.00 | $ 1,000.00 | $ 4,333.33 | $ 52,000.00 | Over Budget |
| Home Care Attendant: Personal Care | $ 2,000.00 | $ 8,666.67 | $ 104,000.00 | $ 1,500.00 | $ 6,500.00 | $ 78,000.00 | Under Budget |
| Personal Care Aide | $ 800.00 | $ 3,466.67 | $ 41,600.00 | $ 800.00 | $ 3,466.67 | $ 41,600.00 | Equal to Max Budget |
| Waiver Nursing: Non-Agency Licensed Professional Nurse | $ - | $ - | $ - | $ - | $ - | $ - | Not Applicable |
| Waiver Nursing: Non-Agency Registered Nurse | $ 500.00 | $ 2,166.67 | $ 26,000.00 | $ 400.00 | $ 400.00 | $ 4,800.00 | Under Budget |
| TOTALS | $ 3,800.00 | $ 16,466.67 | $ 197,600.00 | $ 3,700.00 | $ 14,700.00 | $ 176,400.00 | |

# How Total Available Budget is Calculated for Budget Authority Self-Directed Services

The total budget available for self-directed services is calculated using the information below.

| Total approved weekly caregiver hours listed in person-centered care plan* | Multiplied | Max fee for service hourly rate as listed in the related Ohio Administrative Code (OAC) Rule | Equals | Total budget available |
|---|---|---|---|---|

*inserted by care manager in budget worksheet

# Self-Directed Home Modifications Overview

Individuals who use budget authority can select self-directed home modification services.

- Providers must be enrolled with the Ohio Department of Medicaid (ODM) or, for the MyCare waiver only, approved for home modification services or certified by the Ohio Department of Aging (ODA) for home modification services.
- Based on the identified need, services may be authorized within the self-directed budget as long as the amount does not exceed available funds.
- The annual $10,000 limit applies, but funds available in the self-directed budget can be added to cover costs.

# Self-Direction Resources

- Key points of contact:
  - If you have questions about self-direction in Ohio, please email selfdirection@medicaid.ohio.gov.
  - Individuals on the Ohio Home Care Waiver or the MyCare Waiver should direct questions about self-direction to their waiver case manager or service coordinator.
  - For questions related to PPL, please call 844-351-9185 or email ohiohomecare-cs@pplfirst.com.
- Additional resources:
  - Resources for individuals, caregivers, and care managers can be found at the following link: https://medicaid.ohio.gov/families-and-individuals/self-direction
  - Information related to ODM's Financial Management Service (PPL) can be found at the following link: https://pplfirst.com/programs/ohio/ohio-department-of-medicaid/
  - Relevant Ohio Administrative Code (OAC) rules can be found at the following links:
    - Self-direction: https://codes.ohio.gov/ohio-administrative-code/rule-5160-45-03.2 -
    - Self-directed goods and services: https://codes.ohio.gov/ohio-administrative-code/rule-5160-45-03.5

# “Caregiver Rule” OAC 5160-44-32

October 23, 2024

Ohio Department of Medicaid

# Home and Community Based Medicaid Waiver Program Provider Direct Care Worker Relationships

Ohio Administrative Code 5160-44-32

Effective January 1, 2024

The rule allows:

- Parents of minor children and spouses to serve as a direct care worker of waiver personal care and nursing services.
- Other relatives designated or appointed legal authority to serve as a direct care worker of waiver services.

# Rule Outline

The new rule is outlined by the following:

| | |
|---|---|
| Paragraph A- | Applicability: Details the programs and services subject to the rule |
| Paragraph B- | Definitions |
| Paragraph C & D- | Exceptions to the rule |
| Paragraph E- | Parents of minor children and spouses' conditions and parameters |
| Paragraph F- | Relatives and those with legal authority to make decisions conditions and parameters |
| Paragraph G- | Limitations |
| Paragraph H & I- | Other conditions |

# Applicability

## Paragraph A: Nursing facility (NF) based waiver programs

| Ohio Home Care | MyCare | PASSPORT |
| --- | --- | --- |
| • Personal care aide services provided through an agency<br>• Waiver nursing services provided through an agency | • Choices home care attendant, participant-directed<br>• Homemaker services provided through an agency<br>• Personal care services provided through an agency and participant-directed<br>• Waiver nursing services provided through an agency | • Choices home care attendant, participant-directed<br>• Homemaker services provided through an agency<br>• Personal care services provided through an agency and participant-directed<br>• Waiver nursing services provided through an agency |

# Definitions

## Paragraph B

| | |
|---|---|
| **Agency** | • A home health agency provider of Ohio home care waiver services as described in Chapter 5160-46 of the Administrative Code; or<br>• An Ohio Department of Aging (ODA) agency provider certified under Section 173.391 of the Revised Code. |
| **Appendix K** | • A standalone appendix that may be utilized by states during emergency situations to request amendment to approved 1915(c) waivers. It includes actions that states can take under the existing 1915(c) home and community-based waiver authority in order to respond to an emergency. |
| **Care Management Agency** | • An agency or entity delegated or contracted by ODA, or ODM to perform care coordination activities and related functions for individuals enrolled on a fee for service or managed care waiver program. |
| **Direct Care Worker** | • Person providing hands on care to an individual receiving a Medicaid 1915(c) waiver program service. |

# Definitions

| | |
|---|---|
| **Extraordinary Care** | • Hands-on assistance with activities of daily living, incidental activities of daily living, and supervisory monitoring care exceeding the range of activities a parent of a minor child or spouse would ordinarily perform in the household on behalf of an individual without a disability or chronic illness of the same age, or on behalf of a spouse without a disability or chronic illness. |
| **Financial Management Service** | • Entity contracted with ODA, ODM or their designee to process payment of participant-directed waiver services. |
| **Home and Community-Based Services** | • Services available to individuals to help maintain their health and safety in a community setting in lieu of institutional care. |

# Definitions

| | |
|---|---|
| **Individual** | • Medicaid recipient receiving services through an HCBS waiver program authorized under 1915(c) of the Social Security Act. |
| **Legal Representative** | • Person or entity who has a legal standing to make decisions on behalf of another person (e.g., a guardian who has been appointed by the court or an individual who has power of attorney granted by the individual). |
| **Non-agency provider** | • A non-agency provider of Ohio home care waiver services, as described in Chapter 5160-46 of the Administrative Code; and<br>• An ODA certified non-agency provider, certified under section 173.391 of the Revised Code. |
| **Parent** | • Adoptive, biological or step-parent of an individual. |
| **Relative** | • Children, grandparents, grandchildren, great-grandparents, great grand-children, brothers, sisters, aunts, uncles, nephews, nieces, and step-relations and parents of an individual above the age of seventeen. |

# Exceptions

## Paragraph C & D

Unless otherwise permitted in this rule or other home and community-based services (HCBS) waiver program rules or other ODM rules, a parent of a minor child, a spouse, and other legal representatives are not eligible to bill for Medicaid reimbursable waiver services to an individual for whom they serve as a legal representative.

**Ohio Home Care and MyCare Exception:** "Unless otherwise permitted" pertains to 5160-44-31 conditions of participation:

A provider may be designated as an authorized representative or pursuant to a declaration for mental health treatment, general power of attorney, health care (medical) power of attorney, financial power of attorney or guardianship for the individual if:

a) The provider was serving in that capacity prior to September 1, 2005; and
b) The provider was the individual's paid medical provider prior to September 1, 2005; and
c) The designation is not otherwise prohibited by law.

**PASSPORT**

**Program Exception:** *No exceptions.*

# Exceptions

## Paragraph D

An agency fully or partially owned by an individual's legal representative is not eligible to bill for Medicaid reimbursable waiver services to an individual for whom they serve as legal representative.

**Ohio Home Care**
**Program Exception:** *No program exceptions.*

**MyCare**
**Program Exception:** *No program exceptions.*

**PASSPORT**
**Program Exception:** *No program exceptions.*

# PARENTS OF MINOR CHILDREN AND SPOUSES

# Parents of Minors and Spouses

## Paragraph E

The direct care service worker rule is designed to allow parents of minor children and spouses to provide direct care to an individual in need of extraordinary care. The rule includes certain conditions and parameters for:

- **Spouses:** for all NF waiver programs.
- **Parents of minor children:** Ohio Home Care.

# Conditions

## Paragraph E1

A parent of a minor child, or the spouse of an individual may only provide HCBS waiver services to an individual if *both of the following conditions are met*:

- There is no other willing and able provider or direct care worker available to provide the HCBS waiver services to the individual.
- ODM, ODA or their designee has determined the health and safety needs of the individual can be ensured.

Additionally, HCBS waiver services provided by a parent of a minor child or by a spouse must be determined to meet extraordinary care requirements, as determined through the ODM-approved Extraordinary Care Instrument (ODM 10372 “Ohio Extraordinary Care Instrument”).

# Parameters

Paragraph E2

## Employment Requirements

The parent of a minor child or spouse must be employed through an agency provider or provide an eligible participant-directed service through an FMS.

## Contact and Visit Requirements

A parent of a minor child, or the spouse of an individual, may serve as the direct care worker when:

- Individuals agree to and cooperate with monthly care management agency contacts. Contacts may be a combination of phone and in-person visits, with no more than 60 calendar days between in-person visits.
- The parent of a minor child or spouse participates in contact and visit requirements described in the individual's person-centered services plan (PCSP).

# MAXIMUM HOURS & LIMITATIONS

# MAXIMUM WORKING HOURS

## Paragraph E – Parameters applicable to all waiver programs

| Direct Care Worker | Condition | Rule Language | Exceptions to Requirements |
|---|---|---|---|
| **Parent of a Minor or Spouse** | Maximum of **40 hours per week** from spouse | Unless otherwise permitted in HCBS waiver program rules, or determined by ODM, ODA, or their designee, as necessary to ensure the health and safety of the individual and authorized on the PCSP, **an individual may receive a maximum of forty hours per week of paid care from their spouse** and may not exceed the amount of service the individual is assessed to need. | **Exception process applies** |
| **Relative** | Maximum of **40 hours per week** per relative | Unless otherwise permitted in HCBS waiver program rules or determined by ODM, ODA, or their designee, as necessary to ensure the health and safety of the individual and authorized on the PCSP, **paid care is limited to forty hours per week per relative with legal decision- making authority**, and may not exceed the amount of service the individual is assessed to need. | **Exception process applies** |

**Note:** ODM, ODA, or their designee may grant an exception to the above limitations.

# Limitations

## Paragraph G- Limitations

- HCBS waiver services *may not* be provided by the foster parent of the individual or by an agency in which the foster parent of the individual has an ownership interest.
- Services provided by a parent of a minor child *may not* be provided for respite purposes.
- A direct care worker providing services described in paragraph (A) of this rule *may not* verify service provision on behalf of the individual.
- A direct care worker *may not* receive payment from any source for activity other than the direct care for the individual during the time authorized to provide HCBS waiver services.
- A direct care worker *may not* provide care to a person other than the authorized individual(s) during Medicaid billed hours.
- **Participant directed services:** If an individual chooses to designate a representative through the FMS, the FMS designated representative(s) *may not* serve as a direct care worker.

# Other Conditions

Paragraph H & I: all waiver programs

## The Person-Centered Services Plan

The **person-centered services plan** will document that the conditions set forth in paragraphs (E) and (F) of this rule are met.

## Appeals

A decision by ODM, ODA, or their designee related to whether someone qualifies under this rule to serve as a provider or a direct care worker for an individual **is not subject to notice and appeal rights** under division 5101:6 of the Administrative Code.

This condition applies to ***all*** NF waiver programs.

# OPERATIONAL EXPECTATIONS

# OHIO EXTRAORDINARY CARE INSTRUMENT

- The Extraordinary Care Instrument **screens individuals enrolled on a qualifying waiver to determine  if the care that they require meets a standard of extraordinary care** as defined by CMS and OAC Rule 5160-44-32 Medicaid Waiver Program Provider and Direct Care Worker Relationships.
- CMS regulations stipulate that service authorization to a legally responsible individual (parent of a minor or spouse) is limited to extraordinary care.
- In Ohio, **extraordinary care** is defined as:

  "Hands-on assistance with activities of daily living, incidental activities of daily living, and supervisory monitoring care exceeding the range of activities a parent of a minor child would ordinarily perform in the household on behalf of an individual without a disability or chronic illness of the same age, or on behalf of a spouse without a disability or chronic illness".

# ODM FORM 10372 - OHIO EXTRAORDINARY CARE INSTRUMENT

ODM10372Fillx.pdf (ohio.gov)

Ohio Department of Medicaid

## OHIO EXTRAORDINARY CARE INSTRUMENT

| Individual's First Name | Individual's Last Name | Assessor's Name |
|---|---|---|
| Date of Birth | Age at Assessment | Date Completed |

**INSTRUCTIONS**

The purpose of this tool is to fulfill the extraordinary care criteria requirement as defined in OAC 5160-44-32.

Using the Rating Scale, the assessing agency will assign one value that indicates the greatest level of support required by the individual to meet each need. All needs must be assessed and may be completed in any order. Medical documentation is not required to meet the standard of Extraordinary Care for any of the needs below. Please note that there is an age range presumed as not applicable for some needs. For those needs, score as a **(0)**. Authorization requires meeting both a standard of extraordinary care and applicable provider certification rule requirements.

*Refer to Ohio Extraordinary Care Instrument — Definitions for additional instructions.*

**RATING SCALE**

| | |
|---|---|
| Independent or N/A **(0)** | Requires Assistive Device **(1)** |
| Sometimes Requires Physical/Verbal Support **(2)** | Always Requires Physical/Verbal Support **(3)** |

| Need | Score | Need | Score |
|---|---|---|---|
| Feeding Assistance | 0 | Seizure Protocol | 0 |
| Respiratory/Pulmonary Care | 0 | Catheter or Ostomy Care | 0 |
| Turning/Positioning *Enter (0) for ages 8 months and younger* | 0 | Ambulation *Enter (0) for ages 17 months and younger* | 0 |
| Transfer Assistance *Enter (0) for ages 17 months and younger* | 0 | Oral Hygiene *Enter (0) for ages 4 years and younger* | 0 |
| Dressing *Enter (0) for ages 4 years and younger* | 0 | Toileting *Enter (0) for ages 4 years and younger* | 0 |
| Behavioral Support *Enter (0) for ages 4 years and younger* | 0 | Bathing *Enter (0) for ages 6 years and younger* | 0 |
| Hair, Nail, and/or Skin Care *Enter (0) for ages 9 years and younger* | 0 | Communication *Enter (0) for ages 15 years and younger* | 0 |
| Basic Purchases *Enter (0) for ages 15 years and younger* | 0 | Basic Meal Preparation *Enter (0) for ages 15 years and younger* | 0 |
| Basic Household Chores *Enter (0) for ages 15 years and younger* | 0 | Laundry *Enter (0) for ages 15 years and younger* | 0 |
| Accessing Transportation *Enter (0) for ages 15 years and younger* | 0 | Accessing Personal Funds *Enter (0) for ages 15 years and younger* | 0 |
| Cognition/Decision Making *Enter (0) for ages 15 years and younger* | 0 | Medication Administration *Enter (0) for ages 17 years and younger* | 0 |

**OHIO EXTRAORDINARY CARE INSTRUMENT RESULTS**

If the individual scores a **(3)** in at least three of the items above, then the individual meets the standard of extraordinary care as defined by OAC 5160-44-32.

| Are there at least three ratings of **(3)** for the items listed above? | ☐ Yes ☐ No | Does the individual meet the standard of extraordinary care as defined by OAC 5160-44-32? | ☐ Yes ☐ No |
|---|---|---|---|

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Department of Medicaid

# CARE COORDINATOR RESPONSIBILITIES

Care coordinators will:

- Prepare the Extraordinary Care Instrument with information found in the person-centered services plan and case documentation.
- Complete the Extraordinary Care Instrument during face-to-face contact with the waiver member and their spouse.
- Medical documentation is not required to meet the standard of extraordinary care for any need.
- Complete a new Extraordinary Care Instrument
  - Annually, at redetermination.
  - Whenever there is a significant change in the individual's needs or condition.

# PROVIDER AVAILABILITY

- OAC 5160-44-32 (E)(1)(a) requires authorizing entities to **determine that there are no other willing and able providers or direct care workers available** to provide home and community-based waiver services to the individual.
- Complete a provider search that lasts 10-15 calendar days with re-engagement every 4-6 months.
- Utilize your typical methods for provider search, such as contacting applicable providers directly or posting a request for provider.
- Provider search re-engagement can be incorporated into routine monitoring contacts when appropriate.
- Provider search engagement may not result in a suspension of current service delivery.

# EXCEPTION REVIEW CONSIDERATIONS

- Relationship type of direct care worker to individual.
- Type of legal authority.
- Number of hours required to meet the individual's assessed needs.
- Current number of hours authorized to a qualifying parent or spouse caregiver.
- Current service plans.
- Aide Norms Tool and/or Nursing Acuity Tool.
- Hospice or End of Life plans.
- Documentation of provider search efforts.
- Additional physician/supporting documentation.
- Language or geographic barriers.

# HEALTH SAFETY AND WELFARE EXCEPTION CONSIDERATIONS

- Social isolation.
  - Is the member able to leave their home?
  - Does the member receive any other services?
  - What is the member's level of community involvement?
- Caregiver burnout.
- Incident reporting.
- Protective services and/or law enforcement involvement.
- Facility/hospital care.
- Does the member live with the direct care worker?
- Is the direct care worker listed as the member's primary backup plan?

# FREQUENTLY ASKED QUESTION

**We are unable to locate an alternate willing and able provider to fill the hours, or the individual consistently refuses alterative staffing. What is allowable?**

- If an alternate willing and able provider is identified, then the authorization of a direct care worker under 5160-44-32 must be ended. This is required per the rule and CMS regulations.
- Care coordinators must complete due diligence efforts to secure a provider.
- Direct care worker authorizations can continue to be authorized for all unfilled hours until a provider is secured.
- If an alternate willing and able provider can only meet partial hours, then the direct care worker authorization can continue to cover unfilled hours.

# FREQUENTLY ASKED QUESTION

**We have been unable to secure an able and willing provider to fill all assessed hours needed by the member, which exceeds the 40-hour maximum authorization in the rule. How can we meet this member's needs?**

- CMAs have authority within the scope of 5160-44-32 as ODM's designee to authorize more than 40 hours per week to a direct care worker if assessed as necessary, appropriate, and all other rule requirements are met.
- Exemption review requests must be documented in the *Forty-Hour Exemption Review Form* and approved by CMA leadership.
- CMAs can contact ODM Care Coordination for technical assistance.

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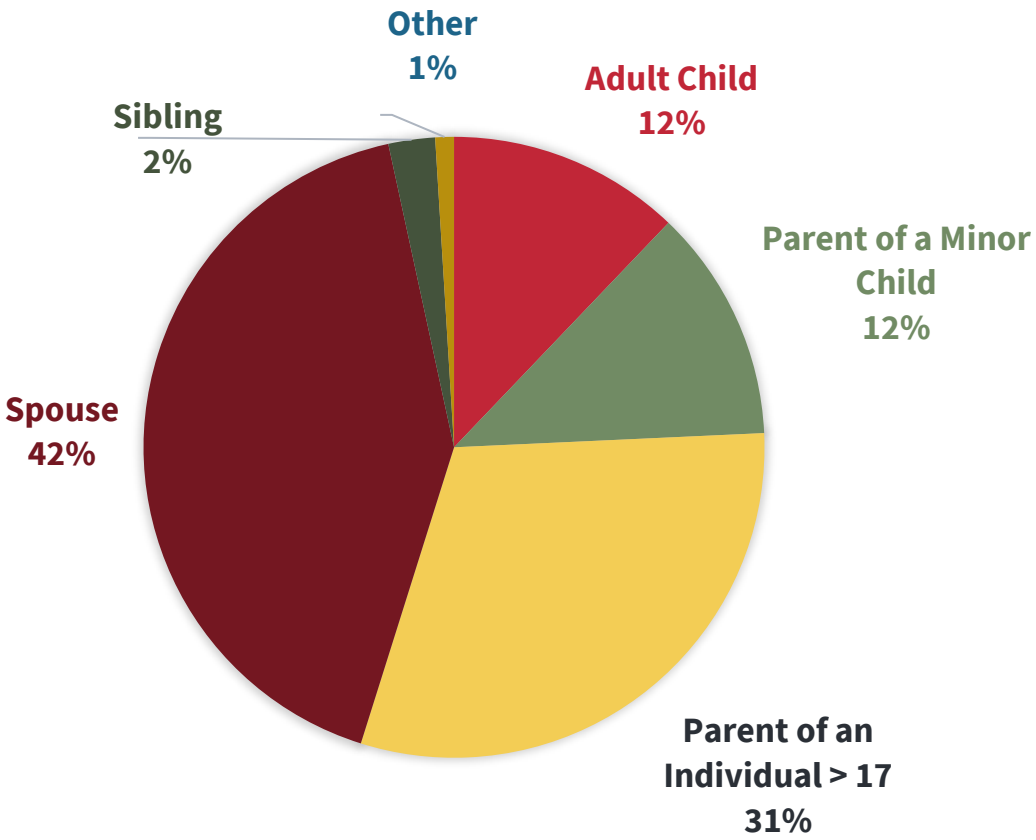
# OHCW TRENDS

# Ohio Home Care Waiver Initial Data

At the time of the first data collection in May 2024, **211** direct care workers were authorized to provide care under OAC 5160-44-32.

## DIRECT CARE WORKER RELATIONSHIP TO INDIVIDUAL

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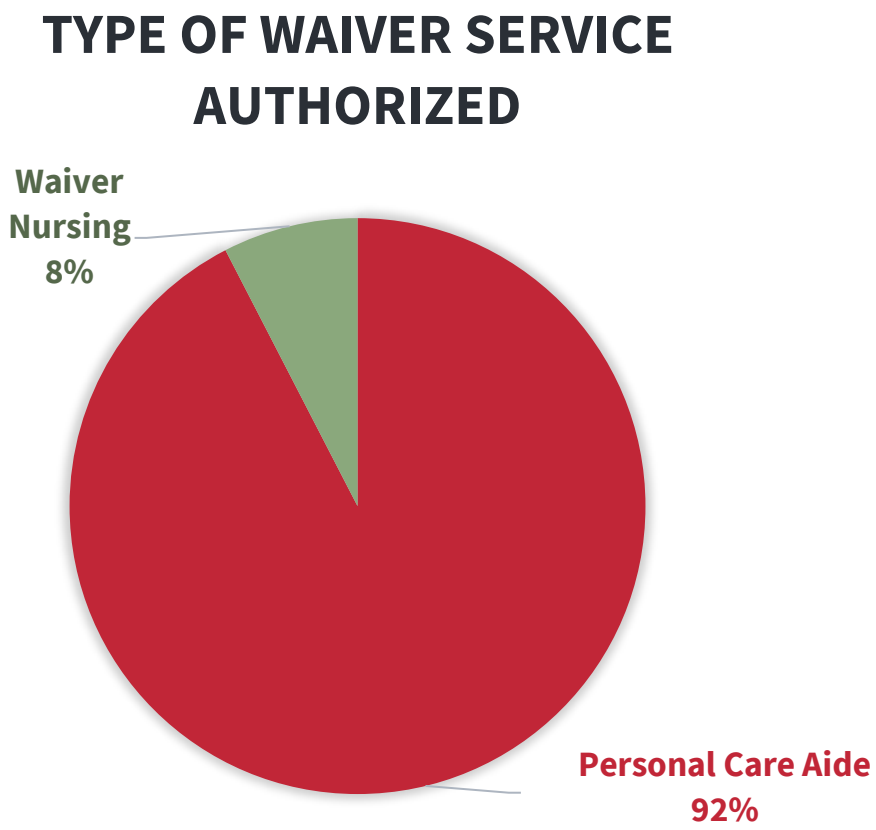
# Ohio Home Care Waiver Data

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# THANK YOU!

## QUESTIONS? PLEASE CONTACT
## HCBSPOLICY@MEDICAID.OHIO.GOV

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