<table>
<tr><th colspan="2"># REIMBURSEMENT POLICY STATEMENT
Ohio MyCare</th></tr>
<tr><th>Policy Name & Number</th><th>Date Effective</th></tr>
<tr><td>Assisted Living Facilities-OH MyCare-PY-0348</td><td>05/01/2024</td></tr>
<tr><th colspan="2">Policy Type</th></tr>
<tr><td colspan="2">REIMBURSEMENT</td></tr>
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Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.
CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Assisted Living Facilities

B. Background

Assisted living services are designed to promote aging in place by supporting a member's independence, choice, and privacy and can include hands-on assistance, nursing activities, coordination of appropriate meals, and coordination of social, recreational, and leisure activities that promote community participation and integration. Assisted living does not include twenty-four-hour skilled nursing care.

The Ohio Department of Aging (ODA) is responsible for the daily operation of the assisted living home and community-based services (HCBS) waiver and operates the waiver with the Ohio Department of Medicaid.

C. Definitions

- **Patient Liability** – A member's share of cost for care when the individual is not living in a medical institution. Liability is calculated as post-eligibility treatment of income (PETI) described in the Ohio Administrative Code 5160:1-6-07.1.
- **Assisted Living Waiver (ALW) Program** – The Medicaid-funded component of the assisted living program approved by the Centers for Medicare and Medicaid Services (CMS) with the purpose of assisting individuals to live in a home setting rather than a nursing facility or hospital.
- **Level of Care (LOC)** – Determination made by an agent of the State regarding an individual's physical mental, social, and/or emotional status, including an ability to manage medical conditions and/or activities of daily living (ADL) and instrumental activities of daily living (IADL) needs. Intermediate or skilled level of care qualify an individual for home and community-based services, which allows Medicaid payment of assisted living services.
- **Member Eligibility** – Ohio Administrative Code 5160-33-03 defines eligibility as follows:
  - Eligible for Ohio Medicaid in accordance with Ohio Admin. Code.
  - Intermediate or skilled level of care in accordance with Ohio code.
  - 21 years old or older at time of enrollment.
  - Participate in the development of a person-centered services plan.
  - Make room and board payments calculated at the current supplemental security income (SSI) federal benefit level minus fifty dollars.
  - Have health and safety-related needs met, as determined by ODA's designee.
- **Person-Centered Services Plan (PCSP)** – The outline of services that a case manager authorizes a provider to deliver to an individual, regardless of the funding source for those services.

D. Policy

I. A review of medical necessity by CareSource is required for assisted living facility care.

II. CareSource will reimburse assisted living facilities as follows:
   A. Provider must bill on a CMS 1500 claim form or via provider portal with correct Healthcare Common Procedure Coding System (HCPCS) code(s).
   B. Provider must submit claim as a single line with date of service span and units billed to match.
   C. If the member has member liability, that information must be documented on the claim (CMS 1500 Amount Paid). However, member liability will be applied based on the current 834 report supplied by the Ohio Department of Medicaid. If the claim is submitted via the provider portal, member liability is handled through the claims process.

III. Assisted living facilities and providers must follow and adhere to the PCSP process as outlined in Ohio Administrative Code 5160-44-02.
   A. All services must be documented and authorized on the PCSP prior to billing for those services.
   B. It is the responsibility of the provider to ensure medical necessity, level of care, and financial eligibility are met by coordinating with CareSource case manager prior to admission.

E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, submitting approved HCPCS and Current Procedural Terminology (CPT) codes along with appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	08/24/2017	
Date Revised	12/16/2020 11/09/2022 02/14/2024	Updated definitions and process. Annual review. Updated definitions and background. Added D. III. (PCSP) Annual Review, Approved at Committee
Date Effective	05/01/2024	
Date Archived		

H. References

1. Assisted Living HCBS Waiver Program, OHIO ADMIN. CODE 5160-33-02 to 07 (2023).
2. Home and Community-Based Care, Ohio Admin. Code. 5160-44-01 to 32 (2024).

The REIMBURSEMENT Policy Statement detailed above has received due consideration as defined in the REIMBURSEMENT Policy Statement Policy and is approved.

3. Home and Community-Based Services (HCBS) Waivers: Assisted Living, OHIO ADMIN. CODE 5160-1-6.5 (2024).
4. Medicaid-Funded Assisted Living Program, OHIO ADMIN. CODE 173-38-01 to 05 (2024).
5. Medicaid: Post-Eligibility Treatment of Income for Individuals Receiving Services Through a Home and Community-Based Services (HCBS) Waiver or the Program of All-Inclusive Care for the Elderly (PACE), OHIO ADMIN. CODE 5160:1-6-07.1 (2023).
6. ODA Provider Certification: Assisted Living Service, OHIO ADMIN. CODE 173-39-02.16 (2024).