REIMBURSEMENT POLICY STATEMENT
Ohio MyCare

Policy Name & Number	Date Effective
Assisted Living Facilities-MyCare OH FIDE-PY-1680	01/01/2026
Policy Type	
REIMBURSEMENT	

Reimbursement Policies 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 agreements, 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 or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan 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 or Certificate of Coverage) for the service(s) referenced herein. Except as otherwise required by law, if there is a conflict between the Reimbursement Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination. We may use reasonable discretion in interpreting and applying this policy to services provided in a particular case and we 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.

Table of Contents

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 24-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 (ODM).

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 (OAC) 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 LOC qualifies an individual for HCBS, which allows Medicaid payment of assisted living services.
- **Member Eligibility** – OAC 5160-33-03 defines eligibility as follows:
  - Eligible for Ohio Medicaid in accordance with OAC.
  - Intermediate or skilled level of care in accordance with OAC.
  - 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)** –Outlines the services that a case manager authorizes to deliver waiver services to an individual.

D. Policy
I. A review of medical necessity 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 a claim as a single line with a 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 ODM. 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 OAC 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 the 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

N/A

G. Review/Revision History

	DATE	ACTION
Date Issued	06/18/2025	Approved at Committee.
Date Revised		
Date Effective	01/01/2026	
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).
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).

Approved by ODM 08/04/2025

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