Ohio Administrative Code

Rule 5160-58-02.2 MyCare Ohio waiver: eligibility and enrollment.

Effective: January 1, 2026

(A) To be eligible for enrollment in the MyCare Ohio waiver, a member meets all of the following requirements:

(1) Is enrolled in the MyCare Ohio program at the time of application for the MyCare Ohio waiver;

(2) Is determined to have a nursing facility-based level of care (i.e., intermediate or skilled) in accordance with rule 5160-3-08 of the Administrative Code;

(3) In the absence of the MyCare Ohio waiver, require hospitalization or institutionalization in a nursing facility to meet his or her needs;

(4) The member:

(a) Has a need for and agrees to receive at least one waiver service monthly that is otherwise unavailable through another source (including, but not limited to: private pay, community resources, and the medicaid state plan services) in an amount sufficient to meet the individual's assessed need; or

(b) Has a need for:

(i) Continuous nursing services more than four hours in length,

(ii) At least one waiver service annually, and

(iii) Monthly monitoring of the individual's health and welfare through a combination of telephonic and in-person contacts with the waiver service coordinator and agrees to cooperate with the monthly monitoring.

(5) Resides, or is able and agrees to reside, in a setting that possesses the home and community-based setting characteristics set forth in rule 5160-44-01 of the Administrative Code, and is not a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF-IID) or another licensed/certified facility, any facility covered by section 1616(e) of the Social Security Act (January 1, 2026), residential care facility (except an assisted living facility as described in rule 173-39-02.16 of the Administrative Code), adult foster home or another group living arrangement subject to state licensure or certification; and

(6) Is able to have waiver services that can be identified in a person-centered care plan as described in rule 5160-44-02 of the Administrative Code that safely meets his or her assessed needs.

(B) To be enrolled, and maintain enrollment in the MyCare Ohio waiver, a member should be determined by the MyCare Ohio plan to meet all of the following requirements:

(1) Be determined eligible for the MyCare Ohio waiver in accordance with paragraph (A) of this rule;

(2) Be able to have his or her health and welfare ensured through the waiver as determined by the Ohio department of medicaid (ODM) or its designee;

(3) Participate in the development and implementation of an integrated, individualized care plan that includes a person-centered services plan, and waiver services plan, in accordance with the process and requirements set forth in rule 5160-44-02 of the Administrative Code, and sign and date the plan as a condition of its acceptance. If the individual is unable to sign the plan when initially developed, the individual submits an electronic signature or standard signature via regular mail, or otherwise provide a signature in no instance any later than at the next face-to-face visit with the waiver services coordinator;

(4) Agree to receive waiver service coordination from the MyCare Ohio plan or its designee;

(5) Agree to participate in quality management and evaluation activities during his or her enrollment on the MyCare Ohio waiver; and

(6) Sign an agreement prior to waiver enrollment confirming that the member was informed of service alternatives, choice of qualified providers available in the MyCare Ohio plan's provider panel and the options of institutional and community-based care, and he or she elects to receive MyCare Ohio services. If the member is unable to sign the agreement prior to waiver enrollment, the member submits an electronic signature and standard signature via regular mail, or otherwise provides a signature, in no instance any later than at the next face-to-face visit with the waiver services coordinator.

(C) If a member fails to meet any of the requirements set forth in paragraph (A) or paragraph (B) of this rule, the member is denied enrollment on the MyCare Ohio waiver.

(D) Once enrolled in the MyCare Ohio waiver, a member's level of care is reassessed at least annually, and more frequently if there is a significant change in the member's situation that impacts his or her health and welfare, including when the member is admitted to a hospital for inpatient services. If the reassessment determines the member no longer meets the requirements set forth in paragraph (A) or paragraph (B) of this rule, he or she is disenrolled from the MyCare Ohio waiver.

(E) If a member enrolled in the MyCare Ohio waiver who requires monthly waiver service does not receive at least one waiver service for ninety consecutive days, the MyCare Ohio plan , within ten days of the ninetieth day, reassesses the member's need for waiver services. If it is determined the member no longer meets the requirements set forth in paragraph (A) or paragraph (B) of this rule, he or she is disenrolled from the MyCare Ohio waiver.

(F) If, at any other time, it is determined that a member enrolled in the MyCare Ohio waiver no longer meets the requirements set forth in paragraph (A) or paragraph (B) of this rule, or fails to meet the member responsibilities set forth in rule 5160-58-03.2 of the Administrative Code, he or she is disenrolled from the MyCare Ohio waiver.

(G) If a member is denied enrollment in the MyCare Ohio waiver pursuant to paragraph (C) of this rule, or is disenrolled from the waiver pursuant to paragraph (D), (E) or (F) of this rule, the member is afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.