5101:3-40-01 Medicaid home and community-based services program - individual options waiver.

(A) Purpose

(1) The purpose of this rule is to establish the individual options waiver as a component of the medicaid home and community-based services program pursuant to sections 5111.85 and 5111.87 of the Revised Code.

(2) The individual options waiver program provides necessary waiver services to individuals who meet the level of care criteria for an intermediate care facility for individuals with mental retardation and other developmental disabilities (ICF/MR) as set forth in rule 5101:3-3-07 of the Administrative Code, as well as other eligibility requirements established in this rule.

(3) The Ohio department of mental retardation and developmental disabilities (ODMRDD), through an interagency agreement with the Ohio department of job and family services (ODJFS), administers the individual options waiver program on a daily basis in accordance with section 5111.91 of the Revised Code.

(B) Definitions

(1) "County board of mental retardation and developmental disabilities" (CBMRDD) means a board established under Chapter 5126. of the Revised Code.

(2) "Funding range" means the dollar range to which an individual has been assigned for the purpose of funding waiver services. The funding range applicable to an individual is determined by the score derived from an assessment using the Ohio developmental disability profile "ODDP" that has been completed by a county board employee qualified to administer the tool.

(3) "Home and community-based services" (HCBS) means any federally approved medicaid waiver service provided to a waiver enrollee as an alternative to institutional care under Section 1915(c) of the Social Security Act, 49 Stat. 620 (1935), 42 U.S.C.A. 1396n (as in effect on March 31,2006) under which federal reimbursement is provided for designated home and community-based services to eligible individuals.

(4) "Individual" means a person with mental retardation or other developmental disability who is eligible to receive HCBS as an alternative to placement in an intermediate care facility for the mentally retarded under the applicable

HCBS waiver. A guardian or authorized representative may take any action on behalf of the individual, may make choices for an individual or may receive notice on behalf of an individual to the extent permitted by applicable law.

(5) "Individual funding level" means the total funds, calculated on a twelve month basis, that are necessary for payment for waiver services that have been determined through the individual service plan (ISP) development process to be sufficient in amount, duration and scope to meet the health and welfare needs of an individual.

(6) "Individual Service Plan" (ISP) means a written description of the services, supports, and activities to be provided to an individual.

(7) "Provider" means a person or agency certified by ODMRDD that has met the provider qualification requirements to provide the specific individual options waiver service as specified in paragraph (I)(1) of this rule and holds a valid medicaid provider agreement in accordance with paragraph (I)(2) of this rule.

(8) "SSA" means a service and support administrator who is certified in accordance with rules adopted by the ODMRDD under Chapter 5123:2-5 of the Administrative Code and who provides the functions of service and support administration.

(C) Application for the individual options waiver

(1) Individuals seeking to enroll in the individual options waiver program must complete the JFS 02399 "Request for Medicaid Home and Community-Based Services (HCBS)." (rev. 1/2006) Forms shall be available at all CBMRDD. Forms are also available at the county department of job and family services (CDJFS). Forms are to be used in accordance with rule 5101:1-38-01.2 of the Administrative Code.

(2) The CBMRDD is responsible for explaining to individuals requesting HCBS the services available through the individual options waiver benefit package including the amount, scope and duration of services and any applicable benefit package limitations.

(D) Eligibility criteria for the individual options waiver

(1) The individual applying for the individual options waiver program must be determined to require the level of care provided in an ICF/MR and be eligible

for ICF/MR services upon initial enrollment and no later than every twelve months thereafter, as specified in rules 5101:3-3-07 and 5123:2-9-01 of the Administrative Code and in accordance with the process set forth in rule 5101:3-3-15.5 of the Administrative Code; and

(2) The individual's medicaid eligibility has been established in accordance with Chapters 5101:1-37 to 5101:1-42 of the Administrative Code; and

(3) The individual's health and welfare needs can be met through the utilization of individual options waiver services at or below the federally approved cost limitation, and, other formal and informal supports regardless of funding source.

(4) The individual must require, at a minimum, one waiver service, as described in paragraph (F) of this rule, to be considered eligible for this waiver.

(E) Individual options waiver enrollment, continued enrollment, and disenrollment

(1) Individuals who meet the eligibility criteria in paragraph (D) of this rule, or their legal representative, shall be informed of the following:

(a) All services available on this individual options waiver, as delineated in paragraph (F) of this rule, and any choices that the individual may make regarding those services;

(b) Any feasible alternative to the waiver; and

(c) The right to choose either institutional or home and community-based services.

(2) An individual determined eligible for and seeking to enroll, but not yet enrolled on the individual options waiver or an individual whose continued enrollment in the individual options waiver program is being redetermined shall be assessed using the Ohio developmental disabilities profile as pursuant to Chapter 5123:2-9 of the Administrative Code. This instrument shall assess the relative needs and circumstances of an individual compared to others, which is then used to assign the individual to a funding range.

(3) ODMRDD shall allocate waiver slots to the county board in accordance with rule 5123:2-9-03 of the Administrative Code.

(4) The CBMRDD shall offer available individual options waiver slots to eligible individuals in accordance with applicable waiting list category requirements set forth in rules 5101:3-41-05 and 5123:2-1-08 of the Administrative Code.

(5) An individual's continued enrollment in the individual options waiver program shall be redetermined no less frequently than every twelve months beginning with the individual's initial enrollment date or subsequent redetermination date. Individuals must continue to meet the eligibility criteria specified in paragraph (D) of this rule to continue enrollment in the waiver program.

(6) The maximum number of individuals that can be enrolled in the individual options waiver program statewide shall not exceed the allowable number specified in the federally approved waiver document. The approved waiver document is available at http://jfs.ohio.gov/OHP/bca/individualOptionsWaiver.pdf.

(7) The individual must require at least one waiver service monthly, or, if less than monthly, require monthly monitoring of the individual's health and welfare. If no services are planned to be delivered in a month, monthly monitoring of the individual's health and welfare must be required in the ISP, as designated in paragraph (G) of this rule, and must include at least periodic face-to-face monitoring.

(8) While enrolled in the individual options waiver program, if the enrollee does not receive any waiver services as listed in paragraph (F) of this rule for one month , the county board shall, within fifteen days after the end of the calendar month , assess the enrollee's current need for waiver services, and discuss these needs with the enrollee and their representative. As a result of the assessment and discussion, if no waiver services are needed , the enrollee shall be recommended for disenrollment from the waiver program and shall be given notification of hearing rights as established in paragraph (L) of this rule.

(9) Individuals enrolled in the individual options waiver program who are recommended for disenrollment from the waiver program shall be given notification of hearing rights as established in paragraph (L) of this rule.

(F) Individual options waiver program benefit package, as included in the federally approved waiver document:

The individual options waiver program benefit package is limited to the following services:

(1) Homemaker / personal care;

(2) Social work;

(3) Interpreter;

(4) Nutrition;

(5) Home-delivered meals;

(6) Day habilitation, available until December 31, 2007;

(7) Supported employment, available until December 31, 2007;

(8) Environmental accessibility modifications;

(9) Transportation;

(10) Adaptive and assistive equipment;

(11) Respite;

(12) Supported employment - community;

(13) Supported employment - enclave;

(14) Adult day supports;

(15) Vocational habilitation;

(16) Supported employment - adapted equipment;

(17) Non-medical transportation to access the services listed in paragraphs (F)(12) to (F)(15) of this rule;

(18) Adult foster care;

(19) Homemaker/personal care-daily billing unit.

(G) Limits on sets of individual options waiver services

(1) The following benefits are subject to specific benefit limitations that, when combined cannot exceed the maximum amount as specified in appendix B to rule 5101:3-41-15 of the Administrative Code, effective in twelve month periods beginning with the individual's enrollment or redetermination date:

(a) Supported employment - enclave;

(b) Supported employment - community;

(c) Supported employment - adapted equipment;

(d) Adult day supports;

(e) Vocational habilitation.

(2) Non-medical transportation services are subject to a benefit limitation not to exceed the amount specified in appendix B to rule 5101:3-41-15 of the Administrative Code.

(H) Individual options service plan requirements

(1) All services shall be provided to an individual enrolled in the individual options waiver program pursuant to a written ISP.

(2) The ISP shall be developed by qualified persons with input from the individual options waiver enrollee and the SSA in accordance with section 5126.15 of the Revised Code. Providers shall participate in the ISP meetings when a request for their participation is made by the individual enrollee.

(a) The ISP shall list the individual options waiver services and the non-waiver services, regardless of funding source, that are necessary to ensure the enrollee's health and welfare; and

(b) The ISP shall include an individual funding level as defined in paragraph B(5) of this rule. If the county board, with the involvement of the individual enrolled on the individual options waiver program, is unable to recommend an ISP that includes a funding level that is within or below the funding range, the county board shall inform the individual

of the right to request prior authorization as specified in division 5101:3 of the Administrative Code and shall provide the individual notification of hearing rights as established in paragraph (L) of this rule; and

(c) The ISP shall contain the following medicaid required elements:

(i) Type of service to be provided; and

(ii) Amount of service to be provided; and

(iii) Frequency and duration of each service to be provided; and

(iv) Type of provider to furnish each service; and

(d) The ISP shall be developed on at least an annual basis consistent with the individual's redetermination as indicated in paragraph (E)(5) of this rule or as the individual's needs change and in accordance with division 5123:2 of the Administrative Code; and

(e) The ISP shall be developed to include only waiver services which are consistent with efficiency, economy and quality of care. When reasonable, waiver services are not provided entirely at a one to one ratio. When combined with other non-waiver services, waiver services must ensure the health and welfare for the individual for whom the ISP is developed; and

(f) The ISP is subject to approval by ODJFS and ODMRDD pursuant to section 5111.871 of the Revised Code. Notwithstanding the procedures set forth in this rule, ODJFS may in its sole discretion, and in accordance with section 5111.852 of the Revised Code direct the CBMRDD or ODMRDD to amend ISPs for individuals if ODJFS determines that such services are medically necessary and the procedures set forth in division 5101:3 of the Administrative Code would not accommodate a request for such medically necessary services.

(I) Free choice of provider

Individuals enrolled in the individual options waiver program shall be given a free choice of qualified individual options waiver providers in accordance with Chapters 5101:3-41 and 5123:2-9 of the Administrative Code. A provider is qualified if they meet the standards established in paragraph (I) of this rule. ODMRDD shall create

and maintain an internet-based list of those providers who are qualified to provide individual options waiver services in accordance with section 5126.046 of the Revised Code. This list will be accessible to county boards and individuals applying for or receiving services. The CBMRDD shall provide information about the internet-based provider list to applicants and enrollees and shall assist an individual to access this list to assure the individual's free choice of qualified providers.

(J) Provision of individual options waiver services

(1) Individual options waiver services shall be provided by persons or agencies who have certification in accordance with section 5123.045 of the Revised Code and division 5123:2 of the Administrative Code; and

(2) Individual options waiver services shall be provided by persons or agencies who have a valid medicaid provider agreement in accordance with rule 5101:3-1-17.2 of the Administrative Code; and

(3) Individual options waiver services shall be provided only to individuals who have met the eligibility requirements in paragraph (D) of this rule and are enrolled in the individual options waiver program at the time of service delivery; and

(4) Individual options waiver services shall be provided in accordance with each enrollee's ISP as specified in paragraph (G) of this rule; and

(5) No provider of individual options waiver services shall enter into or maintain any contract for the provision of waiver services except as noted in paragraph (J)(2) of this rule. Only those subcontracts specified in Chapter 5123:2-9 of the Administrative Code are permissible.

(K) Provider payment standards

Individuals enrolled in the individual options waiver program shall be subject to the payment standards set forth in rules 5123:1-2-08, 5123:1-2-11, and paragraphs (A) to (C) of rule 5101:3-1-60 of the Administrative Code. At such time as reimbursement standards in rules 5101:3-41-11 and 5123:2-9-06 of the Administrative Code are in effect those payment standards shall apply.

(L) Monitoring, compliance, and sanctions

ODJFS shall conduct periodic monitoring and compliance reviews related to the

individual options waiver program in accordance with Chapter 5111. of the Revised Code. Reviews may consist of, but are not limited to, physical inspections of records and sites where services are provided, interviews of providers, recipients, and administrators of waiver services. Certified individual options waiver providers, in accordance with the medicaid provider agreement, ODMRDD, and CBMRDD shall furnish to ODJFS, the center for medicare and medicaid services (CMS), and the medicaid fraud control unit or their designees any records related to the administration and/or provision of individual options waiver services. Individuals enrolled in the individual options waiver program shall cooperate with all monitoring, compliance, and quality assurance reviews conducted by ODJFS, CMS, and the medicaid fraud control unit or their designee.

(M) Due process

(1) Whenever an applicant for or enrollee of the individual options waiver program is affected by any action proposed or taken by ODMRDD and/or ODJFS, or when action is recommended by the CBMRDD, the entity recommending or taking the action will provide medicaid due process in accordance with section 5101.35 of the Revised Code through the state fair hearing process, and as specified in Chapters 5101:6-1 to 5101:6-9 of the Administrative Code. Such actions may include, but are not limited to, the approval, denial, or termination of enrollment or a denial or change in the level, and/or type of waiver services delivered to an individual options waiver enrollee.

(2) If an applicant or enrollee requests a hearing, as specified in Chapters 5101:6-1 to 5101:6-9 of the Administrative Code, the participation of ODMRDD and the CBMRDD is required during the hearing proceedings to justify the decision under appeal.

Effective:

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Certification

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Date

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