5160-32-03 **Eligibility for enrollment for the choices home and community-based services (HCBS) waiver program.**

The current effective choices waiver is set to expire on June 30, 2014. Therefore, in accordance with Section 173.53 of the Revised Code, enrollment in the Choices waiver is suspended effective March 1, 2014. This suspension shall remain in effect until the choices waiver is terminated.

The following criteria must be met in order for a consumer to be eligible for enrollment:

(A) The consumer must be age sixty or older at time of enrollment.

(B) The consumer must have an intermediate or skilled level of care in accordance with rule ~~5101:3-3-05~~5160-3-05 or rule ~~5101:3-3-06~~5160-3-06 of the Administrative Code.

(C) The consumer must be eligible for medicaid as determined by the county department of job and family services (CDJFS) in accordance with rules ~~5101:1-38-01.8~~5160:1-2-01.8 and ~~5101:1-38-01.6~~5160:1-2-01.6 of the Administrative Code.

(D) Prior to enrollment in the choices program the consumer must be a current preadmission screening systems providing options and resources today (PASSPORT) program participant.

(E) The needed services are not readily available through another source at the level required to allow the individual to live in the community.

(F) The individual's health related needs can be safely met in a home setting as determined by the passport administrative agency (PAA).

(G) The individual agrees to participate in choices and shall not be simultaneously enrolled in another home and community based medicaid waiver, residential state supplement (RSS), or the program of all inclusive care for the elderly (PACE) while enrolled in choices.

(H) While receiving choices program services, the consumer shall reside in the service area defined in the approved 1915(c) waiver for the choices program.

(I) The consumer shall not reside in any of the following living arrangements while enrolled in the choices program:

(1) Adult foster home certified under section 5119.362 of the Revised Code;

(2) Adult family homes or adult group homes as defined in section 3722.01 of the Revised Code that is licensed as an adult care facility under section 3722.04 of the Revised Code;

(3) Residential care facility as defined in section 3721.02 of the Revised Code;

(4) Community alternative home as defined in section 3724.01 of the Revised Code that is licensed under section 3724.03 of the Revised Code;

(5) Residential facility of the type defined in division (A)(1)(d)(ii) of section 5119.22 of the Revised Code that is licensed by the Ohio department of mental health (ODMH);

(6) An apartment or room that is used to provide community mental health housing services, is certified by the ODMH under division (M) of section 5119.611 of the Revised Code, and is approved by a board of alcohol, drug addiction, and mental health services in accordance with division (A)(14) of section 340.03 of the Revised Code;

(7) Hospital or nursing facility (NF) as defined in rule ~~5101:3-31-02~~5160-31-02 of the Administrative Code;

(8) "Keys amendment facility" as defined in section 1616(e) of the Social Security Act; or

(9) Any other facility that is licensed and/or certified by any state or local government.

(J) The consumer or the consumer's authorized representative must be willing and capable of directing provider activities. The consumer's capability to self-direct their services is demonstrated through a consumer certification process conducted by the PAA. To obtain certification, the consumer or his or her designee must meet all of the following:

(1) Attend all required trainings;

(2) Demonstrate all skills necessary to supervise direct service workers, including but not limited to:

(a) An understanding of what service activities are covered that the consumer

may self-direct and provider requirements including criminal records check requirements; and

(b) Methods for selecting and dismissing providers; and

(c) Methods for entering into written agreements with providers for specific activities and corresponding payment rates; and

(d) Methods for training providers to meet the consumer's specific needs; and

(e) Methods for supervising and monitoring providers' performance of specific activities, including written approval of provider time sheets and billing invoices; and

(f) Development of a reliable service delivery back-up plan for situations in which a provider is unable to deliver the agreed-upon service(s); and

(g) Methods for lodging complaints, including use of the regional and state long term care ombudsman, and familiarity with the state's Ohio department of aging (ODA) ombudsman long term care complaint line; and

(h) Familiarity with state appeal and fair hearing request procedures; and

(i) Record keeping and ability to manage service delivery.

(3) Agree to actively participate with the case manager in the development, monitoring and revision of the service plan.

(4) Agree to inform the case manager of negotiated rates prior to delivery of choices services. ODA and/or the PAA retains the authority to approve negotiated rates.

(5) The consumer must use the financial management service (FMS) to process all consumer-directed individual provider claims.

(K) If, at any time, the individual or consumer fails or ceases to meet any of the eligibility criteria identified in this rule, he or she shall be denied or disenrolled from choices. In such instances, he or she shall be notified by the CDJFS and entitled to hearing rights in accordance with rules contained in Chapters 5101:6-1 to 5101:6-9 of the Administrative Code.

(L) The choices program has not reached the center for medicaid and medicare services (CMS) authorized limit of participants for the current year.

(M) The waiver service cost of the twelve-month service plan does not exceed the individual cost limit. The individual cost limit is calculated by ODA at least biennially. The cost limit is the dollar amount equal to sixty per cent of the total medicaid cost for NF services. The total medicaid cost for NF services is obtained by multiplying the average annual medicaid NF per diem rate by the number of days in the most recent state fiscal year in which data is available.

(1) If the PAA determines that the applicant's needs cannot be met within the cost limit the individual shall not be enrolled; however if a consumer who is enrolled on the waiver and receiving choices services experiences a change in his or her condition that causes the cost of care to exceed the cost limit, the consumer may remain on the waiver at a higher cost, not to exceed one hundred per cent of the total medicaid cost for NF services to avoid service disruption to the consumer if the PAA grants approval to do so.

(2) If the consumer's needs exceed one hundred per cent of the total medicaid cost of NF services, the consumer shall be disenrolled from the waiver.

(N) Prior to choices enrollment the individual's attending physician must approve that the services contained in the individual's service plan are appropriate to meet the individual's needs. The approval may be either verbal or written; however if the approval is verbal, written approval of the service plan must be obtained within thirty days of the consumer's enrollment date. If the written approval is not obtained within this timeframe, the individual shall be deemed to have not met the eligibility criteria set forth in this rule and be disenrolled from the choices waiver pursuant to paragraph (K) of this rule.

Effective:

R.C. 119.032 review dates: 11/29/2013

Certification

Date

Promulgated Under:	119.03
Statutory Authority:	5166.02
Rule Amplifies:	5166.02, 173.53
Prior Effective Dates:	8/30/01, 7/01/05, 7/01/06, 10/01/07, 9/29/11