5160-40-01 **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 5166.02 and 5166.20 of the Revised Code.

(2) The individual options waiver program provides necessary waiver services to individuals who meet the criteria for a developmental disabilities level of care in accordance with rule 5123-8-01 of the Administrative Code, as well as other eligibility requirements established in this rule.

(3) The Ohio department of developmental disabilities (DODD), through an interagency agreement with the Ohio department of medicaid (ODM), administers the individual options waiver program on a daily basis in accordance with section 5162.35 of the Revised Code.

(B) Definitions

(1) "County board" means a county board of developmental disabilities 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 disabilities 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 October 1, 2019, under which federal reimbursement is provided for designated home and community-based services to eligible individuals.

(4) "Individual" means a person with a developmental disability who is eligible to receive HCBS as an alternative to placement in an intermediate care facility for individuals with intellectual disabilities (ICF/IID) under the applicable HCBS waiver. A guardian or authorized representative may give, refuse to give or withdraw consent for services 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 in accordance with paragraph (H) of this rule.

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

(8) "SSA" means a service and support administrator who is certified in accordance with rule 5123:2-5-02 of the Administrative Code and who provides the functions of service and support administration.

(C) Request for a referral for an individual options waiver

(1) Individuals seeking to enroll in the individual options waiver program may do one of the following:

(a) Request a referral through a local county job and family services (CDJFS);

(b) Request a referral to a local county board;

(c) Request a referral online through the Ohio benefits self-service portal (www.benefits.Ohio.gov);

(d) Request a referral over the phone (800-324-8680).

(2) The county board 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 requesting a referral for the individual options waiver program must be determined to meet the criteria for a developmental disabilities level of

care in accordance with rule 5123-8-01 of the Administrative Code upon initial enrollment and no later than every twelve months thereafter; and

(2) The individual's medicaid eligibility has been established in accordance with Chapters 5160:1-1 to 5160:1-6 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.

(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, 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 in the individual options waiver, or an individual with continued enrollment in the individual options waiver program, 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) DODD shall allocate waivers to the county board in accordance with section 5166.22 of the Revised Code.

(4) The county board shall offer an available individual options waiver to eligible individuals in accordance with applicable waiting list category requirements set forth in rules 5160-41-05 and 5123-9-04 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.

(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 (H) 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 for one month, the county board shall assess the enrollee's current need for waiver services, monitor the individual to verify the individual's ongoing need for waiver enrollment, 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.

(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 (M) of this rule.

(F) The individual options waiver program benefit package, as indicated in the federally approved waiver application, is limited to the services specified in Chapters 5123:2-9 and 5123-9 of Administrative Code.

(G) Limits on sets of individual options waiver services

(1) The following benefits are subject to specific benefit limitations:

(a) Adult day support;

(b) Career planning;

(c) Group employment support;

(d) Individual employment support;

(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 5123:2-9-19 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.

(3) The ISP shall contain the following required criteria, and will comport with the outlined procedures for review and revision:

(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 rule 5123-9-07 of the Administrative Code and shall provide the individual notification of hearing rights as established in paragraph (M) 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.

(d) The ISP shall be reviewed 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 rule 5123:2-1-11 of the Administrative Code; and

(e) The SSA shall review and revise the ISP more frequently than the required annual basis under the following circumstances:

(i) At the request of the individual or a member of the individual's team; or

(ii) Whenever the individual's assessed needs, situation, circumstances or status changes; or

(iii) If the individual chooses a new provider or type of service or support; or

(iv) As a result of the continuous review process of the ISP; or

(v) Identified trends and patterns of unusual or major unusual incidents; or

(vi) When services are reduced, denied, or terminated.

(f) 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

(g) The ISP is subject to approval by ODM and DODD pursuant to section 5166.05 of the Revised Code. Notwithstanding the procedures set forth in this rule, ODM may in its sole discretion, and in accordance with section 5166.05 of the Revised Code direct the county board or DODD to amend ISPs for individuals if ODM determines that such services are medically necessary and the procedures set forth in.this rule 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 rules 5160-41-08 and 5123:2-9-11 of the Administrative Code. A provider is qualified if they meet the standards established in paragraph (J) of this rule. DODD shall create and maintain an online database of those providers who are qualified to provide individual options waiver services. This list will be accessible to county boards and individuals applying for or receiving services. The county board shall assist an individual, as needed, with exercising the right to free choice of provider in accordance with rule 5123:2-9-11 of the Administrative Code.

(J) Provision of individual options waiver services

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

(2) At the discretion of DODD, any provider approved by ODM or certified by the Ohio department of aging (ODA) may also be eligible to provide waiver services so long as the provider has satisfied the requirements for certificiation by DODD for the same or similar services; and

~~(2)~~(3) Individual options waiver services shall be provided by persons or agencies who have a valid medicaid provider agreement in accordance with rule 5160-1-17.2 of the Administrative Code; and

~~(3)~~(4) 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)~~(5) Individual options waiver services shall be provided in accordance with each enrollee's ISP as specified in paragraph (H) of this rule; and

~~(5)~~(6) No provider of individual options waiver services shall enter into or maintain any contract with an enrollee for the provision of waiver services except as noted in paragraph (J)(2) of this rule.

(K) Provider payment standards

Provider payment standards for the individual options waiver are established in Chapters 5160-41, 5123:2-9, and 5123-9 of the Administrative Code.

(L) Monitoring, compliance, and sanctions

ODM shall conduct periodic monitoring and compliance reviews related to the individual options waiver program in accordance with section 5162.10 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 or licensed individual options waiver providers, in accordance with the medicaid provider agreement, DODD, and county board shall furnish to ODM, 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 ODM, CMS, and the medicaid fraud control unit or their designee.

(M) Due process

(1) When DODD, ODM, or the county board takes action to approve, deny, or terminate enrollment in the individual options waiver, or to deny or change the level and/or type of waiver services delivered to an individual options waiver enrollee, the entity recommending or taking 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.

(2) When an individual requests a hearing, as specified in Chapters 5101:6-1 to 5101:6-9 of the Administrative Code, the participation of DODD and the county board is required during the hearing proceedings to justify the decision under appeal.

Effective:

Five Year Review (FYR) Dates: 7/28/2020

Certification

Date

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