CSI - Ohio
The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: HCBS Settings and Person-centered Planning

Rule Number(s): 5160-44-02

For Informational Purposes Only 5160-44-01 and 5160-46-02

Date: April 15, 2016

Rule Type:

X	New		5-Year Review
	Amended		Rescinded

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Regulatory Intent

1. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.

   OAC Rule 5160-44-02 sets forth the requirements of the person-centered planning process for nursing facility-based level of care home and community-based service (HCBS) programs (i.e., Ohio Department of Medicaid (ODM) –administered 1915(c) HCBS waivers, Ohio Department of Aging (ODA) –operated 1915(c) HCBS waivers and the 1915(i) Medicaid state plan option). It also contains the elements that must be in a person-centered

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services plan and sets forth the process for modifying the person-centered services plan when changes are warranted regarding the individual's HCBS setting.

2. **Please list the Ohio statute authorizing the Agency to adopt this regulation.**

   Ohio Revised Code Sections 5162.03, 5164.02 and 5166.02.

3. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**
   If yes, please briefly explain the source and substance of the federal requirement.

   Yes. OAC Rule 5160-44-02 is being created to codify the person-centered planning requirements issued by the Centers for Medicare and Medicaid Services (CMS) on January 16, 2014 in 42 CFR 441.301 and 42 CFR 441.725. In order for CMS to approve a 1915(c) home and community-based services waiver or a 1915(i) Medicaid state plan option, the state's person centered planning process must include the following:

   (1) ***Person-centered planning process.*** The individual will lead the process where possible and the process shall:

   - Include people chosen by the individual.
   - Provide necessary information and support to ensure the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.
   - Be timely and convenient to the individual.
   - Reflect cultural considerations of the individual and be conducted in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.
   - Include clear conflict-of-interest guidelines.
   - Ensure that providers or those who have an interest in or are employed by a provider of HCBS, must not provide case management or develop the person-centered services plan.
   - Offer the individual informed choices.
   - Permit the individual to update his or her service plan as needed.
   - Record the alternative home and community-based settings that were considered by the individual.

(2) ***The Person-centered services plan.*** The person-centered services plan must reflect the services and supports that are important for the individual to meet the needs identified through the assessment process. The written plan must:

- Reflect that the setting in which the individual resides is chosen by the individual, and that it is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community.
- Reflect the individual's strengths and preferences.
- Reflect clinical and support needs.
- Include individually identified goals and outcomes.
- Reflect the services and supports (paid and unpaid) and the providers that will assist the individual to achieve identified goals.
- Reflect risk factors and measures in place to minimize them
- Be understandable to the individual.
- Identify who is responsible for monitoring the plan.
- Be finalized and agreed to, in writing, with the informed consent of the individual, and be signed by the individual and all providers.
- Be distributed to the individual and other people involved in the plan.
- Include those services the individual chooses to self-direct.
- Prevent the provision of unnecessary or inappropriate services and supports.
- Document that any modification of the additional CMS conditions for provider-owned or controlled settings must be supported by a specific assessed need and justified in the plan.

(3) ***Review of the Person-centered services plan.*** The person-centered services plan must be reviewed, and revised upon reassessment at least every 12 months, when the individual experiences a significant change, or upon the individual's request.

OAC Rule 5160-44-02 is also one of two new rules being proposed in order to meet the State's obligations as proposed in its revised draft HCBS Transition Plan submitted to CMS on December 3, 2015. OAC Rule 5160-44-01 governing HCBS settings, and which is attached to this Business Impact Analysis (BIA) but is not subject to Common Sense Initiative Office (CSIO) review, is being created to implement CMS' new HCBS settings requirements set forth in 42 CFR 441.302 and 42 CFR 441.710 (2014).

4. If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.

Not applicable. This rule establishes the specific process for meeting the person-centered planning requirements set forth by CMS.

5. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

   The public purpose of these regulations is to codify with and implement CMS' requirements regarding person-centered planning as set forth in 42 CFR 441.301 and 42 CFR 441.725. Additionally, these requirements are intended to ensure the Ohio Medicaid program offers individuals receiving HCBS choice and control over how they direct and receive services, while at the same time taking steps to ensure the health and welfare of individuals and HCBS program integrity.

6. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

   Successful outcomes are measured through:

   - CMS' approval of Ohio's HCBS programs.
   - Individuals' active participation in the person-centered planning process, including but not limited to, selection of team members and choice of providers, etc.
   - Signatures of team members on person-centered services plans.
   - Ongoing monitoring, targeted review findings and/or client surveys.

Development of the Regulation

7. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**
   If applicable, please include the date and medium by which the stakeholders were initially contacted.

   ODM program staff actively worked with representatives from ODA and the Ohio Department of Mental Health and Addiction Services (MHAS) to draft OAC 5160-44-02. ODM staff included representatives from the Bureaus of Long Term Care Services and Supports, Health Plan Policy and Managed Care and the Office of Legal Counsel. In addition, the stakeholders listed below met regularly to review and revise the rule.

   AARP

Brain Injury Association of Ohio
Caregiver Homes
CareSource
CareStar
Council on Aging
Disability Rights Ohio
Easter Seals of Ohio
Help 4 Seniors
Individuals served through the Ohio Medicaid program, including HCBS waivers
LeadingAge Ohio
LEAP
Molina Healthcare
NAMI Ohio
Ohio Academy of Senior Health Sciences, Inc.
Ohio Assisted Living Association
Ohio Association of Area Agencies on Aging
Ohio Association of County Behavioral Health Authorities
Ohio Association of Senior Centers
Ohio Council for Home Care and Hospice
Ohio Council of Behavioral Health & Family Services Providers
Ohio Department of Developmental Disabilities
Ohio Health Care Association
Ohio Long Term Care Ombudsman
Ohio Olmstead Task Force
Public Consulting Group (PCG) (provider oversight contractor)
Senior Resource Connection
United Healthcare

8. **What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?**

ODM and ODA first partnered in March 2015 for the purpose of drafting the HCBS rules. MHAS joined in June, at which time ODM's HCBS Rules Workgroup was also expanded to include stakeholders from all three agencies that would be affected by the promulgation of these new rules. The workgroup met monthly beginning in June and finalized the drafts in December. At the workgroup's request, and in order to avoid any misinterpretation of the CMS regulations, the rule was redrafted to reflect consistency with CMS language.

9. **What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?**

   No scientific data was used.

10. **What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?**

    As stated in ODM's response to Question 8, at the workgroup's request, and in order to avoid any misinterpretation of the CMS regulations, ODM redrafted the rule to reflect consistency with CMS language.

11. **Did the Agency specifically consider a performance-based regulation? Please explain.** ***Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.***

    No. The federal regulation set forth in 42 CFR 441.301 and 42 CFR 441.725 is prescriptive and the State's compliance is dependent upon demonstrating person-centered planning includes all the required elements. The rule sets forth the requirements of the person-centered planning process, the required elements in a person-centered services plan and the process for modifying the person-centered services plan when changes are warranted regarding the individual's HCBS setting.

12. **What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?**

    The HCBS person-centered planning regulations issued by CMS impact all 1915(c) waivers and the 1915(i) Medicaid state plan option. In order to ensure this regulation is not duplicated by other state agencies, ODM collaborated with ODA and MHAS to create a single rule that all NF-based level of care HCBS programs could refer to in their own rules and follow. To ensure this, a new OAC rule chapter is being created to house all such rules. Internally, the regulations were also reviewed by Medicaid's legal and legislative staff to ensure there is no duplication within existing OAC 5160-44-02 and other ODM rules.

13. **Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.**

Initial notification of rule promulgation will occur via a variety of communication methods including, but not limited to ODM's issuance via remittance advice, emails to ODM-administered waiver stakeholder groups, electronic communication via the ODM-approved assessment and case management system and the provider oversight contractor's (PCG) website. ODA and MHAS will also notify their respective stakeholders of the new rule.

Adverse Impact to Business

14. **Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:**
    a. **Identify the scope of the impacted business community;**
    b. **Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and**
    c. **Quantify the expected adverse impact from the regulation.**
    The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

(a) The businesses that furnish case management services to any of the State's 1915(c) waivers or that will furnish recovery management services to the State's 1915(i) state plan option (Specialized Recovery Services Program) may be impacted by the proposed rule. Currently, three entities are under contract with ODM to provide case management services, including person-centered planning, to individuals enrolled on the Ohio Home Care Waiver. Their respective contracts are being amended to permit them to provide recovery management services, also including person-centered planning, to individuals participating in the new 1915(i) Medicaid state plan option. Five managed care plans are under contract with ODM to furnish comprehensive care management services as part of the MyCare Ohio Waiver, of which waiver service coordination is a part. Lastly, pursuant to three-party agreements with ODM and ODA, 13 PASSPORT administrative agencies (PAA) are responsible for furnishing

case management services to individuals enrolled on the PASSPORT and Assisted Living waivers. Each of these entities varies in size, infrastructure, delegation of functions and size of caseloads, etc.

(b) ODM solicited input from the entities described in (14)(a) above and received comments from four managed care plans, two case management agencies and one PAA. Generally speaking, the commenters noted many of the CMS-required person-centered planning requirements set forth in OAC rule 5160-44-02 are similar to current requirements the entities must comply with under their current contracts and agreements. The commenters identified obtaining signatures of services providers on the person-centered service plan and the process to document modifications as the requirements likely to have the most significant impact on business operations. ODM has been and will continue to collaborate with ODA, MHAS and affected stakeholders to ensure there are consistent expectations regarding person-centered planning, as well as the availability of the training and technical assistance necessary to support implementation of the new rule.

(c) When asked to quantify the expected adverse impact, respondents' projections varied, taking into consideration each of these entities varies in size, infrastructure, delegation of functions and size of caseloads, etc. Concern was expressed that the requirements could result in additional administrative expense due to increased staffing, travel, training, communication, documentation and data collection/system modification needs. One managed care plan estimated an increase of 35% over existing staff time to develop and monitor waiver service plans in accordance with the provisions of OAC rule 5160-44-02. Other entities estimated increases ranging from $150,000 to more than $500,000 for salary, benefit and other administrative expenses. Conversely, other respondents saw minimal business impact but were more concerned about the potential impact on the amount, duration and timeliness of service delivery.

15. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

The State's compliance with CMS' HCBS regulations is required. CMS will not approve, nor will it renew HCBS programs if the State does not comply. CMS could also withhold

federal medical assistance percentage (FMAP) dollars if an HCBS program is found to be out of compliance.

Many of the requirements set forth in OAC Rule 5160-44-02 are already embedded in contracts and/or agreements that ODM and ODA hold with entities responsible for HCBS case management (e.g. ODM-administered waiver case management entities, managed care plans and PAAs). Failure to comply with this rule could result in violations of their respective contracts or agreements and subject the entities to corrective action and/or sanctioning, including termination of their contracts and/or agreements.

Regulatory Flexibility

16. **Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.**

    No.

17. **How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?**

    Not applicable.

18. **What resources are available to assist small businesses with compliance of the regulation?**

    ODM has been and will continue to collaborate with ODA, MHAS and affected stakeholders to ensure there are consistent expectations regarding person-centered planning, as well as the availability of the training and technical assistance necessary to support implementation of the new rule. Case management guides will include or be updated to reflect the new HCBS requirements, including those set forth in OAC Rule 5160-44-02, and training will be conducted with the entities responsible for case management and provider oversight. Additionally, ODM and ODA will be available to answer questions associated with the rule.

5160-44-01 **Nursing facility-based level of care home and community-based services programs: home and community-based settings.**

(A) Individuals receiving home and community-based services (HCBS) through either an Ohio department of medicaid (ODM) or Ohio department of aging (ODA) -administered waiver program authorized under section 1915(c) of the Social Security Act (as in effect on January 1, 2016) or the Ohio medicaid state plan authorized under section 1915(i) of the Social Security Act (as in effect on January 1, 2016) must reside in and/or receive HCBS in a private residence or another setting that meets the home and community-based setting requirements set forth in this rule.

(1) A private residence is presumed to be a home and community-based setting provided it meets the requirements set forth in paragraph (B) of this rule. For the purposes of this rule, provider owned or controlled settings are not private residences.

(2) Home and community-based settings do not include any of the following:

(a) A nursing facility;

(b) An insititution for mental diseases;

(c) An intermediate care facility for individuals with intellectual disabilities;

(d) A hospital; or

(e) Any other locations as determined by the ODM or its designee.

(B) Home and community-based settings must have all of the following characteristics, and such other characteristics as the secretary of the U.S. department of health and human services determines to be appropriate, based on the needs of the individual as indicated in their person-centered services plan:

(1) The setting is integrated in and supports full access of individuals receiving medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as individuals not receiving services through the ODM or ODA-administered waiver programs authorized under section 1915(c) of the Social Security Act (as in effect on January 1, 2016) or Ohio medicaid state plan authorized under section 1915(i) of the Social Security Act (as in effect on January 1, 2016).

(2) The setting is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting.

(a) The setting options are identified and documented in the person-centered services plan and are based on the individual's needs, preferences, and for residential settings, resources available for room and board.

(b) For the purposes of this rule, non-disability specific setting means a home and community-based setting that is not limited to same or similar types of disabilities, or any disabilities at all.

(3) The setting ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

(4) The setting optimizes, but does not regiment, individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.

(5) The setting facilitates individual choice regarding services and supports, and who provides them.

(C) In addition to the characteristics set forth in paragraph (B) of this rule, in a provider-owned or controlled residential setting, the following additional conditions must be met, consistent with the individual's approved person-centered services plan.

(1) The individual's unit or dwelling is a specific physical place that can be rented or occupied under either:

(a) A legally enforceable agreement between the individual receiving services, and the owner of the dwelling pursuant to Chapter 5321. of the Revised Code.

(b) For settings in which Chapter 5321 of the Revised Code does not apply, a lease, residency agreement or other legally enforceable agreement in effect for the individual which provides protections that address eviction processes and appeals comparable to those provided under Chapter 5321. and Chapter 1923. of the Revised Code. The agreement must:

(i) Specify the responsibilities of the individual and the home and community-based setting;

(ii) Specify the circumstances under which the individual would be required to relocate, resulting in the termination of the agreement;

(iii) Address the steps an individual must follow in order to request a review and/or appeal of the relocation that results in termination of the agreement; and

(iv) Permit the additional conditions set forth in paragraphs (C)(2) to (C)(5) of this rule unless modified in the individual's person-centered services plan.

(2) The individual has privacy in his or her sleeping or living unit including all of the following:

(a) The setting and unit have entrance doors lockable by the individual, with only appropriate staff having keys; and

(b) An individual sharing a unit has a choice of roommates in that setting.

(3) The individual has the freedom to furnish and decorate his or her sleeping or living unit within the lease or legally enforceable agreement.

(4) The individual has the freedom and support to control his or her own schedule and activities, and has access to food at any time.

(5) The individual is able to have visitors of his or her choosing at any time.

(6) The setting is physically accessible to the individual.

(D) Any modification of the additional conditions set forth in paragraphs (C)(1) to (C)(5) of this rule must be supported by a specific assessed need and justified in the individual's person-centered services plan in accordance with rule 5160-44-02 of the Administrative Code. The condition in paragraph (C)(6) of this rule cannot be modified in any way.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5166.02
Rule Amplifies:	5162.03, 5164.02, 5166.02

5160-44-02 **Nursing facility-based level of care home and community-based services programs: person-centered planning.**

(A) Person-centered planning process.

Individuals receiving home and community-based services (HCBS) through either an Ohio department of medicaid (ODM) or Ohio department of aging (ODA) -administered waiver program authorized under section 1915(c) of the Social Security Act (as in effect on January 1, 2016) or the Ohio medicaid state plan authorized under section 1915(i) of the Social Security Act (as in effect on January 1, 2016) will lead the person-centered planning process where possible. The individual's authorized representative should have a participatory role, as needed, and as defined by the individual, unless Ohio law confers decision-making authority to the legal representative. All references to individuals include the role of the individual's authorized representative. In addition to being led by the individual receiving services and supports, the person-centered planning process shall:

(1) Include a team of people chosen by the individual.

(2) Provide necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.

(3) Be timely and occur at times and locations of convenience to the individual.

(4) Reflect cultural considerations of the individual. The process shall be conducted by providing information in plain language and in a manner that is accessible to persons with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b) (as in effect October 1, 2015).

(5) Include strategies for solving conflict or disagreement within the process.

(6) Ensure that providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management, provider oversight, or develop the person-centered services plan.

(7) Offer informed choices to the individual regarding the services and supports he or she receives and from whom.

(8) Include a method for the individual to request updates to the plan as needed. The individual may request a person-centered services plan review at any time.

(B) Person-centered services plan.

(1) The person-centered services plan describes the person-centered goals, objectives and interventions selected by the individual and team to support him or her in his or her community of choice. The plan addresses the assessed needs of the individual by identifying medically-necessary services and supports provided by natural supports, medical and professional staff and community resources. The plan must:

(a) Identify the setting in which the individual resides is chosen by the individual and record the alternative home and community-based settings that were considered by the individual.

(b) Reflect the individual's strengths.

(c) Reflect the individual's preferences.

(d) Reflect clinical and support needs as identified through the assessment process.

(e) Include the individual's identified goals and desired outcomes.

(f) Identify the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports and those services the individual elects to self-direct.

(g) Address any risk factors and measures in place to minimize them, when needed.

(h) Include back-up plans that meet the needs of the individual.

(i) Reflect that the setting chosen by the individual is integrated in, and supports the full access of individuals receiving medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community to the same degree of access as people not receiving medicaid HCBS.

(2) The person-centered services plan contains documentation that any modification of the additional conditions for provider-owned or controlled residential settings set forth in rule 5160-44-01 of the Administrative Code must be supported by a specific assessed need and justified in the person-centered services plan. The following requirements must be documented in the person-centered services plan:

(a) Identify a specific and individualized assessed need;

(b) Document the positive interventions and supports used prior to any modifications to the person-centered services plan;

(c) Document less intrusive methods of meeting the need that have been tried but did not work;

(d) Include a clear description of the condition that is directly proportionate to the specific assessed need;

(e) Include a regular collection and review of data to measure the ongoing effectiveness of the modification;

(f) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;

(g) Include informed consent of the individual; and

(h) Include an assurance that interventions and supports will not cause any harm to the individual.

(3) The person-centered services plan must:

(a) Be understandable to the individual receiving services and supports, and the people important in supporting him or her. At a minimum, it must be written in plain language and in a manner that is accessible to persons with disabilities and persons who are limited english proficient, consistent with 42 CFR 435.905(b) (as in effect on October 1, 2015).

(b) Identify the person and/or entity responsible for monitoring the plan.

(c) Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all people and providers responsible for its implementation. Acceptable signatures include, but are not limited to a handwritten signature, initials, a stamp or mark, or an electronic signature. Any accommodations to the individual's or authorized representative's signature shall be documented on the plan.

(d) Be distributed to the individual and other people involved in the plan.

(e) Prevent the provision of unnecessary or inappropriate services and supports.

(f) Be reviewed, and revised upon reassessment of functional need as required by 42 CFR 441.365(e) (as in effect on October 1, 2015), at least every

twelve months, when the individual experiences a significant change, or at the request of the individual.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5166.02
Rule Amplifies:	5162.03, 5164.02, 5166.02

5160-46-02 **Ohio home care waiver program: eligibility and enrollment.**

(A) To be eligible for enrollment in the Ohio home care waiver program, an individual must meet all of the following requirements:

(1) Be between the ages of birth through age fifty-nine;

(2) Be determined eligible for Ohio medicaid in accordance with ~~rules 5160:1-2-01.6 and 5160:1-3-24~~chapters 5160:1-1 to 5160:1-5 of the Administrative Code;

(3) Participate in an initial assessment to determine if the individual has needs that can be met through the Ohio home care waiver program;

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

(5) In the absence of the Ohio home care waiver program, require hospitalization or institutionalization in a NF to meet his or her needs;

(6) Be determined to require and agree 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/or the medicaid state plan) in an amount sufficient to meet the individual's assessed needs;

(7) Be able to establish residency in a place that possesses the home and community-based setting characteristics set forth in rule 5160-44-01 of the Administrative Code, and that is not a hospital, NF, intermediate care facility for individuals with an intellectual disability (ICF-IID) or another licensed/certified facility, any facility covered by section 1616(e) of the Social Security Act (42 U.S.C. 1382(e) (~~March 2, 2004~~January 1, 2016)), residential care facility, adult foster home or another group living arrangement subject to state licensure or certification.

(8) Sign an agreement prior to waiver enrollment confirming that the individual has been informed of service alternatives, choice of qualified providers available in the Ohio home care waiver program and the options of institutional and community-based care, and he or she elects to receive Ohio home care waiver services; and

(9) Have needs that can be safely met through the Ohio home care waiver in a home or community setting as determined by the Ohio department of medicaid (ODM) or its designee.

(B) Subject to paragraph (H) of this rule, to be enrolled and maintain enrollment in the Ohio home care waiver program, an individual must be determined by ODM or its designee to meet all of the following requirements:

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

(2) ~~Not reside~~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, NF, intermediate care facility for individuals with an intellectual disability (ICF-IID) or another licensed/certified facility, any facility covered by section 1616(e) of the Social Security Act (42 U.S.C. 1382(e) (~~March 2, 2004~~January 1, 2016)), residential care facility, adult foster home or another group living arrangement subject to state licensure or certification.

(3) Have his or her health and welfare assured while enrolled on the waiver;

(4) Participate in the development and implementation of a person-centered ~~all services~~ services plan in accordance with the process and requirements set forth in rule 5160-44-02 of the Administrative Code, and consent to the plan by signing and dating it;

(5) Agree to and receive case management services from ODM or its designee including, but not limited to:

(a) Annual and other assessments, as needed,

(b) Home safety evaluations,

(c) Contact with the case manager and/or the individual's team members, including, but not limited to telephone communications, and face-to-face and in-home visits; and

(6) Agree to and participate in quality assurance and participant satisfaction activities during his or her enrollment on the Ohio home care waiver program including, but not limited to, face-to-face visits.

(C) An individual shall be given priority for assessment to determine eligibility for enrollment in the Ohio home care waiver when ODM is made aware that he or she meets the criteria for any of the priority categories set forth in paragraphs (C)(1) to (C)(6) of this rule.

(1) The individual is under twenty-one years of age, and at the time of application,:

(a) Received inpatient hospital services for at least fourteen consecutive days; or

(b) Had at least three inpatient hospital stays during the preceding twelve months.

(2) The individual is at least twenty-one but less than sixty years of age and received inpatient hospital services for at least fourteen consecutive days immediately preceding the date of application.

(3) The individual is under sixty years of age and received private duty nursing services in accordance with rule 5160-12-02 of the Administrative Code for at least twelve consecutive months immediately preceding application.

(4) The individual is under sixty years of age, lives in the community and is at imminent risk of institutionalization due to the documented loss of a primary caregiver. In such instances, there must be written evidence (such as a doctor's order, a death certificate, or documentation that the primary caregiver is institutionalized or relocated out of the area) that substantiates the primary caregiver is unavailable to provide care and support, and without Ohio home care waiver services, the individual will require care in an inpatient hospital setting or a nursing facility (NF).

(5) The individual is under sixty years of age and resides in a medicaid-funded NF at the time of application.

(6) The individual is under sixty years of age, is determined by ODM to be eligible for the HOME choice ("Helping Ohioans Move, Expanding Choice") ~~demonstration~~ program in accordance with rule 5160-51-02 of the Administrative Code, and resides in a residential treatment facility as defined in rule 5160-51-01 of the Administrative Code, or an inpatient hospital setting.

(D) If an individual fails to meet any of the requirements set forth in paragraph (A) and/or

paragraph (B) of this rule, the individual shall be denied enrollment on the Ohio home care waiver program.

(E) Once enrolled on the Ohio home care waiver program, an individual's NF level of care shall be reassessed at least annually, and more frequently if there is a significant change in the individual's situation that may impact his or her health and welfare. If the reassessment determines the individual no longer meets the requirements set forth in paragraph (A) and/or paragraph (B) of this rule, he or she shall be disenrolled from the Ohio home care waiver program.

(F) If, at any other time, it is determined that an individual enrolled on the Ohio home care waiver program no longer meets the requirements set forth in paragraph (A) and/or paragraph (B) of this rule, he or she shall be disenrolled from the Ohio home care waiver program. Reassessment pursuant to paragraph (E) is not required to make this determination.

(G) If an individual is denied enrollment in the Ohio home care waiver program pursuant to paragraph (D) of this rule, or is disenrolled from the waiver pursuant to paragraph (E) or (F) of this rule, the individual shall be afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

(H) The number of individuals enrolled in the Ohio home care waiver shall not exceed the centers for medicare and medicaid services (CMS) -authorized limit for the waiver program year.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5166.02
Rule Amplifies:	5164.02, 5162.03, 5166.121
Prior Effective Dates:	4/4/77, 12/21/77, 6/1/80, 5/1/87, 4/1/88, 5/15/89, 3/1/92 (Emer), 6/1/92, 7/31/92 (Emer), 10/30/92, 4/30/93 (Emer), 7/30/93, 7/1/98, 9/29/00, 8/1/01, 3/1/02 (Emer), 5/30/02, 7/1/06, 2/8/09, 12/1/14