To: ALL CLEARANCE REVIEWERS

From: Jesse Wyatt, Chief, Bureau of Long-Term Services and Supports

Date: 1/26/24

Subject: HCBS Policy- DD Authority Rules

Attached for your review and comment are the planned rescissions and subsequent new proposed OAC rules describing the Home and Community Based Services (HCBS) waivers for individuals with a Developmental Disability Level of Care. Rules 5160-40-01: Medicaid home and community-based services program-individual options waiver, 5160-41-17: Medicaid home and community-based services program-self-empowered life funding waiver, and 5160-42-01: Medicaid home and community-based services program-level one, are administered by the Ohio Department of Developmental Disabilities (DODD).

The planned changes include the removal of a flexibility authorized through Appendix K of the waiver programs and a new format with language simplification and alignment. Although only one process change is proposed, the new format rearranges the majority of information in the rule and thus qualifies as a rescission and subsequent newly written rule. The changes planned for all three rules listed above are:

- The Appendix K flexibility below will be removed from all three rules:
    - "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 certification by DODD for the same or similar services."
- No further process content will be changed. The remaining changes reflect format and language alignment as listed:
    - A new outline with the following headings and restructure was incorporated:
        - Purpose:
            - Aligned
        - Definitions:
            - Aligned
            - Added participant direction references and person-centered terms to service plan and planning.
        - Eligibility
            - Separated eligibility process from referral and enrollment.
            - Reformat to include monthly service obligation and person- centered planning participation.
        - Enrollment

        - Replaced referral/request processes with a reference to established ODM and DODD rules.
        - Condensed language.
    - Benefit Package
        - Created section to refocus and organize service plan and service specific options.
        - Added references to DODD Rules.
        - Condensed language and added references to other established rules.
    - Service Provision
        - Reformatted service provision requirements.
- Other planned outline changes:
    - Removed restrictive language.
    - Removed repetitive language.
    - Updated OAC references, reduced multiple references, use of ODM references when applicable.
    - Updated federal reference dates.
    - Added participant directed language for Level One and IO.

Questions pertaining to this clearance should be sent to Rules@Medicaid.Ohio.gov.

To receive notification when ODM posts draft rules for public comment please register via the Common Sense Initiative eNotifications Sign-up: eNotifications Sign Up | Governor Mike DeWine (ohio.gov). The Ohio Department of Medicaid will use this list to notify subscribers when draft rules are posted for public comment.

To receive notification when ODM original, revise, refile, or final files a rule package please register for Joint Committee on Agency Rules Review's (JCARR) RuleWatch at www.rulewatchohio.gov where an account can be created to be notified of rule actions by the rule number or department.

The main Ohio Department of Medicaid (ODM) web page includes links to valuable information about its services, programs and rules; the address is http://www.medicaid.ohio.gov.

Thank you in advance for your review of these rules.

DRAFT - NOT FOR FILING

To be rescinded

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 administrative rules promulgated by DODD; 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

(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

(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

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

(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.

DRAFT - NOT FOR FILING

NEW

5160-40-01 Medicaid home and community-based services program - individual options waiver.

(A) Purpose

(1) The Ohio department of developmental disabilities (DODD) is responsible for the daily operations of the individual options (IO) waiver which will be administered pursuant to sections 5166.02 and 5166.20 of the Revised Code.

(2) DODD operates the IO waiver program pursuant to an interagency agreement with the Ohio department of medicaid (ODM) 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 January 1, 2024, 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 and 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. The ISP is developed using a person-centered planning process.

(7) "Participant direction" means an individual has authority to make decisions about the individual's waiver services and accepts responsibility for taking a direct role in managing the services. Participant direction includes the exercise of budget authority and employer authority.

(8) "Person-centered planning" is a process directed by the individual, that identifies his or her strengths, values, capacities, preferences, needs, and desired outcomes. The process includes team members who assist and support the individual to identify and access medically necessary services and supports needed to achieve his or her defined outcomes in the most inclusive community setting.

(9) "Provider" means a person or agency who is eligible per Chapter 5123-2 of the Administrative Code and

rule 5160-1-17.2 of the Administrative Code to provide IO waiver services as specified in this rule.

(10) "SSA" means a service and support administrator who is eligible to perform the functions of service and support administration per rules 5123-4-02 and 5123-5-02 of the Administrative Code.

(C) Eligibility

(1) To be eligible for the IO waiver program:

(a) The individual's medicaid eligibility has been established in accordance with Chapters 5160:1-1 to 5160:1-6 of the Administrative Code;

(b) The individual has been determined to have a developmental disabilities level of care in accordance with rule 5123-8-01 of the Administrative Code;

(c) The individual's health and welfare can be ensured through the utilization of IO waiver services at or below the federally approved cost limitation, and other formal and informal supports regardless of funding source;

(d) The individual participates in the development of a person-centered services plan in accordance with the process and requirements set forth in rules 5123-9-02 and 5123-4-02 of the Administrative Code; and

(e) The individual requires the provision of at least one waiver service monthly as documented in the individual's approved person-centered services plan.

(D) Enrollment

(1) Requests for the IO waiver program are set forth in rules 5160:1-2-03 and 5123-9-01 of the Administrative Code utilizing ODM 02399 form “Request for Medicaid Home and Community Based Services (HCBS) Waiver .

(2) Individuals who meet the eligibility criteria in paragraph (C) of this rule, or their legal representative, will be informed of the following:

(a) All services available on the IO waiver, and any choices that the individual may make regarding those services;

(b) Any viable alternative to the waiver; and

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

(3) DODD allocates waivers to the county board in accordance with section 5166.22 of the Revised Code.

(4) The county board offers an available IO 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 IO waiver program is 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 (C) of this rule to continue enrollment in the waiver program.

(6) The maximum number of individuals that can be enrolled in the IO waiver program statewide will not exceed the allowable number specified in the federally approved waiver document.

(E) Benefit Package

(1) The IO waiver program provides necessary home and community-based services to individuals of any age as an alternative to institutional care in an intermediate care facility for individuals with intellectual disabilities (ICF/IID).

(a) The IO waiver program benefit package, as indicated in the federally approved waiver application, is limited to the services specified in Chapter 5123-9 of Administrative Code.

(b) The IO waiver program supports individuals who want to direct some of their services through participant direction. The individual or the individual's guardian or the individual's designee perform the duties associated with participant direction.

(2) All services will be provided to an individual enrolled in the IO waiver program pursuant to a written person-centered ISP.

(a) The ISP will be developed by qualified persons with input from the individual in accordance with section 5126.15 of the Revised Code;

(b) The ISP will be developed to include only waiver services which are consistent with efficiency, economy and quality of care; and

(c) The ISP will include an individual funding level. If the county board, with the involvement of the individual enrolled on the IO waiver program, is unable to recommend an ISP that includes a funding level within or below the funding range, the county board will inform the individual of the right to request prior authorization as specified in rule 5123-9-07 of the Administrative Code and will provide the individual notification of hearing rights.

(3) 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.

(4) When DODD, ODM, or the county board takes action to approve, deny, or terminate enrollment in the IO waiver program, or to deny or change the level of waiver services delivered to an enrollee, the individual will be notified of his or her hearing rights in accordance with division 5101:6 of the Administrative Code.

(5) 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.

(F) Service Provision

(1) Authorized IO waiver services will be provided by persons or agencies who:

(a) Are eligible per rule 5160-1-17.2 of the Administrative Code and

(b) Are eligible in accordance with chapter 5123-2 and if applicable chapter 5123-3 of the Administrative

Code.

(2) Services will be provided utilizing person-centered practices and in settings in accordance with 42 C.F.R. 441.530 (as in effect January 1, 2024).

(3) Individuals enrolled, or their legal representative, will be informed of freedom of choice in qualified providers in accordance with rule 5160-41-08 of the Administrative Code and 42 C.F.R.431.51 (as in effect on January 1, 2024).

(4) IO waiver program payment standards are operated in accordance with rule 5160-41-18 of the Administrative Code.

(a) The maximum allowable payment rates of the IO waiver program services are provided in Chapter 5123-9 of the Administrative Code.

(5) ODM may conduct periodic monitoring and compliance reviews in accordance with section 5162.10 of the Revised Code.

(a) 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.

(6) Records related to the administration and provision of individual options waiver services may be reviewed by ODM, the auditor of the state, the attorney general, and the medicaid fraud control unit or their designees per sections 5162.10 and 5160.22 of the Revised Code.

(7) Individuals enrolled in the IO waiver program are responsible for the provision of information with administering agencies as set forth in chapter 5160:1-2 of the Administrative Code.

DRAFT - NOT FOR FILING

To be rescinded

5160-41-17 Medicaid home and community-based services program - self-empowered life funding waiver.

(A) Purpose.

(1) The purpose of this rule is to establish the self-empowered life funding 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 self-empowered life funding waiver program provides necessary waiver services to individuals who meet 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 self-empowered life funding waiver program on a daily basis in accordance with section 5162.35 of the Revised Code.

(4) This waiver will provide services under a participant-directed model to individuals with developmental disabilities in order to avoid or delay institutionalization.

(B) Definitions.

(1) "County board" means a county board of developmental disabilities established under Chapter 5126. of the Revised Code.

(2) "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.1396n, as in effect on October 1, 2019, under which federal reimbursement is provided for designated home and community-based services to eligible individuals.

(3) "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.

(4) "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.

(5) "Participant direction" has the same meaning as defined in rule 5123-9-40 of the Administrative Code.

(6) "Provider" means a person or agency certified or licensed by DODD that has met the provider qualification requirements to provide the specific self-empowered life funding 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.

(7) "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.

(8) "Waiver eligibility span" means the twelve-month period following either an individual's initial

enrollment date or a subsequent eligibility re-determination date.

(C) Request for a referral for the self-empowered life funding waiver.

(1) Individuals seeking to enroll in the self-empowered life funding 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 self-empowered life funding waiver benefit package including the amount, scope and duration of services and any applicable benefit package limitations.

(D) Eligibility criteria for the self- empowered life funding waiver.

(1) The individual requesting a referral for the self-empowered life funding 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 self-empowered life funding waiver services at or below the federally approved cost limitation and other formal and informal supports regardless of funding source.

(E) Self-empowered life funding 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 self-empowered life funding 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) DODD shall allocate waivers to the county board in accordance with section 5166.22 of the Revised Code.

(3) The county board shall offer an available self-empowered life funding 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.

(4) An individual's continued enrollment in the self-empowered life funding 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.

(5) The maximum number of individuals that can be enrolled in the self-empowered life funding waiver program statewide shall not exceed the allowable number specfied as federally approved.

(6) 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.

(7) While enrolled in the self-empowered life funding 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 from the waiver program and shall be given notification of hearing rights as established in paragraph (M) of this rule.

(F) The self-empowered life funding waiver program benefit package, as included in the federally approved waiver application, is limited to the services specified in Chapters 5123:2-9 and 5123-9 of Administrative Code.

(G) Self-empowered life funding waiver benefit limitations shall be in accordance with the benefit limitations as established in rule 5123-9-40 of the Administrative Code.

(H) Self-empowered life funding service plan requirements.

(1) All services shall be provided to an individual enrolled in the self-empowered life funding waiver program pursuant to a written ISP.

(2) The ISP shall be developed by qualified persons with input from the self-empowered life funding 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 self-empowered life funding 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 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.

(c) The ISP shall be reviewed on at least an annual basis consistent with the individual's redetermination as indicated in paragraph (E) of this rule or as the individual's needs change and in accordance with rule 5123:2-1-11 of the Administrative Code; and

(d) 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 unusal incidents; or

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

(e) The ISP shall be developed to include only waiver services which are consistent with efficiency, economy and quality of care; and

(f) 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 self-empowered life funding waiver program shall be given a free choice of qualified self-empowered life funding 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)(2) of this rule. DODD shall create and maintain an internet-based list of those providers who are qualified to provide self- empowered life funding 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 self-empowered life funding waiver services.

(1) Self-empowered life funding 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 administrative rules promulgated by DODD; 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

(3) Self-empowered life funding 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

(4) Self-empowered life funding services shall be provided only to individuals who have met the eligibility requirements in paragraph (D) of this rule and are enrolled in the self-empowered life funding waiver program at the time of service delivery; and

(5) Self-empowered life funding waiver services shall be provided in accordance with each enrollee's ISP as specified in paragraph (H) of this rule; and

(6) No provider of self-empowered life funding 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 self-empowered life funding 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 self-empowered life funding 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 self-empowered life funding 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 self- empowered life funding waiver services. Individuals enrolled in the self-empowered life funding 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 self-empowered life funding waiver, or to deny or change the level and/or type of waiver services delivered to a self-empowered life funding 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.

DRAFT - NOT FOR FILING

NEW

5160-41-17 Medicaid home and community-based services program - self-empowered life funding waiver.

(A) Purpose.

(1) The Ohio department of developmental disabilities (DODD) is responsible for the daily operation of the self-empowered life funding (SELF) waiver which will be administered pursuant to sections 5166.02 and 5166.20 of the Revised Code.

(2) DODD operates the SELF waiver program pursuant to an interagency agreement with the Ohio department of medicaid (ODM) in accordance with section 5162.35 of the Revised Code.

(B) Definitions.

(1) "Budget authority" means an individual has the authority and responsibility to manage the individual's budget for participant-directed services. This authority supports the individual in determining the budgeted dollar amount for each participant-directed waiver service that will be provided to the individual and making decisions about the acquisition of participant-directed waiver services that are authorized in the individual service plan.

(2) "Common law employer" means the individual is the legally responsible and liable employer of staff selected by the individual. The individual hires, supervises, and discharges staff. The individual is liable for the performance of necessary employment-related tasks and uses a financial management services entity under contract with the state to perform necessary payroll and other employment-related functions as the individual's agent in order to ensure that the employer-related legal obligations are fulfilled.

(3) "County board" means a county board of developmental disabilities established under Chapter 5126. of the Revised Code.

(4) "Employer authority" means an individual has the authority to recruit, hire, supervise, and direct the staff who furnish supports. The individual functions as the common law employer or the co-employer of these staff.

(5) "Financial management services" means services provided to an individual who directs some or all of the individual's waiver services.

(6) "Financial management services entity" means a governmental entity or another third-party entity designated to perform necessary financial transactions on behalf of individuals who receive participant-directed services.

(7) "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.1396n, as in effect on January 1, 2024 under which federal reimbursement is provided for designated home and community-based services to eligible individuals.

(8) "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 and may receive notice on behalf of an individual to the extent permitted by applicable law.

(9) "Individual Service Plan (ISP)" means a written description of the services, supports, and activities to be provided to an individual. The ISP is developed using a person-centered planning process.

(10) "Participant direction" means an individual has authority to make decisions about the individual's waiver services and accepts responsibility for taking a direct role in managing the services. Participant direction includes the exercise of budget authority and employer authority.

(11) "Person-centered planning" is a process directed by the individual, that identifies his or her strengths, values, capacities, preferences, needs and desired outcomes. The process includes team members who assist and support the individual to identify and access medically necessary services and supports needed to achieve his or her defined outcomes in the most inclusive community setting.

(12) "Provider" means a person or agency who is eligible per Chapter 5123-2 of the Administrative Code and rule 5160-1-17.2 of the Administrative Code to provide the specific SELF waiver service as specified in this rule.

(13) "SSA" means a service and support administrator who is eligible to perform the functions of service and support administration per rules 5123-4-02 and 5123-5-02 of the Administrative Code.

(14) "Waiver eligibility span" means the twelve-month period following either an individual's initial enrollment date or a subsequent eligibility re-determination date.

(C) Eligibility.

(1) To be eligible for the SELF waiver program:

(a) The individual’s medicaid eligibility has been established in accordance with Chapters 5160:1-1 to 5160:1-6 of the Administrative Code;

(b) The individual has been determined to have a developmental disabilities level of care in accordance with rule 5123-8-01 of the Administrative Code;

(c) The individual's health and welfare can be ensured through the utilization of SELF waiver services at or below the federally approved cost limitation and other formal and informal supports regardless of funding source;

(d) The individual participates in the development of a person-centered services plan in accordance with the process and requirements set forth in rules 5123-9-02 and 5123-4-02 of the Administrative Code; and

(e) The individual requires the provision of at least one waiver service on a monthly basis as documented in the individual's approved person-centered services plan.

(D) Enrollment.

(1) Requests for the SELF waiver program are set forth in rules 5160:1-2-03 and 5123-9-01 of the Administrative Code utilizing ODM 02399 form “Request for Medicaid Home and Community Based Services (HCBS) Waiver.

(2) Individuals who meet the eligibility criteria in paragraph (C) of this rule will be informed of the following:

(a) All services available on this self-empowered life funding waiver, and any choices that the individual may make regarding those services;

(b) Any viable alternatives to the waiver; and

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

(3) DODD allocates waivers to the county board in accordance with section 5166.22 of the Revised Code.

(4) The county board offers an available SELF 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 SELF waiver program is redetermined no less frequently than every twelve months beginning with the individual's initial enrollment date or subsequent redetermination date. Individuals will continue to meet the eligibility criteria specified in paragraph (C) of this rule to continue enrollment in the waiver program.

(6) The maximum number of individuals that can be enrolled in the SELF waiver program statewide will not exceed the allowable number specified in the federally approved waiver document.

(E) Benefit Package

(1) The SELF waiver program provides necessary home and community-based services to individuals of any age as an alternative to institutional care in an intermediate care facility for individuals with intellectual disabilities (ICF/IID).

(a) The SELF benefit package, as indicated in the federally approved waiver application, is limited to the services specified in Chapter 5123-9 of Administrative Code.

(b) The SELF waiver program is a participant directed program as described in rule 5123-9-40 of the Administrative Code.

(c) Financial management services provided by a financial management services entity are included in the benefit package.

(d) The individual or the individual's guardian or the individual's designee perform the duties associated with participant direction including budget authority and employer authority in accordance with rule 5123-9-40 of the Administrative Code.

(2) All services will be provided to an individual enrolled in the SELF waiver program pursuant to a written person-centered Individual Service Plan (ISP).

(a) The ISP will be developed by qualified persons with input from the individual in accordance with section 5126.15 of the Revised Code.

(b) The ISP will be developed to include only waiver services which are consistent with efficiency, economy, and quality of care.

(3) 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.

(4) When DODD, ODM, or the county board acts to deny or terminate enrollment in the SELF waiver program, or to deny or reduce the level of waiver services delivered to an enrollee, the individual will be notified of his or her hearing rights in accordance with division 5101:6 of the Administrative Code.

(F) Service Provisions

(1) Authorized SELF waiver services will be provided by persons or agencies who:

(a) Are eligible per rule 5160-1-17.2 of the Administrative Code.

(b) Are eligible per chapter 5123-2 and if applicable chapter 5123-3 of the Administrative Code.

(2) Services will be provided utilizing person-centered practices and in settings in accordance with 42 C.F.R. 441.530 (as in effect January 1, 2023).

(3) Individuals enrolled, or their legal representative will be informed of freedom of choice in qualified providers in accordance with rule 5160-41-08 of the Administrative Code and 42 C.F.R. 431.51 (as in effect on January 1, 2024.

(4) SELF waiver program payment standards are operated in accordance with rules 5160-41-20 and 5123-9-40 of the Administrative Code.

(a) The maximum allowable payment rates of the SELF waiver program services are provided in Chapter 5123-9 of the Administrative Code.

(5) ODM may conduct periodic monitoring and compliance reviews in accordance with section 5162.10 of the Revised Code.

(a) 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.

(6) Records related to the administration and provision of SELF waiver services may be reviewed by ODM, the auditor of the state, the attorney general, and the medicaid fraud control unit or their designees per sections 5162.10 and 5160.22 of the Revised Code.

(c) Individuals enrolled in the waiver program will be responsible for the provision of information with administering agencies as set forth in Chapter 5160:1-2 of the Administrative Code.

DRAFT - NOT FOR FILING

To be Rescinded

5160-42-01 Medicaid home and community-based services program - level one waiver.

(A) The purpose of this rule is to establish the level one waiver as a component of the medicaid home and community-based services program pursuant to sections 5166.20 and 5166.02 of the Revised Code.

(1) The level one waiver program provides necessary waiver services to individuals of any age who meet the criteria for a developmental disabilities level of care in accordance with rule 5123-8-01 of the Administrative Code, and other eligibility requirements established in this rule.

(2) The Ohio department of developmental disabilities (DODD), through an interagency agreement with the Ohio department of medicaid (ODM), administers the level one waiver 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) "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.

(3) "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.

(4) "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.

(5) "Provider" means a person or agency certified or licensed by DODD that has met the provider qualification requirements to provide specific waiver services, as specified in paragraph (J)(1) of this rule, with a valid medicaid provider agreement as specified in paragraph (J)(2) of this rule.

(6) "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 the level one waiver

(1) Individuals seeking to enroll in the level one 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 level one waiver benefit package, including the amount, scope and duration of services and the benefit package limitations.

(D) Eligibility criteria for the level one waiver

(1) The individual requesting a referral for the level one 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 Adminsitrative Code upon initial enrollment and no later than every twelve months thereafter; and

(2) The individual's medicaid eligibility has been determined 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 level one waiver services at or below the benefit limitations designated in paragraph (G) of this rule, and other formal and informal supports regardless of funding source. Other formal or informal supports are not subject to the benefit limitations in this rule.

(E) Level one waiver enrollment, continued enrollment, and disenrollment

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

(a) All services available on the level one waiver, and any choices that the individual may make regarding those services;

(b) Any feasible alternative to the waiver program; and

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

(2) Individuals determined eligible for the level one waiver program in accordance with paragraph (D) of this rule who are seeking to, but are not yet enrolled in the level one waiver program must participate in a prescreening assessment process. This process evaluates whether the individual's health and welfare needs can be met with the level of service provided through the level one waiver program, combined with other non-waiver services regardless of funding source, and within the benefit package limitations specified in paragraph (G) of this rule.

(a) If the prescreening assessment process indicates that the eligible individual's health and welfare needs cannot be met with the level of services provided through the level one waiver program, combined with other non-waiver services regardless of funding sources, and within the benefit package limitations specified in paragraph (G) of this rule, then the individual shall not be enrolled in the level one waiver program and notification of hearing rights shall be provided as established in paragraph (M) of this rule; or

(b) If the prescreening assessment process indicates that the eligible individual's health and welfare needs can be met with the level of services provided through the level one waiver program, when combined with other non-waiver services regardless of funding source, and within the benefit package limitations specified in paragraph (G) of this rule, then the individual shall be enrolled in the level one waiver program in accordance with this rule.

(3) The county board shall offer an available level one waiver to eligible individuals in accordance with applicable waiting list category requirements as set forth in rules 5160-41-05 and 5123-9-04 of the Administrative Code.

(4) An individual's continued enrollment in the level one waiver program shall be redetermined no less frequently than every twelve months after the individual's initial enrollment 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.

(5) 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.

(6) While enrolled in the level one waiver, 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 from the waiver program and shall be given notification of hearing rights.

(7) Disenrollment of level one waiver participants shall be done in accordance with the provisions set forth in this rule.

(a) Individuals enrolled in the level one waiver program shall not be disenrolled from the waiver due to an increase in the need for a covered service(s) that causes the total need for the covered service(s) to exceed the benefit package limitations, as specified in paragraph (G) of this rule. The county board shall evaluate the individual, as set forth in rule 5123:2-9-01 of the Administrative Code, and submit a recommendation to DODD regarding whether or not the individual can remain enrolled in the waiver and have his or her health and welfare assured by one or more of the following measures:

(i) Adding a higher level of available natural supports; and/or

(ii) Recommending additional services covered through the level one waiver benefit package; and/or

(iii) Accessing emergency services covered through the level one waiver benefit package; and/or

(iv) Accessing additional non-waiver services other than natural supports.

(b) If the activities identified in paragraph (E)(7)(a) of this rule do not result in an ISP that contains covered services that are within the benefit package limitations outlined in paragraph (G) of this rule and it is determined that services are not sufficient to assure the individual's health and welfare, then the following will apply:

(i) The individual will be given the opportunity to apply for an alternate home and community-based waiver program, to the extent that such waiver openings exist, that may be more adequate in meeting the individual's service needs. An individual shall be enrolled in accordance with rule 5123-9-04 of the Administrative Code; and

(ii) The individual will be offered an opportunity for placement in an ICF/IID.

(c) Individuals enrolled in the level one 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 level one waiver program benefit package, as included in the federally approved waiver application, is limited to the services specified in Chapters 5123:2-9 and 5123-9 of the Administrative Code.

(G) Limits on sets of level one waiver services

(1) Level one waiver benefit limitations shall be in accordance with the benefit limitations as established in rule 5123-9-06 of the Administrative Code.

(2) The following benefits are subject to specific benefit limitations that, when combined cannot exceed the maximum amount as specified in appendix B to rule 5123:2-9-19 of the Administrative Code, effective in twelve month periods beginning with the individual's enrollment or redetermination date:

(a) Adult day support;

(b) Career planning;

(c) Group employment support;

(d) Individual employment support;

(e) Vocational habilitation.

(3) 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) Level one waiver individual service plan requirements

(1) All services shall be provided to individuals enrolled on the level one waiver pursuant to a written ISP.

(2) The ISP shall be developed by qualified persons with input from the level one 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 level one waiver services and the non-waiver services, regardless of funding source, that are necessary to ensure the enrollee's health and welfare.

(b) 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; and

(iv) Type of provider to furnish each service.

(c) The ISP shall be reviewed on at least an annual basis consistent with the individual's redetermination as referenced in paragraph (E)(2) of this rule or as the individual's needs change and in accordance with rule 5123:2-1-11 of the Administrative Code.

(d) 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.

(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 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, authorize services and 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 level one waiver program shall be given a free choice of qualified level one 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 level one waiver services. This list will be accessible to county boards and individuals applying for or receiving services. 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 level one waiver services

(1) Level one waiver services shall be provided by persons or agencies who hold certification or licensure for each service they provide in accordance with section 5123.045 of the Revised Code, and administrative rules promulgated by DODD; 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

(3) Level one waiver services shall be provided only by persons or agencies who have a valid medicaid

provider agreement in accordance with rule 5160-1-17.2 of the Administrative Code; and

(4) Level one waiver services shall be provided only to individuals who have met the eligibility requirements in paragraph (D) of this rule and have been enrolled in the level one waiver program at the time of service delivery; and

(5) Level one waiver services shall be provided in accordance with each enrollee's individual service plan as specified in paragraph (H) of this rule.

(6) No provider of level one waiver services shall enter into or maintain any contract with the 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 level one 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 level one 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, enrollees, and administrators of waiver services. Certified or licensed level one 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 level one waiver services. Individuals enrolled in the level one 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 level one waiver, or to deny or change the level and/or type of waiver services delivered to a level one 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 are required during the hearing proceedings to justify the decision under appeal.

DRAFT - NOT FOR FILING

NEW

5160-42-01 Medicaid home and community-based services program - level one waiver.

(A) Purpose

(1) The Ohio department of developmental disabilities (DODD) is responsible for the daily operation of the level one (L1) waiver which will be administered pursuant to sections 5166.20 and 5166.02 of the Revised Code.

(2) DODD operates the L1 waiver program pursuant to an interagency agreement with the Ohio department of medicaid (ODM) 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) "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 January 1, 2024 under which federal reimbursement is provided for designated home and community-based services to eligible individuals.

(3) "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 and may receive notice on behalf of an individual to the extent permitted by applicable law.

(4) "Individual Service Plan" (ISP) means a written description of the services, supports, and activities to be provided to an individual. The ISP is developed using a person-centered planning process.

(5) "Participant direction" means an individual has authority to make decisions about the individual's waiver services and accepts responsibility for taking a direct role in managing the services. Participant direction includes the exercise of budget authority and employer authority.

(6) "Person-centered planning" is a process directed by the individual, that identifies his or her strengths, values, capacities, preferences, needs and desired outcomes. The process includes team members who assist and support the individual to identify and access medically necessary services and supports needed to achieve his or her defined outcomes in the most inclusive community setting.

(7) "Provider" means a person or agency who is eligible per Chapter 5123-2 of the Administrative Code and rule 5160-1-17.2 of the Administrative Code to provide L1 waiver services, as specified in this rule.

(8) "SSA" means a service and support administrator who is eligible to perform the functions of service and support administration per rules 5123-4-02 and 5123-5-02 of the Administrative Code.

(C) Eligibility

(1) To be eligible for the L1 waiver program:

(a) The individual’s medicaid eligibility has been established in accordance with Chapters 5160:1-1 to

5160:1-6 of the Administrative Code;

(b) The individual has been determined to have a developmental disabilities level of care in accordance with rule 5123-8-01 of the Administrative Code;

(c) The individual's health and welfare can be ensured through the utilization of L1 waiver services at or below the federally approved cost limitation, and other formal and informal supports regardless of funding source;

(d) The individual participates in the development of a person-centered services plan in accordance with the process and requirements set forth in rules 5123-9-02 and 5123-4-02 of the Administrative Code; and

(e) The individual requires the provision of at least one waiver service monthly as documented in the individual's approved person-centered services plan.

(D) Enrollment

(1) Requests for the L1 waver program are set forth in rules 5160:1-2-03 and 5123-9-01 of the Administrative Code utilizing ODM 02399 form "Request for Medicaid Home and Community Based Services (HCBS) Waiver.

(2) Individuals who meet the eligibility criteria established in paragraph (C) of this rule, or their legal representative will be informed of the following:

(a) All services available on the L1 waiver, and any choices that the individual may make regarding those services;

(b) Any viable alternative to the waiver program; and

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

(3) DODD allocates waivers to the county board in accordance with section 5166.22 of the Revised Code.

(4) The county board offers an available L1 waiver to eligible individuals in accordance with applicable waiting list category requirements as set forth in rules 5160-41-05 and 5123-9-04 of the Administrative Code.

(5) An individual's continued enrollment in the L1 waiver program is redetermined no less frequently than every twelve months after the individual's initial enrollment or subsequent redetermination date. Individuals must continue to meet the eligibility criteria specified in paragraph (C) of this rule to continue enrollment in the waiver program.

(6) The maximum number of individuals that can be enrolled in the L1 waiver program statewide will not exceed the allowable number specified in the federally approved waiver document.

(E) Benefit Package

(1) The L1 waiver program provides necessary home and community-based services to individuals of any age as an alternative to institutional care in an intermediate care facility for individuals with intellectual disabilities (ICF/IID).

(a) The L1 waiver program benefit package, as indicated in the federally approved waiver application, is limited to the services specified in Chapter 5123-9 of the Administrative Code.

(b) The L1 waiver program supports individuals who want to direct some of their services through participant direction. The individual or the individual's guardian or the individual's designee perform the duties associated with participant direction.

(2) All services will be provided to an individual enrolled on the L1 waiver program pursuant to a written person-centered Individual Service Plan (ISP).

(a) The ISP will be developed by qualified persons with input from the individual in accordance with section 5126.15 of the Revised Code.

(b) The ISP will be developed to include only waiver services which are consistent with efficiency, economy, and quality of care.

(3) 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, authorize services and direct the county board or DODD to amend ISPs for individuals.

(4) When DODD, ODM, or the county board acts to, deny, or terminate enrollment in the L1 waiver program, or to deny or reduce the level of waiver services delivered to an enrollee, the individual will be notified of his or her hearing rights in accordance with division 5101:6 of the Administrative Code.

(F) Service Provision

(1) Authorized L1 waiver services will be provided by persons or agencies who:

(a) Are eligible per rule 5160-1-17.2 of the Administrative Code; and

(b) Are eligible per chapter 5123-2 and if applicable chapter 5123-3 of the Administrative Code.

(2) Services will be provided utilizing person-centered practices and in settings in accordance with 42 C.F.R. 441.530 (as in effect January 1, 2024).

(3) Individuals enrolled, or their legal representative will be informed of freedom of choice in qualified providers in accordance with rule 5160-41-08 of the Administrative Code and 42 C.F.R. 431.51 (as in effect on January 1, 2024).

(4) L1 waiver program payment standards are operated in accordance with rule 5160-41-19 of the Administrative Code.

(a) The maximum allowable payment rates of the L1 waiver program services are provided in Chapter 5123-9 of the Administrative Code.

(5) ODM may conduct periodic monitoring and compliance reviews related to the level one waiver program in accordance with section 5162.10 of the Revised Code.

(a) Reviews may consist of, but are not limited to, physical inspections of records and sites where services are provided, interviews of providers, enrollees, and administrators of waiver services.

(6) Records related to the administration and provision of level one services may be reviewed by ODM, the auditor of the state, the attorney general, and the medicaid fraud control unit or their designees per sections 5162.10 and 5160.22 of the Revised Code.

(7) Individuals enrolled in the waiver program will be responsible for the provision of information with administering agencies as set forth in chapter 5160:1-2 of the Administrative Code.