

***** Proposed New Rule - October 26, 2016 *****

5123:2-9-03 Home and community-based services waivers - limit on number of hours an independent provider may provide home and community-based services in a work week.

(A) Purpose

This rule places a limit on the number of hours an independent provider may provide home and community-based services in a work week and establishes a process and the circumstances under which the limit may be exceeded.

(B) Definitions

- (1) "Agency provider" means an entity that directly employs at least one person in addition to the chief executive officer for the purpose of providing services for which the entity must be certified in accordance with rule 5123:2-2-01 of the Administrative Code.
- (2) "County board" means a county board of developmental disabilities.
- (3) "Department" means the Ohio department of developmental disabilities.
- (4) "Emergency" means an unanticipated and sudden absence of an individual's independent provider, agency provider, or natural supports due to illness, incapacity, or other cause.
- (5) "Home and community-based services" has the same meaning as in section 5123.01 of the Revised Code.
- (6) "Home and community-based services medicaid waiver component" has the same meaning as in section 5166.01 of the Revised Code.
- (7) "Independent provider" means a self-employed person who provides services for which he or she must be certified in accordance with rule 5123:2-2-01 of the Administrative Code and does not employ, either directly or through contract, anyone else to provide the services.
- (8) "Individual" means a person with a developmental disability or for purposes of giving, refusing to give, or withdrawing consent for services, his or her guardian in accordance with section 5126.043 of the Revised Code or other person authorized to give consent.
- (9) "Individual service plan" means the written description of services, supports, and activities to be provided to an individual.
- (10) "Provider" means an agency provider or an independent provider.

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(11) "Service and support administrator" means a person, regardless of title, employed by or under contract with a county board to perform the functions of service and support administration and who holds the appropriate certification in accordance with rule 5123:2-5-02 of the Administrative Code.

(12) "Work week" means the seven consecutive days beginning on Sunday at 12:00 a.m. and ending on Saturday at 11:59 p.m. of each week.

(C) Limit on providing home and community-based services in a work week

(1) On or after July 1, 2017, after an independent provider has worked forty hours in a work week providing any medicaid-funded services as an independent provider, that independent provider may only provide additional home and community-based services as an independent provider in that work week if authorized by the service and support administrator for the individual for whom the additional services are provided in accordance with paragraph (D) of this rule.

(2) Individuals receiving home and community-based services and their independent providers and service and support administrators shall take all measures necessary to achieve compliance with the limit established in paragraph (C)(1) of this rule by the date the limit takes effect.

(D) Authorization to exceed limit

(1) Whenever possible, an independent provider shall request authorization to exceed the limit established in paragraph (C) of this rule prior to providing the services.

(2) When requesting authorization and at other times upon the request of a service and support administrator, an independent provider shall inform the service and support administrator of the number of persons for whom the independent provider provides any medicaid-funded services as an independent provider anywhere in the state and the number of hours of services the independent provider provides in a work week for each such person.

(3) The service and support administrator shall review the request and decide whether to authorize the independent provider to exceed the limit in accordance with the assessment and person-centered planning process set forth in rule 5123:2-1-11 of the Administrative Code. The service and support administrator may only authorize an independent provider to exceed the limit in the following circumstances:

(a) An emergency.

(b) A shortage of other available independent providers or agency providers.

(c) A situation where requiring additional independent providers or agency providers would place an individual at risk of harm due to the specialized needs of the

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individual. Examples include:

- (i) An individual with a compromised immune system may be put at risk by having multiple providers; or
 - (ii) The independent provider is the only provider that has been trained by the nurse on delegated tasks or trained by the behavioral specialist to implement unique behavioral strategies in which case, the independent provider could be authorized to exceed the limit until additional providers are trained.
- (d) An individual is traveling for vacation or other reasons and it is not feasible for more than one provider to travel with the individual to provide needed care.
- (4) A service and support administrator may only authorize an independent provider to exceed the limit on a time-limited basis, as specified in the individual service plan. A service and support administrator may extend the period for which an independent provider is authorized to exceed the limit only when circumstances continue to necessitate such authorization. The service and support administrator shall not authorize the independent provider to exceed the limit pursuant to paragraph (D)(3)(b) of this rule unless the service and support administrator has approved and the parties have begun to implement a time-limited plan that will eliminate the circumstances requiring the independent provider to provide the additional units of service.
- (5) A service and support administrator may authorize an independent provider to exceed the limit pursuant to paragraph (D)(3) of this rule even though the cost would cause an individual to exceed the budget limitations applicable to the home and community-based services medicaid waiver component in which the individual is enrolled. When the service and support administrator's authorization to exceed the limit pursuant to paragraph (D)(3) of this rule causes the cost of services to exceed the individual's funding range, the service and support administrator shall ensure a request for prior authorization is initiated in accordance with rule 5123:2-9-07 of the Administrative Code.

(E) Violations of this rule

- (1) An individual's right to obtain home and community-based services from any qualified and willing provider in accordance with 42 C.F.R. 431.51 as in effect on the effective date of this rule and sections 5123.044 and 5126.046 of the Revised Code shall not be interpreted to permit an independent provider to violate this rule.
- (2) An independent provider who violates the requirements of this rule may be subject to denial, suspension, or revocation of certification pursuant to rule 5123:2-2-01 of the Administrative Code.

(F) Due process rights and responsibilities

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- (1) Any applicant for or recipient of services under a home and community-based services medicaid waiver component administered by the department may use the process set forth in section 5160.31 of the Revised Code and rules implementing that statute, for any purpose authorized by that statute. The process set forth in section 5160.31 of the Revised Code is available only to applicants, recipients, and their lawfully appointed authorized representatives. Providers shall have no standing in an appeal under that section.
- (2) Applicants for and recipients of services under a home and community-based services medicaid waiver component administered by the department shall use the process set forth in section 5160.31 of the Revised Code for any challenge related to the type, amount, level, scope, or duration of services included in or excluded from an individual service plan. A county board's denial of authorization for an independent provider to exceed the limit established in paragraph (C)(1) of this rule does not necessarily result in a change in the level of services received by an individual.