

5123:2-9-50

Home and community-based services waivers - administration of the transitions developmental disabilities waiver.**(A) Purpose**

The purpose of this rule is to implement the transitions developmental disabilities waiver, a component of the medicaid home and community-based services program administered by the department pursuant to section 5166.21 of the Revised Code.

(B) Definitions

- (1) "Agency provider" means an entity that employs persons for the purpose of providing services for which the entity must be approved by the Ohio department of medicaid.
- (2) "Alternative services" has the same meaning as in rule 5123:2-1-08 of the Administrative Code.
- (3) "County board" means a county board of developmental disabilities.
- (4) "Department" means the Ohio department of developmental disabilities.
- (5) "Foster caregiver" means a person having a valid foster home certificate issued under section 5103.03 of the Revised Code.
- (6) "Home and community-based services" means any federally approved medicaid waiver service provided to an individual enrolled in a waiver 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 the effective date of this rule, under which federal reimbursement is provided for designated home and community-based services to eligible individuals.
- (7) "Independent provider" means a non-agency, self-employed person approved by the Ohio department of medicaid to provide services who 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 cost cap" means the monthly cost of services that is approved by the department for an individual enrolled in the transitions developmental

disabilities waiver. The department, as the designee of the Ohio department of medicaid, oversees that the cost of covered services does not exceed the individual cost cap, determines when an increase or decrease in the individual cost cap is required, and, taking into consideration a recommendation from a county board, approves an increase or decrease in the individual cost cap in accordance with paragraph (H) of this rule.

- (10) "Individual service plan" means the written description of services, supports, and activities to be provided to an individual.
- (11) "Intermediate care facility" means an intermediate care facility for individuals with intellectual disabilities as defined in rule 5123:2-7-01 of the Administrative Code.
- (12) "Natural supports" means the personal associations and relationships typically developed in the community that enhance the quality of life for individuals. Natural supports may include family members, friends, neighbors, and others in the community or organizations that serve the general public who provide voluntary support to help an individual achieve agreed upon outcomes through the individual service plan development process.
- (13) "Plan of care" means the medical treatment plan that is established, approved, and signed by the treating physician. The plan of care must be signed and dated by the treating physician prior to requesting payment for a service. The plan of care is not the same as the individual service plan.
- (14) "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.
- (15) "Service documentation" means all records and information on one or more documents, including documents that may be created or maintained in electronic software programs, created and maintained contemporaneously with the delivery of services, and kept in a manner as to fully disclose the nature and extent of services delivered that shall include the items delineated in service-specific rules in Chapter 5123:2-9 of the Administrative Code to validate payment for medicaid services.
- (16) "Significant change" means a change experienced by an individual that includes, but is not limited to, a change in health status, caregiver status, or location/residence; referral to or active involvement on the part of a protective services agency; or institutionalization.

(C) Department waiting list for the transitions developmental disabilities waiver

The department shall establish a waiting list for the transitions developmental disabilities waiver for eligible individuals when capacity and appropriations are not available. Enrollment in the transitions developmental disabilities waiver shall be based upon the date of application for the transitions developmental disabilities waiver. In the event an individual is placed on the waiting list for the transitions developmental disabilities waiver, the department shall notify the county board.

- (1) The county board shall assist an individual placed on the waiting list for the transitions developmental disabilities waiver in identifying and obtaining alternative services that are available to meet the individual's immediate needs.
- (2) Due process shall be made available to an individual aggrieved by the establishment or maintenance of, placement on, the failure to offer services in accordance with, or removal from the waiting list for the transitions developmental disabilities waiver.

(D) Benefit package

The transitions developmental disabilities waiver benefit package is comprised of the following services:

- (1) Adult day health center services in accordance with rule 5123:2-9-51 of the Administrative Code;
- (2) Emergency response services in accordance with rule 5123:2-9-52 of the Administrative Code;
- (3) Home-delivered meals in accordance with rule 5123:2-9-53 of the Administrative Code;
- (4) Home modification services in accordance with rule 5123:2-9-54 of the Administrative Code;
- (5) Out-of-home respite in accordance with rule 5123:2-9-55 of the Administrative Code;
- (6) Personal care aide services in accordance with rule 5123:2-9-56 of the Administrative Code;

- (7) Supplemental adaptive and assistive devices in accordance with rule 5123:2-9-57 of the Administrative Code;
- (8) Supplemental transportation in accordance with rule 5123:2-9-58 of the Administrative Code; and
- (9) Waiver nursing services in accordance with rule 5123:2-9-59 of the Administrative Code.

(E) Individual choice and control

- (1) Individuals enrolled in the transitions developmental disabilities waiver exercise choice and control over the arrangement and provision of home and community-based waiver services including selection and direction of approved providers of waiver services.
- (2) An individual may choose to receive waiver services:
 - (a) Exclusively from independent providers;
 - (b) Exclusively from agency providers; or
 - (c) From a combination of independent providers and agency providers.
- (3) The service and support administrator shall ensure that individuals have the authority to choose transitions developmental disabilities waiver service providers as outlined in paragraph (E)(2) of this rule.
- (4) An individual enrolled in the transitions developmental disabilities waiver shall:
 - (a) Participate in the development of the individual service plan and all plans of care.
 - (b) Decide whether anyone besides the service and support administrator will participate in the face-to-face development of the individual service plan and plans of care.
 - (c) Authorize the service and support administrator to exchange information for development of the individual service plan with all of the individual's providers.

- (d) Participate in the development and maintenance of service back-up plans that meet the needs of the individual.
- (e) Communicate, as applicable, to the independent provider and/or assigned staff of the agency provider and the agency provider management staff, personal preferences about the duties, tasks, and procedures to be performed.
- (f) Work with the service and support administrator and, as applicable, the independent provider and/or the agency provider to identify and secure orientation and training for the independent provider and/or assigned staff of the agency provider within the provider's scope of practice in order to meet the individual's specific needs.
- (g) Report to the service and support administrator and, as applicable, the agency provider, in accordance with rule 5123:2-17-02 of the Administrative Code, incidents that may impact the health and welfare of the individual.
- (h) Communicate to the service and support administrator any significant change that may affect the provision of services or result in a need for more or fewer hours of service.
- (i) Provide verification that services have been furnished or approve independent provider or agency provider staff time sheets only after services have been furnished to the individual. An individual shall not approve blank time sheets or time sheets that have been completed before services have been furnished to the individual.
- (j) Participate in the recruitment, selection, and dismissal of providers.
- (k) Notify the provider if the individual is going to miss a scheduled visit.
- (l) Notify the agency provider if the assigned staff of the agency provider misses a scheduled visit.
- (m) Notify the service and support administrator if the independent provider misses a scheduled visit.
- (n) Notify the service and support administrator when the individual wishes to select a different provider. Notification shall include the end date of

the former provider and the start date of the new provider.

- (o) Participate in the monitoring of performance of providers.
- (p) If he or she chooses to receive waiver services from an independent provider:
 - (i) Designate a location in the individual's home in which the individual and the independent provider can safely store a copy of the individual's service documentation in a manner that protects the confidentiality of the individual's records and information, and for the purpose of contributing to the continuity of the individual's care; and
 - (ii) Make the individual's service documentation available upon request by the service and support administrator, the department, or the Ohio department of medicaid.

(5) If the service and support administrator determines that the individual cannot fulfill the requirements regarding the individual's role and responsibilities regarding provision of services by independent providers as set forth in paragraph (E)(4) of this rule and/or the health and welfare of the individual receiving services from an independent provider cannot be assured, the service and support administrator may require that the individual receive services exclusively from agency providers. In that event, the individual shall be afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

(F) Individual service plan requirements

- (1) All services shall be provided to an individual enrolled in the transitions developmental disabilities waiver pursuant to an individual service plan.
- (2) The service and support administrator shall ensure that the individual service plan is developed ~~with the active participation of the individual, the individual's guardian or representative, as applicable, and other persons selected by the individual including, but not limited to, family members and providers~~ in accordance with rule 5123:2-1-11 of the Administrative Code.
 - (a) The individual service plan shall list the transitions developmental disabilities waiver services, the medicaid state plan services, and the non-medicaid services, regardless of funding source, that are necessary

to ensure the individual's health and welfare.

- (b) The individual service plan shall be developed to include waiver services which are consistent with efficiency, economy, quality of care, and the health and welfare of the individual.
- (c) The individual service plan shall contain the following medicaid required elements:
 - (i) Type of service to be provided;
 - (ii) Amount of service to be provided;
 - (iii) Frequency and duration of each service to be provided; and
 - (iv) Type of provider to furnish each service.
- ~~(d) The individual service plan shall be developed on at least an annual basis consistent with the individual's eligibility redetermination or as the individual's needs change and in accordance with division 5123:2 of the Administrative Code.~~
- ~~(e)~~(d) The individual service plan is subject to approval by the department. Notwithstanding the procedures set forth in this rule, the Ohio department of medicaid may in its sole discretion, and in accordance with section 5166.05 of the Revised Code, direct the department or the county board to amend individual service plans for individuals if the Ohio department of medicaid determines that such services are medically necessary.

(G) Provider qualifications

- (1) Independent providers and agency providers of transitions developmental disabilities waiver services shall ~~complete the provider enrollment process set forth in rule 5101:3-45-04 of the Administrative Code and~~ receive approval from the Ohio department of medicaid before providing services to an individual enrolled in the transitions developmental disabilities waiver. Services provided before the Ohio department of medicaid issues such approval shall not be reimbursable.
- (2) Rule 5123:2-2-01 of the Administrative Code does not apply to providers of transitions developmental disabilities waiver services.

- (3) An independent provider and each employee, contractor, and employee of a contractor of an agency provider who is engaged in direct provision of transitions developmental disabilities waiver services shall:
 - (a) Be at least eighteen years of age.
 - (b) Have a valid social security number and one of the following forms of identification:
 - (i) State of Ohio identification;
 - (ii) A valid driver's license; or
 - (iii) Other government-issued photo identification.
 - (c) Be able to read, write, and understand English at a level sufficient to comply with all requirements set forth in administrative rules governing the services provided.
 - (d) Be able to effectively communicate with the individual receiving services.
- (4) The following standards of practice apply to each independent provider and to each agency provider and its employees, contractors, and employees of contractors:
 - (a) Providing services only to individuals whose needs he or she can meet.
 - (b) Implementing services in accordance with the individual service plan and plans of care.
 - (c) Taking all reasonable steps necessary to prevent the occurrence or recurrence of incidents adversely affecting health and safety of individuals served.
 - (d) Complying with the requirements of behavior supports established under rules adopted by the department and ensuring that anyone responsible for implementing a behavior support plan receives training in the plan components prior to implementation of the plan.
 - (e) Arranging for substitute coverage, if necessary, only from a provider

approved by the Ohio department of medicaid and as identified in the individual service plan, notifying the individual or legally responsible person in the event that substitute coverage is necessary, and notifying the person identified in the individual service plan when substitute coverage is not available to allow such person to make other arrangements.

- (f) Notifying, in writing, the individual or the individual's guardian and the individual's service and support administrator in the event that the provider intends to cease providing services to the individual no less than thirty calendar days prior to termination of services. If, however, an independent provider intends to cease providing services to an individual because the health or safety of the independent provider is at serious and immediate risk, the provider shall immediately notify the county board by calling the county board's twenty-four-hour emergency telephone number; once the county board has been notified, the independent provider may cease providing services.
 - (g) Complying with monitoring conducted by the service and support administrator in accordance with rule 5123:2-1-11 of the Administrative Code.
 - (h) Complying with paragraph (C) of rule 5160-45-10 of the Administrative Code.
- (5) An independent provider or an employee, contractor, or employee of a contractor of an agency provider of transitions developmental disabilities waiver services shall not:
- (a) Provide services to his or her minor (under age eighteen) child unless he or she is providing waiver nursing services as an employee of an agency provider of waiver nursing services;
 - (b) Provide services to his or her spouse unless he or she is providing waiver nursing services as an employee of an agency provider of waiver nursing services;
 - (c) Provide services to an individual for whom he or she is the foster caregiver;
 - (d) Engage in sexual conduct or have sexual contact with an individual for whom he or she is providing care; or

- (e) Administer any medication to or perform health care tasks for individuals who receive services unless he or she meets the applicable requirements of Chapter 4723. of the Revised Code.

(H) Service authorization

- (1) Effective January 1, 2013, a baseline funding amount shall be assigned to each individual receiving services under the transitions developmental disabilities waiver. The baseline amount shall be the annualized cost of services determined by the Ohio department of medicaid for the individual for fiscal year 2012.
- (2) A service and support administrator shall submit a proposed service authorization for each individual receiving services under the transitions developmental disabilities waiver to the department for review and approval at least annually and upon identification of a significant change that affects a service authorization. The annual service authorization submission to the department shall contain a monthly breakout of the cost of covered services which shall not exceed the proposed annual service authorization amount except as provided in paragraph (H)(3) of this rule.
- (3) When reviewing a proposed service authorization, the department shall determine whether the waiver services for which authorization is requested are medically necessary unless the requested services have been determined by the Ohio department of medicaid not to be medically necessary within a twelve-month period immediately preceding the service authorization request, in which case a medical necessity review under this paragraph shall not be required. The department shall determine the services to be medically necessary if the services:
 - (a) Are appropriate for the individual's health and welfare needs, living arrangement, circumstances, and expected outcomes; and
 - (b) Are of an appropriate type, amount, duration, scope, and intensity; and
 - (c) Are the most efficient, effective, and lowest cost alternative that, when combined with non-waiver services, ensure the health and welfare of the individual receiving the services; and
 - (d) Protect the individual from substantial harm expected to occur if the requested services are not authorized.

- (4) Notwithstanding the procedures set forth in this rule, the department may approve a proposed service authorization in its entirety or may partially approve a proposed service authorization if it determines that the services set forth in paragraph (D) of this rule are medically necessary. At no time shall an approved service authorization exceed the funding limitations specified in the transitions developmental disabilities waiver.
- (5) The individual shall be afforded notice and hearing rights regarding service authorizations in accordance with division 5101:6 of the Administrative Code.
 - (a) Providers shall have no standing in appeals under this section.
 - (b) A change in staff-to-waiver-recipient service ratios does not necessarily result in a change in the level of services received by an individual which would affect the annual service authorization.

(I) Service documentation

- (1) A provider of services shall maintain service documentation in accordance with this rule and service-specific rules in Chapter 5123:2-9 of the Administrative Code. Services shall not be considered delivered unless the provider maintains service documentation.
- (2) Claims for payment a provider of services submits to the Ohio department of medicaid for services delivered shall not be considered service documentation. Any information contained in the submitted claim may not and shall not be substituted for any required service documentation information that a provider of services is required to maintain to validate payment for medicaid services.
- (3) A provider of services shall maintain all service documentation in an accessible location. The service documentation shall be available, upon request, for review by the centers for medicare and medicaid services, the Ohio department of medicaid, the department, a county board or regional council of governments that submits to the department payment authorization for the service, and those designated or assigned authority by the Ohio department of medicaid or the department to review service documentation.
- (4) A provider of services shall maintain service documentation for a period of six years from the date of receipt of payment for the service or until an initiated audit is resolved, whichever is longer.

- (5) If a provider of services discontinues operations, the provider shall, within seven days of discontinuance, notify the county boards for the counties in which individuals to whom the provider has provided services reside, of the location where the service documentation will be stored, and provide each such county board with the name and telephone number of the person responsible for maintaining the records.

(J) Payment and billing procedures

- (1) Rule 5123:2-9-06 of the Administrative Code does not apply to services provided under the transitions developmental disabilities waiver.
- (2) In order for a provider to be paid for services delivered to an individual enrolled in the transitions developmental disabilities waiver, the services must be delivered in accordance with ~~Chapters 5101:3-45 and~~ Chapter 5123:2-9 of the Administrative Code.
- (3) Providers shall submit claims for payment to the Ohio department of medicaid in accordance with rule ~~5101:3-41-22~~ 5160-41-22 of the Administrative Code.
- (4) The amount of payment for a service shall be the lesser of the provider's billed charge or the medicaid maximum rate.
- (5) Providers of services shall take reasonable measures to identify any third-party health care coverage available to the individual and file a claim with that third party in accordance with the requirements of rule ~~5101:3-1-08~~ 5160-1-08 of the Administrative Code.
- (6) For individuals with a monthly patient liability for the cost of transitions developmental disabilities waiver services and determined by the county department of job and family services for the county in which the individual resides, payment is available only for waiver services delivered to the individual that exceeds the amount of the individual's monthly patient liability. Verification that patient liability has been satisfied shall be accomplished as follows:
 - (a) The department shall provide notification to the appropriate county board identifying each individual who has a patient liability for waiver services and the monthly amount of the patient liability.

- (b) The county board shall assign the waiver services to which each individual's patient liability shall be applied and assign the corresponding monthly patient liability amount to the waiver service provider that provides the preponderance of waiver services. The county board shall notify each individual and waiver service provider, in writing, of this assignment.
 - (c) Upon submission of a claim for payment, the designated waiver service provider shall report the waiver services to which the patient liability was assigned and the applicable patient liability amount on the claim for payment using the format prescribed by the department.
- (7) The department, the Ohio department of medicaid, the centers for medicare and medicaid services, and/or the auditor of state may audit any funds a provider of transitions developmental disabilities waiver services receives pursuant to this rule, including any source documentation supporting the claiming and/or receipt of such funds.
- (8) Overpayments, duplicate payments, payments for services not rendered, payments for which there is no documentation of services delivered or for which the documentation does not include all of the items required in service-specific rules in Chapter 5123:2-9 of the Administrative Code, or payments for services not in accordance with an approved individual service plan are recoverable by the department, the Ohio department of medicaid, the auditor of state, or the office of the attorney general. All recoverable amounts are subject to the application of interest in accordance with rules ~~5101:3-1-25~~ 5160-1-25 and 5101:6-51-03 of the Administrative Code, as applicable.
- (9) A county board shall be responsible for monitoring the utilization of services furnished pursuant to this rule based on quarterly service utilization reports provided by the department.

Effective: 07/01/2014

R.C. 119.032 review dates: 01/01/2018

CERTIFIED ELECTRONICALLY

Certification

06/16/2014

Date

Promulgated Under: 119.03
Statutory Authority: 5123.04, 5166.21
Rule Amplifies: 5123.04, 5166.21
Prior Effective Dates: 01/01/2013, 11/22/2013