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Ohio Revised Code

Section 5166.04 Home and community-based services medicaid waiver components.

Effective: September 29, 2013
Legislation: House Bill 59 - 130th General Assembly

The following requirements apply to each home and community-based services medicaid waiver component:

(A) Only an individual who qualifies for a component shall receive that component's medicaid services.

(B) A level of care determination shall be made as part of the process of determining whether an individual qualifies for a component and shall be made each year after the initial determination if, during such a subsequent year, the administrative agency determines there is a reasonable indication that the individual's needs have changed.

(C) A written plan of care or individual service plan based on an individual assessment of the medicaid services that an individual needs to avoid needing admission to a hospital, nursing facility, or ICF/IID shall be created for each individual determined eligible for a component.

(D) Each individual determined eligible for a component shall receive that component's medicaid services in accordance with the individual's level of care determination and written plan of care or individual service plan.

(E) No individual may receive medicaid services under a component while the individual is a hospital inpatient or resident of a skilled nursing facility, nursing facility, or ICF/IID.

(F) No individual may receive prevocational, educational, or supported employment services under a component if the individual is eligible for such services that are funded with federal funds provided under 29 U.S.C. 730 or the "Individuals with Disabilities Education Act," 111 Stat. 37 (1997), 20 U.S.C. 1400, as amended.

(G) Safeguards shall be taken to protect the health and welfare of individuals receiving medicaid services under a component, including safeguards established in rules adopted under section 5166.02 of the Revised Code and safeguards established by licensing and certification requirements that are applicable to the providers of that component's medicaid services.

(H) No medicaid services may be provided under a component by a provider that is subject to standards that the "Social Security Act," section 1616(e)(1), 42 U.S.C. 1382e(e)(1), requires be established if the provider fails to comply with the standards applicable to the provider.

(I) Individuals determined to be eligible for a component, or such individuals' representatives, shall be informed of that component's medicaid services, including any choices that the individual or representative may make regarding the component's medicaid services, and given the choice of either receiving medicaid services under that component or, as appropriate, hospital services, nursing facility services, or ICF/IID services.

(J) No individual shall lose eligibility for services under a component, or have the services reduced or otherwise disrupted, on the basis that the individual also receives services under the medicaid buy-in for workers with disabilities program.

(K) No individual shall lose eligibility for services under a component, or have the services reduced or otherwise disrupted, on the basis that the individual's income or resources increase to an amount above the eligibility limit for the component if the individual is participating in the medicaid buy-in for workers with disabilities program and the amount of the individual's income or resources does not exceed the eligibility limit for the medicaid buy-in for workers with disabilities program.

(L) No individual receiving services under a component shall be required to pay any cost sharing expenses for the services for any period during which the individual also participates in the medicaid buy-in for workers with disabilities program.