Ohio Administrative Code

Rule 5123-9-06 Home and community-based services waivers - documentation and payment for services under the individual options and level one waivers.

Effective: November 19, 2020

(A) Purpose

This rule establishes standards governing documentation and payment for home and community-based services under the individual options waiver and level one waiver components of the medicaid program that the Ohio department of developmental disabilities administers pursuant to section 5166.21 of the Revised Code.

(B) Definitions

For the purposes of this rule, the following definitions shall apply:

(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) "Cost projection and payment authorization" means the process followed and the form used by county boards (including the payment authorization for waiver services) to communicate the frequency, duration, scope, and amount of payment requested for each home and community-based service that is identified in the individual service plan.

(3) "Cost projection tool" means the web-based analytical tool that is a component of the medicaid services system, developed and administered by the department, used to project the cost of home and community-based services identified in an individual service plan.

(4) "County board" means a county board of developmental disabilities.

(5) "Department" means the Ohio department of developmental disabilities.

(6) "Fifteen-minute billing unit" means a billing unit that equals fifteen minutes of service delivery time or is greater or equal to eight minutes and less than or equal to twenty-two minutes of service delivery time. Minutes of service delivery time accrued throughout a day shall be added together for the purpose of calculating the number of fifteen-minute billing units for the day.

(7) "Funding range" means one of the dollar ranges contained in appendix A to this rule to which individuals enrolled in the individual options waiver have been assigned for the purpose of funding services other than adult day support, career planning, group employment support, individual employment support, non-medical transportation, vocational habilitation, waiver nursing delegation, and waiver nursing services. The funding range applicable to an individual is determined by the score derived from the Ohio developmental disabilities profile that has been completed by a county board employee qualified to administer the tool.

(8) "Guardian" means a guardian appointed by the probate court under Chapter 2111. of the Revised Code. If the individual is a minor, "guardian" means the individual's parents. If no guardian has been appointed for a minor under Chapter 2111. of the Revised Code and the minor is in the legal or permanent custody of a government agency or person other than the minor's natural or adoptive parents, "guardian" means that government agency or person. "Guardian" includes an agency under contract with the department for the provision of protective service in accordance with sections 5123.55 to 5123.59 of the Revised Code.

(9) "Home and community-based services" has the same meaning as in section 5123.01 of the Revised Code.

(10) "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.

(11) "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.

(12) "Individual funding level" means the total funds, calculated on a twelve-month basis, that result

from applying the payment rates in service-specific rules in Chapters 5123-9 and 5123:2-9 of the Administrative Code to the units of all waiver services other than adult day support, career planning, group employment support, individual employment support, non-medical transportation, vocational habilitation, waiver nursing delegation, and waiver nursing services established by the individual service plan development process to be sufficient in frequency, duration, and scope to meet the health and welfare needs of an individual enrolled in the individual options waiver. Unless prior authorization has been obtained in accordance with rule 5123-9-07 of the Administrative Code, the individual funding level for services paid in accordance with this rule shall be within or below the funding range assigned to the individual as the result of administration of the Ohio developmental disabilities profile.

(13) "Individual service plan" means the written description of services, supports, and activities to be provided to an individual developed in accordance with rule 5123-4-02 of the Administrative Code.

(14) "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.

(15) "Ohio developmental disabilities profile" means the standardized instrument used by the department to assess the relative needs and circumstances of an individual compared to others. The individual's responses are scored and the individual is linked to a funding range, which enables similarly situated individuals to access comparable waiver services paid in accordance with rules adopted by the department.

(16) "Prior authorization" means the process to be followed in accordance with rule 5123-9-07 of the Administrative Code to authorize an individual funding level for an individual enrolled in the individual options waiver that exceeds the maximum value of the funding range.

(17) "Provider" means an agency provider or independent provider that:

(a) Is certified by the department to provide home and community-based services; and

(b) Has a medicaid provider agreement with the Ohio department of medicaid.

(18) "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.

(19) "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 Chapters 5123-9 and 5123:2-9 of the Administrative Code to validate payment for medicaid services.

(20) "Team" has the same meaning as in rule 5123-4-02 of the Administrative Code.

(21) "Three-year period" means the three-year period beginning with the individual's initial waiver enrollment date and ending three years later. Subsequent three-year periods begin with the ending date of the previous three-year period and end three years later.

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

(C) Funding ranges and individual funding levels for individuals enrolled in the individual options waiver

(1) Individuals enrolled in the individual options waiver shall be assigned to a funding range based on completion and scoring of the Ohio developmental disabilities profile and the cost-of-doing-business category that applies to the county in which the individual receives the preponderance of services. The funding ranges are contained in appendix A to this rule. The cost-of-doing-business categories are contained in appendix B to this rule.

(2) The funding ranges shall consider:

(a) The natural supports available to the individual;

(b) The individual's living arrangement;

(c) The individual's behavioral support and medical assistance needs;

(d) The individual's mobility;

(e) The individual's ability for self care; and

(f) Any other variable that significantly impacts the individual's needs as determined by the department through statistical analysis.

(3) The service and support administrator shall ensure that an Ohio developmental disabilities profile is completed with input from the individual and the team. The service and support administrator shall inform the individual, and the team with consent of the individual, of the assigned funding range at the time of enrollment and any time the Ohio developmental disabilities profile is reviewed or updated. The service and support administrator shall ensure the individual, and the team with consent of the individual, have access to review the Ohio developmental disabilities profile and other assessments used in relation to completion of the Ohio developmental disabilities profile.

(4) Following assignment of a funding range, an individual service plan that assures the individual's health and welfare shall be reviewed, revised, or developed with the individual. The service and support administrator shall ensure that individuals share services to whatever extent practical and with the agreement of the team. Paid services should be used in conjunction with available natural supports. The service and support administrator shall ensure that development or revision of the individual service plan addresses the availability of natural supports that currently exist or could be developed to meet assessed needs, including:

(a) Supports that family members provide including, but not limited to, basic personal care, performing health care activities, transportation, attending family/social/recreational activities, laundry, meal preparation, and grocery shopping; and

(b) Supports that friends, neighbors, and others in the community provide.

(5) The county board shall apply rates for the units of each waiver service, other than adult day support, career planning, group employment support, individual employment support, non-medical transportation, vocational habilitation, waiver nursing delegation, and waiver nursing services, resulting from completion of the individual service plan development process to calculate the individual funding level.

(6) The county board shall determine whether the individual funding level is within, exceeds, or is below the assigned funding range for the individual. The service and support administrator shall inform the individual of this determination in accordance with procedures developed by the department.

(7) When an individual service plan is revised and a new funding level is determined, the providers of waiver services to the individual shall verify to the county board the number of units of each waiver service delivered during the individual's current waiver eligibility span so that the county board may accurately calculate the number of units of services available for the individual's use during the remainder of the waiver eligibility span.

(8) The county board shall complete the cost projection and payment authorization and the service and support administrator shall ensure waiver services are initiated for an individual whose funding level is within the funding range determined by the Ohio developmental disabilities profile. The service and support administrator shall inform the individual in writing and in a form and manner the individual can understand of the individual's due process rights and responsibilities as set forth in section 5160.31 of the Revised Code.

(9) When the individual funding level exceeds the assigned funding range:

(a) The county board shall inform the individual of the individual's right to request prior authorization to obtain services that result in an individual funding level that exceeds the funding range using the process described in rule 5123-9-07 of the Administrative Code.

(b) If, through the prior authorization process, the request for the funding level is approved, the county board shall ensure the cost projection and payment authorization is completed and waiver services are initiated.

(c) If, through the prior authorization process, the request for the funding level is denied, the service and support administrator shall continue the individual service plan development process to determine if an individual service plan that assures the individual's health and welfare can be developed within the individual's funding range.

(i) If an individual service plan that meets these conditions is developed, the county board shall ensure the cost projection and payment authorization is completed and waiver services are initiated.

(ii) If an individual service plan that meets these conditions cannot be developed, the county board shall propose to deny the individual's initial or continuing enrollment in the waiver and inform the individual of the individual's due process rights and responsibilities as set forth in section 5160.31 of the Revised Code.

(10) The department shall use the twelve-month period following either an individual's initial waiver enrollment date or a subsequent waiver eligibility re-determination date to verify that cumulative payments made for waiver services remain within the approved funding range for each individual or that cumulative payments made for waiver services remain within the approved funding range when prior authorization has been granted.

(11) The department shall periodically re-examine the scoring of the Ohio developmental disabilities profile and the linkage of the scores to the funding ranges.

(D) Payment limitations under the level one waiver

(1) Under the level one waiver, payment for community respite, homemaker/personal care, informal respite, money management, participant-directed homemaker/personal care, remote support, residential respite, and transportation, alone or in combination, shall not exceed six thousand seven hundred fifty dollars per waiver eligibility span.

(2) Under the level one waiver, payment for assistive technology, environmental accessibility adaptations, home-delivered meals, and specialized medical equipment and supplies, alone or in combination, shall not exceed seven thousand five hundred dollars within a three-year period.

(3) In accordance with rule 5123-9-27 of the Administrative Code, payment for emergency assistance under the level one waiver shall not exceed eight thousand five hundred twenty dollars within a three-year period.

(E) Changes to individual funding levels and funding ranges

(1) The individual funding level may increase or decrease based on the outcome of the individual service plan development process. In no instance shall the individual funding level exceed the cost cap approved for the waiver in which the individual is enrolled. The county board has the authority and responsibility to make changes to individual funding levels which result from the individual service plan development process in accordance with paragraph (C) of this rule. Changes to individual funding levels are subject to review by the department.

(2) A funding range established for an individual shall change only when changes in assessment variable scores on the Ohio developmental disabilities profile justify assignment of a new funding range. Any or all Ohio developmental disabilities profile variables may be revised at any time at the request of the individual or at the discretion of the service and support administrator, with the individual's knowledge.

(3) Neither the department nor the county board shall recommend a change in individual funding level within the funding range or assign a new funding range after notification that the individual has requested a hearing pursuant to section 5160.31 of the Revised Code concerning the approval, denial, reduction, or termination of services.

(F) Staffing ratios

(1) In situations where more than one staff member serves more than one individual simultaneously, the individuals' needs and circumstances shall determine staffing ratios, based on a unit of one staff to the portion of the total group that includes the individual. Only when it is impractical to determine

staff ratios based on a unit of one staff, the provider shall, as authorized in the individual service plan, use the applicable service codes and payment rates established in service-specific rules in Chapters 5123-9 and 5123:2-9 of the Administrative Code to indicate both staff size and group size.

(2) Staffing ratios do not change at times when one or more individuals, for whom the staff is responsible, are not physically present, but are within verbal, visual, or technological supervision of the staff providing the service. Technological supervision includes staff contact with individuals through telecommunication and/or electronic signaling devices.

(G) Projection of the cost of an individual's services

(1) Prior to the beginning of an individual's waiver eligibility span, the individual's service and support administrator or other county board designee shall prepare a projection of the annual cost of every individual options or level one waiver service that is authorized in the individual service plan for the waiver eligibility span using the cost projection tool.

(2) The cost projection shall be based on staffing ratios and the total estimated number of service units the individual is expected to receive in accordance with his or her individual service plan during the waiver eligibility span. Staffing ratios contained in the cost projection tool shall be considered a part of the individual service plan.

(3) The total number of service units shall be determined with input from the individual and his or her team as part of the individual service plan development process.

(4) The cost projection tool shall project the cost of services based on the payment rates established in service-specific rules in Chapters 5123-9 and 5123:2-9 of the Administrative Code.

(5) Rule 5123-9-31 of the Administrative Code shall govern the circumstances when an individual receives the homemaker/personal care daily billing unit.

(6) The cost projection tool shall be used to project costs based on medicaid payment rates for individuals, regardless of funding source, who share services with individuals enrolled in home and community-based services waivers.

(7) The individual's provider shall have access to the cost projection tool including, but not limited to, the detail and summary information. At the request of the individual, other persons shall have access to the detail and summary information in the cost projection tool.

(8) When changes occur that the team determines affect the service authorization, the county board shall enter changes to the cost projection tool within ten calendar days of a recommendation from the team to change the service authorization. These changes shall be made along with any necessary revisions to the individual service plan and prior authorization request (as applicable) for the individual or individuals affected by the changes.

(9) County boards shall complete a cost projection using the cost projection tool when an individual is initially enrolled in an individual options or level one waiver and when an individual is annually re-determined eligible for continued enrollment in an individual options or level one waiver. The cost projection tool shall be the only authorized cost projection instrument.

(H) Service documentation

(1) Providers shall maintain service documentation in accordance with this rule and service-specific rules in Chapters 5123-9 and 5123:2-9 of the Administrative Code.

(2) Claims for payment a provider submits to the department for services delivered shall not be considered service documentation. Any information contained in the submitted claim for payment may not and shall not be substituted for any required service documentation information that a provider is required to maintain to validate payment for medicaid services.

(3) Each provider shall maintain all service documentation in an accessible location. The service documentation shall be made available upon request for review by the department, the Ohio department of medicaid, the centers for medicare and medicaid services, 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 department or the Ohio department of medicaid to review service documentation.

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

(I) Payment for waiver services

(1) Providers shall be paid the lesser of their usual and customary rate or the payment rate for each waiver service that is delivered. The department shall establish a mechanism through which providers shall communicate their usual and customary rates to the department. A single provider may charge different usual and customary rates for the same service when the service is provided in different geographic areas of the state. In this instance, the usual and customary rates charged shall be declared for each cost-of-doing-business category contained in appendix B to this rule that identifies the counties in which the provider intends to provide specific services. Upon notification of a provider's usual and customary rate or change in usual and customary rate, the department shall provide notice to the appropriate county board.

(2) The billing units, service codes, and payment rates for waiver services are contained in service-specific rules in Chapters 5123-9 and 5123:2-9 of the Administrative Code including, but not limited to:

(a) 5123-9-12 (assistive technology under the individual options and level one waivers);

(b) 5123-9-13 (career planning under the individual options and level one waivers);

(c) 5123-9-14 (vocational habilitation under the individual options and level one waivers);

(d) 5123:2-9-15 (individual employment support under the individual options and level one waivers);

(e) 5123:2-9-16 (group employment support under the individual options and level one waivers);

(f) 5123-9-17 (adult day support under the individual options and level one waivers);

(g) 5123-9-18 (non-medical transportation under the individual options and level one waivers);

(h) 5123-9-20 (money management under the individual options and level one waivers);

(i) 5123-9-21 (informal respite under the level one waiver);

(j) 5123-9-22 (community respite under the individual options and level one waivers);

(k) 5123-9-23 (environmental accessibility adaptations under the individual options and level one waivers);

(l) 5123-9-24 (transportation under the individual options and level one waivers);

(m) 5123-9-25 (specialized medical equipment and supplies under the individual options and level one waivers);

(n) 5123-9-27 (emergency assistance under the level one waiver);

(o) 5123:2-9-28 (nutrition services under the individual options waiver);

(p) 5123-9-29 (home-delivered meals under the individual options and level one waivers);

(q) 5123-9-30 (homemaker/personal care under the individual options and level one waivers);

(r) 5123-9-31 (homemaker/personal care daily billing unit under the individual options waiver);

(s) 5123-9-32 (participant-directed homemaker/personal care under the individual options and level one waivers);

(t) 5123-9-33 (shared living under the individual options waiver);

(u) 5123-9-34 (residential respite under the individual options and level one waivers);

(v) 5123-9-35 (remote support under the individual options and level one waivers);

(w) 5123:2-9-36 (interpreter services under the individual options waiver);

(x) 5123:2-9-37 (waiver nursing delegation under the individual options and level one waivers);

(y) 5123:2-9-38 (social work under the individual options waiver);

(z) 5123-9-39 (waiver nursing services under the individual options waiver); and

(aa) 5123-9-48 (community transition under the individual options waiver).

(3) The department shall periodically collect payment information for a comprehensive, statistically valid sample of individuals from providers of home and community-based services at the time the information is collected. Based upon the department's review of the information, the department shall recommend to the Ohio department of medicaid any changes necessary to assure that the payment rates are sufficient to enlist enough waiver providers so that waiver services are readily available to individuals, to the extent that these types of services are available to the general population, and that provider payment is consistent with efficiency, economy, and quality of care.

(4) Payment for home and community-based services constitutes payment in full. Payment shall be made for home and community-based services when:

(a) The service is identified in an approved individual service plan;

(b) The service is recommended for payment through the cost projection and payment authorization process; and

(c) The service is provided by a provider selected by an individual enrolled in the waiver.

(5) Payment for waiver services shall not exceed amounts authorized through the cost projection and payment authorization for the individual's corresponding waiver eligibility span.

(J) Claims for payment for home and community-based services

(1) When home and community-based services are also available on the medicaid state plan, state plan services shall be billed first. Only home and community-based services in excess of those covered under the medicaid state plan shall be authorized.

(2) Claims for payment for home and community-based services shall be submitted to the department in the format prescribed by the department. The department shall inform county boards of the billing information submitted by providers in a manner and at a frequency necessary to assist county boards to manage the waiver expenditures being authorized.

(3) Claims for payment for home and community-based services shall be submitted within three hundred fifty calendar days after the home and community-based services are provided. Payment shall be made in accordance with the requirements of rule 5160-1-19 of the Administrative Code. Claims for payment shall include the number of units of service.

(4) All providers of home and community-based 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 5160-1-08 of the Administrative Code.

(5) For individuals with a monthly patient liability for the cost of home and community-based services, as described in rule 5160:1-6-07.1 of the Administrative Code, and determined by the county department of job and family services for the county in which the individual resides, payment is available only for the home and community-based services delivered to the individual that exceed 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 home and community-based services and the monthly amount of the patient liability.

(b) The county board shall assign the home and community-based services to which each individual's

patient liability shall be applied and assign the corresponding monthly patient liability amount to the provider that provides the preponderance of home and community-based services. The county board shall notify each individual and provider, in writing, of this assignment.

(c) Upon submission of a claim for payment, the designated provider shall report the home and community-based 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.

(6) 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 home and community-based services receives pursuant to this rule, including any source documentation supporting the claiming and/or receipt of such funds.

(7) 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 Chapters 5123-9 and 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 rule 5160-1-25 of the Administrative Code.

(8) Providers of home and community-based services shall maintain the records necessary and in such form to disclose fully the extent of home and community-based services provided, for a period of six years from the date of receipt of payment or until an initiated audit is resolved, whichever is longer. The records shall be made available upon request to the department, the Ohio department of medicaid, the centers for medicare and medicaid services, and/or the auditor of state. Providers who fail to produce the records requested within thirty calendar days following the request shall be subject to denial, suspension, or revocation of certification and/or loss of their medicaid provider agreement.

(K) Due process rights and responsibilities

(1) Applicants for and recipients of waiver services 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 waiver services administered by the department shall use the process set forth in section 5160.31 of the Revised Code and rules implementing that statute for any challenge related to the administration and/or scoring of the Ohio developmental disabilities profile or to the type, amount, level, scope, or duration of services included in or excluded from an individual service plan. 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.

(L) Ohio department of medicaid authority

The Ohio department of medicaid retains final authority to establish funding ranges for waiver services; to establish payment rates for waiver services; to review and approve each service identified in an individual service plan that is funded through a home and community-based services waiver; and to authorize the provision of and payment for waiver services through the cost projection and payment authorization.

(M) Authority of director to suspend or modify provisions of this rule

During the COVID-19 state of emergency declared by the governor, the director of the department may:

(1) Suspend the requirement described in paragraph (C)(9) of this rule for an individual to request prior authorization when his or her individual funding level exceeds his or her assigned funding range;

(2) Suspend the level one waiver payment limitations in paragraphs (D)(1) and (D)(2) of this rule;

(3) Suspend the requirement that a county board complete a cost projection pursuant to paragraph (G)(4) of this rule; and/or

(4) Modify the requirements in paragraphs (G)(1), (G)(2), (G)(6), (G)(7), (G)(8), and (G)(9) of this rule to allow use of the cost projection tool to be optional rather than mandatory.