Ohio Administrative Code

Rule 5160-44-02 Nursing facility-based level of care home and community-based services programs: person-centered planning.

Effective: July 1, 2024

(A) Person-centered planning process.

Individuals receiving home and community-based services (HCBS) through either an Ohio department of medicaid (ODM) or Ohio department of aging (ODA) -administered waiver program authorized under section 1915(c) of the Social Security Act (as in effect on January 1, 2024) or the Ohio medicaid state plan authorized under section 1915(i) of the Social Security Act (as in effect on January 1, 2024) will lead the person-centered planning process where possible. The individual's authorized representative should have a participatory role, as needed, and as defined by the individual, unless Ohio law confers decision-making authority to the legal representative. All references to individuals include the role of the individual's authorized representative. In addition to being led by the individual receiving services and supports, the person-centered planning process will:

(1) Include a team of people chosen by the individual.

(2) Provide necessary information and support to ensure that the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions.

(3) Be timely and occur at times and locations of convenience to the individual.

(4) Reflect cultural considerations of the individual. The process will be conducted by providing information in plain language and in a manner that is accessible to persons with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b) (as in effect October 1, 2023).

(5) Include strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants.

(6) Ensure that providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual will not provide case management, provider oversight, or develop the person-centered services plan.

(7) Offer informed choices to the individual regarding the services and supports he or she receives and from whom.

(8) Include a method for the individual to request updates to the person-centered services plan as needed. The individual may request a person-centered services plan review at any time.

(B) Person-centered services plan.

(1) The person-centered services plan describes the person-centered goals, objectives and interventions selected by the individual and team to support him or her in his or her community of choice. The person-centered services plan addresses the assessed needs of the individual by identifying medically-necessary services, natural supports, medical and professional staff, and community resources. The person-centered services plan will:

(a) Identify the setting in which the individual resides is chosen by the individual and document the alternative home and community-based settings that were considered by the individual.

(b) Reflect the individual's strengths.

(c) Reflect the individual's preferences.

(d) Reflect clinical and support needs as identified through the assessment process.

(e) Include the individual's identified goals and desired outcomes.

(f) Identify the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports and those services the individual elects to self-direct. This includes all services and supports provided through private insurance, medicare, medicaid state plan, and waiver services.

(g) Address any risk factors and measures in place to minimize them, when needed.

(h) Include back-up plans that meet the needs of the individual.

(i) Reflect that the setting chosen by the individual is integrated in, and supports the full access of individuals receiving medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community to the same degree of access as people not receiving medicaid HCBS.

(2) The person-centered services plan will document that any modification of the additional conditions for provider-owned or controlled residential settings set forth in rule 5160-44-01 of the Administrative Code is supported by a specific assessed need and justified in the person-centered services plan. In these cases, the person-centered services plan will:

(a) Identify a specific and individualized assessed need;

(b) Document the positive interventions and supports used prior to any modifications to the person-centered services plan;

(c) Document less intrusive methods of meeting the need that have been attempted but were unsuccessful;

(d) Include a clear description of the condition that is directly proportionate to the specific assessed need;

(e) Include a regular collection and review of data to measure the ongoing effectiveness of the modification;

(f) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;

(g) Include informed consent of the individual; and

(h) Include an assurance that interventions and supports will not cause any harm to the individual.

(3) The person-centered services plan will:

(a) Be understandable to the individual receiving services and supports, and the people important in supporting him or her. At a minimum, it will be written in plain language and in a manner that is accessible to persons with disabilities and persons who are limited english proficient, consistent with 42 CFR 435.905(b) (as in effect on October 1, 2023).

(b) Identify the person and/or entity responsible for monitoring the plan.

(c) Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all people and providers responsible for its implementation. Acceptable signatures include, but are not limited to a handwritten signature, initials, a stamp or mark, or an electronic signature. Any accommodations to the individual's or authorized representative's signature will be documented on the plan.

(d) Be distributed to the individual and other people involved in the plan.

(e) Prevent the provision of unnecessary or inappropriate services and supports.

(f) Be reviewed and revised upon reassessment of functional need as required by 42 CFR 441.365(e) (as in effect on October 1, 2023), at least every twelve months, when the individual experiences a significant change, or at the request of the individual.

(C) Documentation standards.

(1) Documentation standards apply to entities delegated to perform assessments and care coordination activities for nursing facility-based waiver programs. Assessments and care coordination activities include in-person visits, telephone conversations, or email exchanges.

(2) Documentation for each assessment and care coordination activity will include the following:

(a) Individual's name.

(b) Name and relationship to the individual for all that participate.

(c) Date of the assessment or care coordination activity.

(d) Location of the assessment or care coordination activity.

(e) Type of assessment or care coordination activity.

(f) Detailed description of the assessment or care coordination activity, including the reason for the activity, actions completed, outcome and next steps.

(3) Documentation of all assessments and care coordination activities will be:

(a) Written in a manner that is objective, accurate, and understandable to the individual as described in paragraph (B)(3)(a) of this rule.

(b) Completed within three business days of the assessment or care coordination activity.

(c) Accessible to ODM in the system designated by ODM.