5123:2-9-06 **HCBS waivers - waiver reimbursement methodology.**

(A) Purpose

The purpose of this rule is to establish the standards governing payment for home and community-based services (HCBS), other than day habilitation and transportation to access day habilitation services, as defined in section 5126.01 of the Revised Code provided to individuals enrolled in HCBS waivers administered by the department and to implement sections 5111.871 and 5111.873 of the Revised Code.

(B) Definitions

(1) "County board" means a county board of mental retardation and developmental disabilities that performs HCBS waiver administration functions either independently, within a regional council of government formed under Chapter 167. of the Revised Code or through a private entity who contracts with a county board for administration of the HCBS waiver and the entity does not provide any service other than administration to the individuals of that county.

(2) "Department" means the Ohio department of mental retardation and developmental disabilities as established by section 121.02 of the Revised Code.

(3) "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.

(4) "Funding range" means one of the dollar ranges contained in appendix C to this rule to which individuals have been assigned for the purpose of funding waiver services. Notwithstanding paragraph (E)(9)(a) of this rule, the funding range applicable to an individual is determined by the score derived from the Ohio developmental disabilities profile (ODDP) that has been completed by a county board employee qualified to administer the tool. The funding range for an individual receiving level one waiver services shall be determined within the payment limitations contained in appendix A to this rule and not through the ODDP.

(5) "Guardian" means a guardian appointed by the probate court under Chapter 2111. of the Revised Code. If the individual is a minor for whom no guardian has been appointed under that chapter, "guardian" means the individual's parents. If no guardians have been appointed for a minor 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" also includes an agency under contract with the department for the provision of protective service under sections 5123.55 to 5123.59 of the Revised Code.

(6) "Individual" means a person with mental retardation or other developmental disability who is eligible to receive HCBS as an alternative to placement in an intermediate care facility for the mentally retarded under the applicable HCBS waiver. A guardian may take any action on behalf of the individual, may make choices for an individual or may receive notice on behalf of an individual to the extent permitted by applicable law.

(7) "Individual funding level" means the total funds that result from applying the rates in appendix A to this rule to the units of all waiver services except for day habilitation and supported employment that have been determined through the individual service plan (ISP) development process to be sufficient in amount, duration and scope to meet the health and welfare needs of an individual. Unless prior authorization has been obtained in accordance with rule 5101:3-41-12 of the Administrative Code, the individual funding level for services reimbursed in accordance with this rule except supported employment shall be within or below a funding range assigned to the individual as the result of administration of the ODDP.

(8) "ISP" means the individual service plan, a written description of the services, supports, and activities to be provided to an individual.

(9) "ODJFS" means the Ohio department of job and family services as established by section 121.02 of the Revised Code.

(10) "Ohio developmental disabilities profile (ODDP)" means the standardized instrument utilized by the department to assess the relative needs and circumstances of an individual compared to others. The consumer-specific responses are scored and the individual is linked to a funding range, which enables similarly situated individuals to access comparable waiver services reimbursed in accordance with this rule on a statewide basis.

(11) "Payment authorization for waiver services (PAWS)" means the process followed and the form used to communicate the amount of payment for each waiver service that has been established through the approved ISP process and is contained in the ISP for an eligible enrollee.

(12) "Prior authorization" means the process to be followed in accordance with rule 5101:3-41-12 of the Administrative Code to authorize an individual funding

level that exceeds the maximum value of the funding range that is determined for an individual through the use of the ODDP.

(13) "Provider" means an agency or individual that:

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

(b) Has a medicaid provider agreement from ODJFS that covers the services.

(14) "SSA" means a service and support administrator who is certified in accordance with rules adopted by the department under Chapter 5123:2-5 of the Administrative Code and who provides the functions of service and support administration.

(15) "Transportation" means a service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the ISP. This service is offered in addition to medical transportation required under 42 C.F.R. 431.53 as in effect on the effective date of this rule and transportation services under the state plan, defined at 42 C.F.R. 440.170 (a) as in effect on the effective date of this rule (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the ISP.

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

(C) Payment rate requirements

Providers shall be reimbursed at the lesser of their usual and customary rate (UCR) or the statewide payment rate for each waiver service that is delivered. The department shall establish a mechanism through which providers shall communicate their UCRs to the department. A single provider may charge different UCRs for the same service when the service is provided in different geographic areas of the state. In this instance, the UCRs charged shall be declared for each cost of doing business category described 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 UCR or change in UCR, the department shall provide notice to the appropriate county board.

(D) Statewide payment rates

(1) ODJFS retains the final authority, based on the recommendation of the department, to establish payment rates for all waiver services included in HCBS waivers administered by the department. The services and payment rates for all waiver services other than day habilitation and transportation to access day habilitation are included in appendix A to this rule. The payment rates for day habilitation and transportation to access day habilitation are contained in rule 5123:2-9-12 of the Administrative Code.

(2) Payment rates for homemaker/personal care (HPC) services shall be established separately for services provided through agency providers and for services provided by non-agency providers. Staff HPC responsibilities extend to those times when the individual is not physically present and staff is performing homemaker activities on behalf of the individual living in the home.

(3) Payment rates for HPC services shall include an adjustment for geography based on the county cost of doing business category. The county cost of doing business category for an individual is the category assigned to the county in which the waiver service is actually provided. The cost of doing business categories and the counties assigned to each are contained in appendix B to this rule.

(4) The payment rates for interpreter services, nutritional services, and social work services shall be adjusted to reflect provider certification types and for geographic variations as established in appendix B to this rule.

(5) The payment rate for supported employment services shall be adjusted to reflect geographic variations as established in appendix B to this rule.

(6) The payment rates for transportation shall be based on the internal revenue service (IRS) mileage allowance as established in appendix A to this rule. The number of individuals in a group shall be determined by totaling the number of waiver enrollees and those receiving non-waiver services for whom transportation is being provided. Transportation may be provided on behalf of a waiver enrollee.

(7) The department shall collect reimbursement information periodically for a comprehensive statistically valid sample of individuals from the providers providing HCBS at the time the information is collected. Based upon the department's review of the information, the department shall recommend to ODJFS any changes necessary to assure that the payment amounts 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 reimbursement is consistent with efficiency, economy and quality of care. ODJFS retains the final authority to make this determination.

(8) Payment rates for HPC may be modified to reflect the needs of individuals requiring medical assistance and individuals requiring behavior support. Routine HPC is the only waiver service that may be modified in this manner. Only individuals meeting criteria established by the department as specified in paragraphs (D)(9) and (D)(10) of this rule shall be eligible for these rate modifications. Upon determination by the county board that the individual meets the criteria established by the department, the county board shall recommend and implement rate modifications for behavior support and/or medical assistance. Rate modifications are subject to review by the department. The duration of approval for medical assistance and/or behavior support rate modifications shall be limited to the individual's twelve-month waiver eligibility span prior to re-determination and may be determined needed or no longer needed within that twelve-month waiver eligibility span. Rate modifications may be renewed annually at the individual's re-determination time if the individual continues to meet the criteria established by the department. A modification to the HPC rate shall be applied for each individual in a congregate setting meeting the criteria, and shall be included in the payment rates of only those individuals meeting the criteria.

(9) The behavior support rate modification is applicable to routine HPC services only and is to be paid during all times when routine HPC services are provided to an individual who qualifies for the modification. The amount of the behavior support rate modification for each fifteen minute unit of service is contained in appendix A to this rule.

(a) Because of the serious nature of the behaviors of individuals, the purpose of the behavior support rate modification is to provide funding for the implementation of behavior support plans by staff who have the level of training necessary to implement the plans and who are working under the direction of licensed or certified personnel or other professionals who have specialized training or experience implementing behavior support plans.

(b) In order for an individual to receive the behavior support rate modification, the following conditions shall be met:

(i) Only an individual who presents a danger to self or others, or who has been assessed to have the potential to present a danger, shall be eligible for the behavior support rate modification.

(ii) A behavior support plan that is a component of the individual's ISP has been developed in accordance with the requirements contained in rules established by the department;

(iii) The individual routinely receives clinical services from a licensed, certified or other type of professional who has specialized training or experience related to the design, development and implementation of the behavior support plan and the individual either;

(iv) Responds 'yes' to at least four items in question number thirty-two of the behavior domain of the ODDP, or

(v) Requires a structured environment that, if removed, will result in the individual's engagement in behavior destructive to self or others.

(c) When determined through the ISP development process that the criteria contained in paragraph (D)(9)(b) of this rule has been met, the county board shall authorize the behavior support rate modification for routine HPC. The department retains the right to review and validate the qualifications of any provider of clinical services identified in this paragraph. ODJFS retains the final authority, based on the recommendation of the department, to review, revise and approve any element of the decision process resulting in a determination to make a behavior support modification to the HPC rate.

(10) The amount of the medical assistance rate modification for each fifteen minute unit of service is contained in appendix A to this rule. The medical assistance rate modification is applicable to routine HPC services only and shall be paid during all times when an individual who meets the medical assistance rate modification criteria is receiving routine HPC, as recommended during the ISP development process.

(a) The county board shall authorize the medical assistance rate modification when the following criteria have been met:

(i) An individuals requires routine feeding and/or the administration of prescribed medications through gastrostomy and/or jejunostomy tubes, when the tubes are stable and labeled, and/or requires the administration of routine doses of insulin through subcutaneous injections and insulin pumps; or

(ii) An individual requires a nursing procedure or nursing task that a licensed nurse agrees to delegate in accordance with the rules contained in Chapter 4723-13 of the Administrative Code when such procedure or nursing task is not the administration of oral or topical medication or one of the health-related activities listed in paragraphs (L)(1) to (L)(8) of rule 5123:2-6-01 of the Administrative Code and provided in accordance with section 5123.42 of the Revised Code.

(b) ODJFS retains the final authority, based on the recommendation of the department, to review, revise, and approve any element of the decision process resulting in a determination to make a medical assistance modification to the HPC rate.

(11) ODJFS retains the final authority, based on the recommendation of the department, to establish on-site/on-call payment rates for HPC services provided on an on-call basis within the individual's residential setting, as indicated in appendix A to this rule. The ISP development process shall be used to determine the frequency, duration, and scope of HPC services to be paid at the on-site/on-call rate during the ISP planning process. Neither the medical assistance nor the behavior support rate modification is applicable to the on-site/on-call payment rates for HPC services.

(a) A provider is eligible to be reimbursed at the on-site/on-call payment rate for HPC services when:

(i) Based upon assessed and documented need, the ISP indicates the days of the week and the beginning and ending times each day when it is anticipated that an individual will require on-site/on-call services; and

(ii) The individual is asleep and does not require intervention or assistance during this time; and

(iii) The HPC provider is required to be on-site, but is not required to remain awake; and

(iv) On-site/on-call time does not exceed any more than eight hours for the individual in any twenty-four-hour period.

(b) A provider shall be paid the routine HPC rate when an individual receives intervention/supports during the times the ISP indicates a need for

on-site/on-call services. In these instances, the provider shall document the start and stop times and dates during which intervention/supports were provided to the individual.

(12) ISPs shall indicate the ratios at which services are to be delivered, as defined in appendix A to this rule, when individuals share waiver services. The base rate paid to a provider for HPC services shall be adjusted to reflect the numbers of individuals sharing the services.

(a) If two individuals receive service from one staff member, the base rate shall be one hundred seven per cent of the base rate for one-to-one service. If three individuals share the service, the base rate shall be one hundred seventeen per cent of the base rate for one-to-one service. If four or more individuals share the service, the base rate shall be one hundred thirty per cent of the base rate for one-to-one service.

(b) The base rate established is divided by the number of individuals sharing the service to determine the rate paid per individual.

(c) In those situations where more that 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 ISP, use the applicable billing codes and rates contained in appendix A to this rule to indicate both staff size and group size.

(d) Group size shall be identified on the billing document submitted by the provider to the department for each waiver service delivered.

(e) 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.

(E) Funding ranges, individual funding levels, and statewide payment rates under the individual options waiver and community access model waiver for new enrollees and individuals enrolled on the individual options waiver and residential facility waiver prior to the effective date of this rule

(1) ODJFS shall retain the final authority, based on the recommendation of the department, to establish funding ranges for waiver services. Individuals enrolled to receive waiver services on or after the effective date of this rule, other than those enrolling to receive level one waiver services, shall be assigned to a funding range based on completion and scoring of the ODDP. The ODDP levels and corresponding funding ranges are contained in appendix C to this rule.

(2) The funding ranges shall consider:

(a) The unpaid care available to the individual;

(b) The individual's living arrangement;

(c) The individual's behavior support 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) Each individual shall be assigned a funding range based on his/her ODDP score.

(a) The SSA shall assure that an ODDP is appropriately completed within one month following the month in which this rule is effective for each individual enrolled on the IO or RFW prior to the effective date of this rule.

(b) On or before five months following the month in which this rule is effective, the SSA shall inform each individual enrolled on the IO waiver or RFW prior to the effective date of this rule of his/her assigned funding range resulting from the ODDP score. The information shall be provided to each individual in accordance with procedures established by the department.

(c) The SSA shall inform the individual of his/her assigned funding range amounts at the time of enrollment and at any other time a change in circumstances results in an ODDP score that assigns the individual to a

different funding range.

(4) The department shall re-examine the scoring of the ODDP and the linkage of the scores to the individual funding ranges no later than twenty-four months following the month in which this rule is effective and, at the department's discretion, periodically thereafter.

(5) Following assignment of a funding range, an ISP shall be reviewed, revised or developed with the individual. The county board shall apply rates for the units of each waiver service, other than day habilitation and transportation to access day habilitation services, resulting from the completion of the ISP planning process to calculate the individual funding level. Twelve months following the month in which this rule is effective, the rates applied to the units of supported employment services shall not be used to calculate individual funding levels for either individuals newly enrolled on a waiver or, at the point of their eligibility re-determination, for individuals currently enrolled on the waiver.

(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 SSA shall inform the individual of this determination in accordance with procedures developed by the department.

(7) When an ISP change is made and a new funding level is determined, the providers of waiver services to the individual shall verify to the county board the numbers 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 available service to be provided that is approved for the individual's use during the remainder of the waiver eligibility span.

(8) The county board shall complete a PAWS and the SSA shall assure waiver services are initiated for an individual whose funding level is within the funding range determined by an ODDP assessment. The SSA shall also inform the individual in writing and in a form and manner the individual can understand of his/her due process rights and responsibilities as set forth in section 5101.35 of the Revised Code.

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

(a) The county board shall inform the individual of his/her right to request a prior authorization to obtain services that result in a funding level that exceeds the funding range using the process described in rule 5101:

3-41-12 of the Administrative Code.

(b) If, through the prior authorization process, the request for a funding level that exceeds the individual's funding range is approved, the county board shall assure a PAWS is completed and waiver services are initiated.

(c) If, through the prior authorization process, the request for a funding level that exceeds the individual's funding range is denied, the SSA shall initiate the ISP planning process to determine if an ISP that assures the individual's health and welfare can be developed within the individual's funding range.

(i) If an ISP that meets these conditions is developed, the county board shall assure a PAWS is completed and shall assure waiver services are initiated;

(ii) If an ISP that meets these conditions is unable to be developed, the county board shall propose to deny the individual's initial or continuing enrollment on the waiver and inform the individual of his/her due process rights and responsibilities as set forth in section 5101.35 of the Revised Code.

(10) When the funding level of an individual is below the assigned funding range, the SSA shall:

(a) Coordinate an ISP planning process to assure that the services reflected in the ISP are sufficient to meet the health and welfare needs of the individual.

(b) Assure waiver services are initiated and assure completion of a PAWS.

(c) Prepare a statement indicating that the services in the ISP are sufficient to assure the health and welfare of the individual, personally sign the statement and obtain the signature of the individual or guardian indicating agreement with the statement.

(d) Notify the department within the timelines and in the manner prescribed by the department.

(e) Inform the individual of his/her due process rights and responsibilities as set forth in section 5101.35 of the Revised Code.

(11) The department shall use the twelve-month period following either an individual's initial enrollment date or the subsequent 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.

(F) Changes to individual funding levels and funding ranges

(1) If an individual requests a change in ISP services, the individual funding level may increase or decrease based on the outcome of the ISP planning process. In no instance may the individual funding level exceed the cost cap approved for the waiver on which the individual is enrolled. The county board has the authority and responsibility to make changes to individual funding levels, which result from the ISP planning process in accordance with paragraph (E) of this rule. Changes to individual funding levels are subject to review by the department. No prior state level review will be required for funding level changes that occur within or below a funding range when changes result from a change in ISP services that have been agreed to by an individual through the ISP planning process.

(2) Notwithstanding paragraph (E)(9)(a) of this rule, a funding range established for an individual shall change only when changes in assessment variable scores on the ODDP that justify assignment of a new funding range have occurred. Any or all ODDP variables can be revised at any time at the request of the individual or at the discretion of the SSA, 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 concerning the approval, denial, reduction or termination of services in an ISP that has been developed within the funding parameters of this rule by requesting a hearing pursuant to section 5101.35 of the Revised Code.

(G) Authorization required

(1) ODJFS retains the final authority, based upon the recommendation of the department, to review and approve each service identified in the ISP that is funded through the HCBS waiver and the payment rate for the service.

(2) ODJFS retains the final authority, based upon the recommendation of the department, to authorize the provision and payment of waiver services

through the PAWS process.

(3) When combined, payment amounts for waiver services shall not exceed the amounts authorized through the PAWS process for the corresponding time period for an individual.

(H) Payment limitations for HCBS waiver services

Payment for an HCBS waiver service constitutes payment-in-full. Payment shall be made for HCBS waiver services when:

(1) The service is identified in an approved ISP;

(2) The service is recommended for payment through the PAWS process;

(3) The service is provided by a HCBS waiver service provider selected by an individual enrolled on the waiver;

(4) No greater than twenty-four hourly units of HPC waiver services, or equivalent fifteen minute units, are authorized through the PAWS process; and

(5) Payment for waiver services is the lesser of the provider's UCR or the statewide payment rate as described in paragraph (C) of this rule.

(I) Claims for payment of HCBS waiver services

(1) When HCBS services are also available on a state plan, state plan services must be billed first. Only those HCBS waiver services in excess of those covered under the state plan will be authorized.

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

(3) Claims for payment shall be submitted within three hundred thirty days after the HCBS waiver service is provided. Payment shall be made in accordance with the requirements of rule 5101:3-1-19.7 of the Administrative Code, except that claims submitted beyond the three-hundred-thirty-day deadline shall be

rejected. No claims shall be paid that do not provide both the number of units of services, the numbers of staff providing the service and the number of individuals sharing the service.

(4) All HCBS waiver service providers 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 of the Administrative Code.

(5) For individuals with a monthly patient liability for the cost of HCBS waiver services, as defined in rule 5101:1-39-95 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 HCBS waiver service(s) 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 HCBS waiver services and the monthly amount of the patient liability.

(b) The county board shall assign the HCBS waiver service(s) to which each individual's patient liability shall be applied and assign the corresponding monthly patient liability amount to an HCBS waiver service provider. The county board shall notify each individual and HCBS waiver service provider, in writing, of this assignment.

(c) Upon submission of a claim for payment, the designated HCBS waiver service provider shall report the HCBS waiver service 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 in billing instructions for HCBS waiver services.

(6) Claims for payment of environmental modification, personal response system, and community transition services shall be submitted to the department with verification from the county board that the project meets the requirements specified in the approved ISP, the project is satisfactorily completed, and the project is in compliance with all applicable state and local requirements, including building codes. The verification submitted shall be in the format prescribed by the department.

(7) The department, ODJFS, the centers for medicare and medicaid services and/or the state auditor may audit any funds a provider of HCBS waiver services

receives pursuant to this rule, including any source documentation supporting the claiming and/or receipt of such funds.

(8) An HCBS waiver service provider shall maintain the records necessary and in such form to disclose fully the extent of HCBS waiver 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, ODJFS, the centers for medicare and medicaid services and/or the state auditor. Providers who fail to produce the records requested within thirty days following the request will be subject to decertification and/or loss of their medicaid provider agreement.

(J) Implementation of individual funding ranges, levels and statewide payment rates for individuals enrolled in the level one waiver, IO waiver or the RFW prior to the effective date of this rule

(1) Between November 1, 2005 and May 1, 2006, county boards shall initiate statewide payment rates following completion of the ISP planning process for each individual enrolled on the level one waiver.

(2) By December 1, 2005, each county board shall provide to the department a plan of how the county board will implement paragraphs (J)(3), (J)(4) and (J)(5) of this rule. The information shall be provided in accordance with timelines and in the format prescribed by the department.

(a) The county board plan shall be subject to modification by the department to assure that the transition plans by the county and/or in the aggregate support the redistribution of general revenue funds appropriated as match for waiver services.

(b) Nothing in this paragraph shall be interpreted to prevent a county board, an individual and a provider from agreeing to accelerate the transition phases contained in paragraph (J) of this rule when the department approves the accelerated phase-in periods and activities.

(c) The county board shall participate in the quarterly process of reporting the progress of the transition to the centers for medicare and medicaid services (CMS). Information required from the board shall be specified by the department and submitted in a format required by the department. Any modifications to the county plan provided in accordance with this paragraph shall be reported as a component of the quarterly reporting process.

(3) Between January 1, 2006 and December 31, 2007, county boards shall apply individual funding ranges and initiate statewide payment rates following completion of the ISP planning process for each individual enrolled on the IO waiver who is living alone.

(4) Between February 1, 2006 and ~~December 31, 2007~~ March 31, 2008, county boards shall apply individual funding ranges and initiate statewide payment rates following completion of the ISP planning process for each individual who resides with other waiver recipients, when all individuals:

(a) Have a funding level that, as the result of the application of the rates contained in appendix A to this rule, is within or below their assigned funding ranges; and

(b) Are able to receive services that assure their health and welfare at the funding level resulting from completion of the ISP planning process.

(5) Between February 1, 2006 and ~~December 31, 2007~~ March 31, 2008, county boards shall apply individual funding ranges and initiate statewide payment rates following completion of the ISP planning process for each individual who resides with other waiver recipients, some of whom, as the result of the application of the rates contained in appendix A to this rule, have a funding level that is above their assigned funding range.

(6) Notwithstanding paragraph (E)(9)(a) of this rule, the provisions of paragraph (J) of this rule shall be implemented for all individuals enrolled on HCBS waivers administered by the department no later than ~~December 31, 2007~~ March 31, 2008.

(7) From the effective date of this rule until the implementation times specified in paragraph (J) of this rule, waiver funding for individuals who have not completed the transition and/or those participating in the appeal process set forth in section 5101.35 of the Revised Code shall be made in accordance with Chapters 5123:1-2 and 5123:2-8 of the Administrative Code. ODJFS shall make the final determination of the payment rate to be used when the provider and county board cannot reach agreement when negotiating a payment rate pursuant to Chapters 5123:1-2 and 5123:2-8 of the Administrative Code.

(8) County boards and waiver service providers shall complete the transition of individuals to their individual funding ranges and implement statewide funding rates in conformance with this rule and guidelines provided by the

department.

(9) As of the effective date of an individual's transition to the rates in appendix A and ranges in appendix C to this rule the department shall establish a one-time process to verify that the annual funding level that is authorized for the individual for waiver services that are subject to the funding range are within the funding range for the individual assigned by the ODDP or such funding level remains within the funding range that results when prior authorization has been granted.

(K) Due process rights and responsibilities

(1) Any recipient or applicant for waiver services administered by the department may utilize the process set forth in section 5101.35 of the Revised Code, in accordance with division 5101:6 of the Administrative Code for any purpose authorized by that statute and the rules implementing the statute. The process set forth in section 5101.35 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 this section.

(2) Applicants for and recipients of waiver services administered by the department shall use the process set forth in section 5101.35 of the Revised Code for any challenge related to the administration and/or scoring of the ODDP or to the type, amount/level, scope or duration of services included or excluded from an ISP or individual behavior plan addendum. For purposes of clarity, a change in staff: waiver recipient service ratios does not automatically result in a change in the level of services received by an individual.

Effective: 03/20/2008

R.C. 119.032 review dates: 07/01/2010

CERTIFIED ELECTRONICALLY

Certification

03/10/2008

Date

Promulgated Under: 119.03
Statutory Authority: 5123.04, 5111.871
Rule Amplifies: 5123.04, 5111.871, 5111.873
Prior Effective Dates: 07/01/2005, 07/01/2007, 12/21/2007 (Emer.)