CHAPTER 7

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HOME AND COMMUNITY BASED SERVICES

7.1 HOME AND COMMUNITY-BASED SERVICES PROVIDER SELECTION PROCESS

(A) Definitions

(1) "Adult day support" has the same meaning as in rule 5123:2-9-17 of the Administrative Code.

(2) "Agency provider" means an entity that employs persons for the purpose of providing services for which the entity must be certified under rules adopted by the department.

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

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

(5) "Home and community-based services" has the same meaning as in section5123.01 of the Revised Code.

(6) "Homemaker/personal care" has the same meaning as in rule 5123:2-9-30 of the Administrative Code.

(7) "Independent provider" means a self-employed person who provides services for which he or she must be certified under rules adopted by the department and 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) "Integrated employment" has the same meaning as in rule 5123:2-9-44 of the Administrative Code.

(10) "Non-medical transportation" has the same meaning as in rule 5123:2-9-18 of the Administrative Code.

(11) "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.

(12) "Supported employment-community" has the same meaning as in rule 5123:2-9-15 of the Administrative Code.

(13) "Supported employment-enclave" has the same meaning as in rule 5123:2-9-16 of the Administrative Code.

(14) "Vocational habilitation" has the same meaning as in rule 5123:2-9-14 of the Administrative Code.

(B) Notification of free choice of providers, assistance with the provider selection process, and procedural safeguards

(1) The Board shall notify each individual at the time of enrollment in a home and community-based services waiver and at least annually thereafter, of the individual's right to choose any qualified and willing provider of home and community-based services. The notification shall specify that:

(a) The individual may choose agency providers, independent providers, or a combination of agency providers and independent providers;

(b) The individual may choose providers from all qualified and willing providers available statewide and is not limited to those currently providing services in a given county;
(c) The individual may choose to receive services from a different provider at any time;
(d) An individual choosing to receive homemaker/personal care in a licensed residential facility is choosing both the place of residence and the homemaker/personal care provider, but maintains free choice of providers for all other home and community-based services and the right to move to another setting at any time if a new homemaker/personal care provider is desired; and
(e) The service and support administrator will assist the individual with the provider selection process if the individual requests assistance.

(2) A service and support administrator shall assist an individual enrolled in a home and community-based services waiver with one or more of the following, as requested by the individual:
(a) Accessing the department's website to conduct a search for qualified and willing providers;
(b) Providing the individual with the department's guide to interviewing prospective providers;
(c) Sharing objective information with the individual about providers that includes reports of provider compliance reviews, approved plans of correction submitted by providers in response to compliance reviews, number of individuals currently served, and any information about services offered by the provider to meet the unique needs of a specific group of individuals such as aging adults, children with autism, or individuals with intense medical or behavioral needs;
(d) Utilizing the statewide, uniform format to create a profile that shall include the type of services and supports the individual requires, hours of services and supports required, the individual's essential service preferences, the funding source of services, and any other information the individual chooses to share with prospective providers;
(e) Making available to all qualified providers in the county that have expressed an interest in serving additional individuals, the individual-specific profile to identify willing providers of the service;
(f) Contacting providers on the individual's behalf;
(g) Developing provider interview questions that reflect the characteristics of the individual's preferred provider; and (h) Scheduling and participating as needed in interviews of prospective providers. If the individual chooses to interview the Board as a prospective provider, the service and support administrator shall disclose to the individual that the service and support administrator is employed by the same agency. The service and support administrator may participate in this interview as directed by the individual.

(3) The Board shall document the alternative home and community-based services settings that were considered by each individual and ensure that each individual service plan reflects the setting options chosen by the individual.

(4) The Board shall document that each individual has been offered free choice among all qualified and willing providers of home and community-based services.

(5) If the Board receives a complaint from an individual regarding the free choice of

provider process, the Board shall respond to the individual within thirty days and provide the department with a copy of the individual's complaint and the Board's response.

(C) The Board's written procedures will ensure that home and community-based services begin in accordance with the date established in the individual service plan. The procedures shall include a requirement for the Board to monitor the service commencement process and implement corrective measures if services do not begin as indicated.

(D) Due process and appeal rights

(1) Any recipient of or applicant for home and community-based services may utilize the process set forth in section 5101.35 of the Revised Code for any purpose authorized by that statute and the rules implementing the statute, including being denied the choice of a provider who is qualified and willing to provide home and community-based services. The process set forth in section 5101.35 of the Revised Code is available only to applicants, recipients, and their lawfully authorized representatives.

(2) Providers shall not utilize or attempt to utilize the process set forth in section 5101.35 of the Revised Code. Providers shall not appeal or pursue any other legal challenge to a decision resulting from the process set forth in section 5101.35 of the Revised Code.

(3) The Board shall inform the individual, in writing and in a manner the individual can understand, of the individual's right to request a hearing.

(4) The Board shall immediately implement any final state hearing decision or administrative appeal decision relative to free choice of providers for home and community-based services issued by the Ohio Department of Medicaid, unless a court of competent jurisdiction modifies such a decision as the result of an appeal by the Medicaid applicant or recipient.

7.1.1 NON-MEDICAID PROVIDER SELECTION PROCESS

(A) The purpose of this procedure is to establish guidelines by which eligible individuals receiving supported living or respite services and their guardians, if applicable, will select residential service providers. These guidelines shall reflect the options for selection methods. Regardless of the type of selection method chosen by the individual/guardian, the right to choose his/her provider will be maintained. The individual/guardian also has the right to terminate existing provider contracts within the framework established within the contract and to select a new provider using any of the methods outlined in this procedure.

(B) For individuals currently receiving residential services or approved for residential services, the Service and Support Administrator (SSA) will review the provider selection methods during the initial and subsequent ISPs. These methods include the following:

1. Certified provider list maintained by DODD.
2. Interviews arranged by the Board with service providers who appear to be "matched" to the individual's needs/desires

(C) Determination of Services/Supports

1. Once resources are available for an individual to receive residential services, the ISP will be developed or amended to determine the supports and services required to meet the needs of the individual.
2. Concurrently, the individual will be informed of the methods for selection of providers.
3. If the individual is determined to be in emergency need of residential services, the ~~County~~ Board may retain a provider on a temporary basis until such time as the individual is able to participate in the selection process.

(D) Interviews will be arranged by the Board with the individual/guardian and providers who appear to meet the individual's desires/needs upon completion of the ISP to outline services/supports required by the individual. The SSA will inform the individual/guardian of providers who have expressed interest in providing similar services.

(E) Upon selection of a provider by the individual/guardian, a contract will be developed by the Board to specify the obligations and responsibilities of all parties providing services to the individual.

(F) The provider selection process will be reviewed annually, in conjunction with the annual self-review process established by the ~~County~~ Board to ensure that the process is implemented in a manner that allows fair and equitable access.

7.2 HCBS WAIVER ENROLLMENT AND DISENROLLMENT

(A) The purpose of this policy is to establish procedures for the enrollment, denial of enrollment, and disenrollment of individuals in the HCBS waivers.

(B) The Board shall ensure and/or assist the eligible individual with the submission of the application for HCBS waiver enrollment (JFS 2399) to the Pickaway CJFS.

(C) The Board shall notify the Department, in writing, if the Board enters into a contract with a person or government entity for assistance with its Medicaid local administrative authority.

(D) Upon authorization by the Department to enroll eligible individuals in HCBS waivers, the Board shall:

1. Determine the individual's eligibility for Board services. Individuals determined to have an ICF/DD level of care and who meet all other eligibility criteria shall be eligible for HCBS waiver enrollment even if determined not eligible for Board services.

2. Complete the required assessments of the individual in accordance with rules. 5101: 3-3-07,5101: 3-3-15.5

3. Forward to the Department all necessary enrollment information, including a request for an ICF/DD-level of care determination with respect to the individual.

(E). Notification of waiver eligibility is the responsibility of DODD.

(F) Redetermination

1. The Board shall submit an ICF/DD level of care redetermination to the Department in accordance with rule 5101: 3-3-15 and 5101: 3-3-07 of the Administrative Code.
2. Subsequent to initial enrollment in HCBS waivers, the Board shall evaluate the current needs and circumstances of the individual in relationship to the services and activities described on the individual's most current individual service plan (ISP) and recommend appropriate action to the Department, which may include a recommendation to disenroll the individual from the HCBS waiver when one of the following occur:
   a. There is a significant change in the individual's condition as defined in rule 5101: 3-3-15 (B)(10) of the Administrative Code.
   b. The individual is admitted to a nursing facility or ICF/DD or is incarcerated.
   c. The individual fails or refuses to receive services in accordance with the ISP.
   d. The individual interferes with or otherwise refuses to cooperate with the Board and such interference or refusal to cooperate renders the Board unable to perform its Medicaid local administrative authority under section 5126.055 of the Revised Code.
   e. The individual fails to meet the eligibility criteria for enrollment in the HCBS waiver. The individual does not require a monthly waiver service.

(G) When the cost of waiver services for the individual exceeds the amount authorized by CMS for the waiver in which the individual is enrolled, the Board shall evaluate the individual and submit a recommendation to the Department regarding whether or not the individual can remain enrolled in the waiver and have his or her health and welfare assured by one or more of the following measures:

1. Adding more available natural supports;
2. Accessing available non-waiver services, other than natural supports;
3. Accessing additional Medicaid state-plan services; 4.Accessing private health insurance plan benefits; and/ or
4. Sharing supports and services, such as natural supports and non-waiver services, by collaborating with other systems, organizations, agencies, people with and without disabilities.

(H) When the Department proposes to disenroll an individual in accordance with 5123: 2-9-01 (F)(2) or (F)(3)1-09 (1)(2) of the Administrative Code, the Board shall do the following:

1. Offer the individual the opportunity to apply for an alternate HCBS waiver for which the individual is eligible that may more adequately respond to the service needs of the individual, to the extent that such waiver openings exist: and

2. Assist the eligible individual in identifying and obtaining alternative services that are available and may more adequately address the needs of the individual.

(I) Replacement of an individual disenrolled from a waiver may be initiated by the Board and authorized by the Department when the federally authorized limit of participants and federal financial participation for the current waiver year has not been reached.

1. The Board shall replace the disenrolled individual within 90 calendar days from the disenrollment notification with an individual selected pursuant to rule 5123: 2-1-08 of the Administrative Code.
2. Failure of the Board to replace the disenrolled individual within 90 calendar days of the disenrollment notification shall result in a withdrawal of the waiver capacity by the Department.

(J) When the enrollment or denial of enrollment in or disenrollment from an HCBS waiver is proposed, written notice shall be provided to the individual at least fifteen days prior to the proposed action. Notification shall include information informing the individual of his or her right to a state hearing under section 5101.35 of the Revised Code and Chapters 5101: 6-1 to 5101: 6-9 of the Administrative Code. If the individual exercises his or her right to appeal within fifteen days of the date of the notice, the proposed action shall not be taken pending the outcome of the state hearing. When enrollment, denial of enrollment, or disenrollment is proposed because of the Board's recommendation, and the individual requests a state hearing, the Board shall comply with its obligation to participate in the state hearing in accordance with section 5126.055 of the Revised Code. The Department and the Board shall abide by the findings of the state hearing.

7.3 CONSUMER RECORDS FOR ELIGIBLE INDIVIDUALS RECEIVING RESIDENTIAL SERVICES

A. Each eligible individual's official record shall contain, at a minimum:

1. Evidence that the Bill of Rights was reviewed at least annually
2. Consent(s) for services signed by the individual, guardian, or parent of a minor
3. Copies of all assessments used to develop services/supports identified in the individual's Individual Support Plan (ISP)
4. Initial and subsequent ISP's
5. Evidence that ISPs are reviewed at least annually
6. Completed Medication Administration Quality Assurance reviews and documented follow-up
7. Evidence that the eligible individual was provided appropriate notification of any action to withhold, reduce, or terminate services in accordance with rule 5101:6-2-04 of the Administrative Code and County Board Policies (2.19 Administrative Resolution of Complaints)
8. For waiver records, the following information is also required:
    a. Evidence that a level of care was completed at a minimum of every twelve (12) months

b. Confirmation by the Ohio Department of Developmental Disabilities of payment authorization for waiver services (PAWS)
c. Patient liability amounts and identification of contractors to whom each amount is assigned
d. Freedom of Choice Form.
e. Waiver Protocol
f. ODHS 2399 Form (initial application only)

C. Record Retention
1. A permanent record will be made for each consumer receiving services from PCBDD. A "permanent record" will be maintained without limitation. This record will include:
a. The name of the individual
b. The address of the individual
c. The telephone number of the individual
d. General applications for program approval
e. The type of program/service in which the individual was enrolled
2. All other records will be maintained in accordance with federal and state regulations and the Board's records ~~County Recorder's~~ retention schedule. All information will be kept for a minimum of seven years, or longer if required for audit purposes.
3. When data is no longer necessary to the provision of services to an individual, the data will be destroyed in a manner which ensures no unauthorized access to personally identifiable information.
4. Written permission will be requested from the individual, guardian, or parent if a minor prior to the destruction information. The notification will include a description of the type of information to be destroyed and the method to be utilized. Copies of the information may be provided to the individual, guardian, or parent if a minor upon request.

7.4 SUPPORTED LIVING COST CAP

A. Purpose

The Pickaway County Board of Developmental Disabilities has limited resources, including both state and local money, for Supported Living services. In order to provide supports to the most number of people, the Board desires to establish a policy establishing cost controls. The intent of the ensuing policy is to enable the Board to provide Supported Living supports that ensure the health, safety, and welfare of individuals while remaining fiscally accountable.

B. Definition

Supported Living funds shall mean those funds received from the Ohio Department of and Developmental Disabilities for provision of Supported Living services and the local funds allocated by the Board for those services. Individual funds and funds

from other resources specific to an individual shall not be included in the definition of Supported Living funds. Any non-individual-specific funds available to the Board may be included in the local allocation.

C. Policy

The Board shall establish a per person cost ceiling for the annual expenditure of state and local money for the purpose of identified Supported Living services.

The Board shall also establish procedures to create funding categories within the annual cost ceiling. Funding categories will be based upon the level of need and types of services required by the individual.

The Board shall ensure that all Supported Living services are provided in the most effective and efficient manner. This includes ensuring that individuals utilize natural supports and shared services to the greatest extent possible.

In the event that the supports required for any individual currently receiving Supported Living services or for any individual about to receive Supported Living services will require expenditures in excess of the ceiling amount, the Board may require documentation of efforts to secure additional resources, including individual and family supports.

The Board may authorize an increase in the ceiling due to variables such as cost of living, inflation, or demand at any time.

The Board may establish the allowable percentage increase of expenditures for individuals currently receiving Supported Living services.

The ceiling amount or the increase in annual expenditures above the allowable percentage may only be exceeded in the case of an emergency as defined in policy 4.17 and with the approval of the Superintendent or designee.

Any individual or agency may use additional resources to pay for costs above the ceiling or the current annually cost for an individual. Those resources shall not be used to obligate future Board Supported Living funds.

7.5 HEALTH AND RESPITE BUDGET POLICY

A. ELIGIBILITY:
1. Health and Respite Budget refers to local funding set aside by the Board to assist individuals in paying for specific health and respite needs. In order to be considered eligible for Health and Respite Funding, individuals must meet all of the following criteria:
   a. Reside in Pickaway County;
   b. Receive formal services through an ISP or IFSP

2. The Board will determine appropriation and funding limits for Health and Respite Budgets on an annual basis.

B. ELIGIBLE SERVICES:
Approved items and services for purchase through Health and Respite Funding are limited to the cost of items and services directly related to an eligible individual's disability, and are not meant to cover standard or routine costs of living. An individual or guardian may select the provider or vendor of choice. Requested items and services must not be available through an alternate source of payment.

C. REQUEST AND APPROVAL OF FUNDING:
1. The Superintendent or designee will appoint a Health and Respite Committee to evaluate funding requests. The Committee will consist of a three-person panel of Board personnel.
2. Requests for funds must be made through the eligible individual's Service and Support Administrator or Early Intervention Specialist.
3. Requests for funds should be discussed during the annual ISP or IFSP process. The amount of the request will be based on identified needs. Requests submitted outside of the service plan process will only be considered when:
   a. The eligible individual has experienced a significant change in status;
   b. The eligible individual or their representative can demonstrate a need for additional approval of funding.
4. All requests for Health and Respite Budget funds are reviewed by the Health and Respite Committee on a monthly basis. The Committee reserves the right to approve, deny, or approve in part any request.

D. APPEALS:
Decisions by the Committee may be appealed by following the Board's Grievance Policy. A representative of the Board will review this policy with Health and Respite Budget recipients on an annual basis as part of the ISP process.

E. MONITORING:

Allocation usage and service satisfaction will be monitored by SSAs and EI Specialists as part of routine follow-along procedures.

7.6 MENTORSHIP FOR INDIVIDUALS PLACED IN INTEGRATED COMMUNITY EMPLOYMENT

Mentors would be recruited and trained in companies to provide natural supports at job placement sites. The mentorship program will not be available if alternative employment services funding job placement services. Training would be customized for the needs of the individual mentor/company and would be provided by the Transition Services Specialists. Communication of responsibilities and needs would be made clear to all parties. The employer would be paid a small, time- limited stipend, to offset the costs of supervision and possible initial loss of worker productivity. A tiered compensation system allows for extended support, if needed.

Mentorship Incentive

The mentorship would consist of a continuum of training/support provided by the mentor(s) as well as some financial support to the employer. The mentor would ultimately assume the "training/supervision" of the employee in the host company. Financial support to the employers would be pre-established and provided via scheduled stipends.

How It Would Work

1. PCBDD would fund the mentorship program.

2. PCBDD will determine the appropriateness of the mentorship program based on the need to secure employment, maintain employment, or learn new job skills.

3. Fund availability would be coordinated through the Service and Support Administrator and Transition Services Specialist for individual mentorships.

4. A feedback mechanism (e.g., survey) would be developed to solicit the impressions of the staff, workers, families/caregivers, mentors and the employers regarding the program's viability.

5. Workers would have to be employed a minimum of 20 hours per week.

Expected Benefits/Outcomes

1. Increase the number of workers moving into integrated community employment jobs.

2. Increase overall integration within the host companies - i.e., reduce the need for paid job coaches.

3. Increase the employers' overall responsibility for training/supervising workers.

4. Increase workforce/families/caregivers support and confidence regarding working in an integrated workplace.

Financial Support Package

The employer would determine if the mentor would be compensated. This model consists of the following two levels:

Level 1 - This covers the first and second months (1 and 2) of employment and is designed for individuals who may require some amount of extra time to meet the employer's level of expectation. The employer would be compensated in the amount of $300 per month for the first two months. Total compensation for this level would equal $600.

Level 2 - This covers the third and fourth months (3 and 4) of employment and is

designed for individuals who will definitely require more time to meet the employer's expectations. These individuals would require extended time due to productivity issues, severe physical disabilities, or other identifiable concerns at the onset of employment. The employer would be compensated in the amount of $300 per month for these next two months. Total compensation for this level would equal $600.

If the worker does not remain at the worksite for at least one month the employer will be given $100. All increments of $300 will accrue to the employer only if the worker is on the payroll of the employer through each subsequent monthly anniversary date. The individual's team would determine if additional mentoring- i.e., more than the first two months is needed, but not to exceed a total of four months or a total of $1200.

Approved:

Home and Community Based Services Policy, Chapter 7, 8/27/15, Board Action #15-53