Ohio Administrative Code

Rule 5123-9-22 Home and community-based services waivers - community respite under the individual options, level one, and self-empowered life funding waivers.

Effective: January 1, 2024

(A) Purpose

This rule defines community respite and sets forth provider qualifications, requirements for service delivery and documentation of services, and payment standards for the service.

(B) Definitions

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

(1) "Agency provider" means an entity that directly employs at least one person in addition to a director of operations for the purpose of providing services for which the entity is certified in accordance with rule 5123-2-08 of the Administrative Code.

(2) "Community respite" means care and support services furnished to an individual on a short-term basis because of the absence or need for relief of those persons routinely providing care. Community respite is provided outside of an individual's home in a camp, recreation center, or other place where an organized community program or activity occurs.

(3) "Community respite 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 will be added together for the purpose of calculating the number of community respite fifteen-minute billing units for the day.

(4) "Community respite full day billing unit" means a billing unit that will be used when community respite is provided for more than seven hours during the day and the individual stays overnight at the community respite service delivery location.

(5) "Community respite partial day billing unit" means a billing unit that will be used when community respite is provided for between five and seven hours during the day and the individual does not stay overnight at the community respite service delivery location.

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

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

(8) "Funding range" means one of the dollar ranges contained in appendix A to rule 5123-9-06 of the Administrative Code, to which individuals enrolled in the individual options waiver have been assigned for the purpose of funding 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.

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

(10) "Independent provider" means a self-employed person who provides services for which the person is certified in accordance with rule 5123-2-09 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, the person's guardian in accordance with section 5126.043 of the Revised Code or other person authorized to give consent.

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

(13) "Ohio developmental disabilities profile" means the standardized instrument utilized 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.

(14) "Participant-directed homemaker/personal care" has the same meaning as in rule 5123-9-32 of the Administrative Code.

(15) "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 includes the items delineated in paragraph (E) of this rule to validate payment for medicaid services.

(16) "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) Provider qualifications

(1) Community respite will be provided by an agency provider that meets the requirements of this rule and that has a medicaid provider agreement with the Ohio department of medicaid.

(2) Community respite will not be provided by an independent provider, a county board, or a regional council of governments formed under section 5126.13 of the Revised Code by two or more county boards.

(3) An applicant seeking approval to provide community respite will complete and submit an application and adhere to the requirements of rule 5123-2-08 of the Administrative Code.

(4) Failure of a certified provider to comply with this rule and rule 5123-2-08 of the Administrative Code may result in denial, suspension, or revocation of the provider's certification.

(5) Failure of a licensed provider to comply with this rule and Chapter 5123-3 of the Administrative Code may result in denial, suspension, or revocation of the provider's license.

(6) A provider of community respite will provide written assurance and ensure that all employees,

contractors, and employees of contractors delivering community respite hold the required certification or license (e.g., water safety instructor) and are trained for any specialized activity (e.g., high ropes or archery) in which an individual may participate.

(D) Requirements for service delivery

(1) Community respite will be provided pursuant to an individual service plan that conforms to the requirements of rule 5123-4-02 of the Administrative Code.

(2) The individual service plan will address emergency and replacement coverage should the individual unexpectedly need to leave the community respite service delivery location.

(3) Community respite is limited to sixty calendar days of service per waiver eligibility span.

(4) Community respite will not be simultaneously provided to an individual at the same location where homemaker/personal care or participant-directed homemaker/personal care is being provided to that individual.

(5) Community respite will not be provided in any residence.

(6) Community respite will not be simultaneously provided at the same location where adult day services are being provided.

(E) Documentation of services

Service documentation for community respite will include each of the following to validate payment for medicaid services:

(1) Type of service (i.e., community respite full day billing unit, community respite partial day billing unit, or community respite fifteen-minute billing unit).

(2) Date of service.

(3) Place of service.

(4) Name of individual receiving service.

(5) Medicaid identification number of individual receiving service.

(6) Name of provider.

(7) Provider identifier/contract number.

(8) Date and time of the individual's arrival at and departure from the community respite service delivery location.

(9) Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider.

(10) Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided.

(F) Payment standards

(1) The billing units, service codes, and payment rates for community respite provided January 1, 2024 through June 30, 2024 are contained in appendix A to this rule. The billing units, service codes, and payment rates for community respite provided on or after July 1, 2024 are contained in appendix B to this rule.

(a) The community respite full day billing unit will be used when community respite is provided for more than seven hours during the day and the individual stays overnight at the community respite service delivery location. Only one provider of community respite will use the community respite full day billing unit on any given day.

(b) The community respite partial day billing unit will be used when community respite is provided for between five and seven hours on a given day and the individual does not stay overnight at the

community respite service delivery location.

(c) The community respite fifteen-minute billing unit will be used for all other community respite scenarios not addressed in paragraph (F)(1)(a) or (F)(1)(b) of this rule.

(d) The community respite full day billing unit, the community respite partial day billing unit, and the community respite fifteen-minute billing unit will not be combined during the same calendar day for the same individual.

(2) Payment rates for community respite are based on the county cost-of-doing-business category. The cost-of-doing-business categories are contained in appendix C to this rule.

(3) Payment rates for community respite will be adjusted by the behavioral support rate modification to reflect the needs of an individual requiring behavioral support upon determination by the department that the individual meets the criteria set forth in paragraph (F)(3)(a) of this rule.

(a) The department will determine that an individual meets the criteria for the behavioral support rate modification when:

(i) The individual has been assessed within the last twelve months to present a danger to self or others or have the potential to present a danger to self or others; and

(ii) A behavioral support strategy that is a component of the individual service plan has been developed in accordance with the requirements in rules established by the department; and

(iii) The individual either:

(A) Has a response of "yes" to at least four items in question thirty-two of the behavioral domain of the Ohio developmental disabilities profile; or

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

(b) The duration of the behavioral support rate modification is limited to the individual's waiver eligibility span, may be determined needed or no longer needed within that waiver eligibility span, and may be renewed annually.

(c) The purpose of the behavioral support rate modification is to provide funding for the implementation of behavioral support strategies by staff who have the level of training necessary to implement the strategies; the department retains the right to verify that staff who implement behavioral support strategies have received training (e.g., specialized training recommended by clinicians or the team or training regarding an individual's behavioral support strategy) that is adequate to meet the needs of the individuals served.

(4) Payment rates for community respite will be adjusted by the medical assistance rate modification to reflect the needs of an individual requiring medical assistance upon determination by the county board that the individual meets the criteria set forth in paragraph (F)(4)(a) of this rule.

(a) The county board will determine that an individual meets the criteria for the medical assistance rate modification when:

(i) The individual requires the administration of fluid, nutrition, and/or prescribed medication through gastrostomy or jejunostomy tube; and/or requires the administration of insulin through subcutaneous injection, inhalation, or insulin pump; and/or requires the administration of medication for the treatment of metabolic glycemic disorder by subcutaneous injection; or

(ii) The individual requires a nursing procedure or nursing task that a licensed nurse agrees to delegate in accordance with rules in Chapter 4723-13 of the Administrative Code, which is provided in accordance with section 5123.42 of the Revised Code, and when such procedure or nursing task is not the administration of oral prescribed medication, topical prescribed medication, oxygen, or metered dose inhaled medication, or a health-related activity as defined in rule 5123-6-01 of the Administrative Code.

(b) The duration of the medical assistance rate modification is limited to the individual's waiver eligibility span, may be determined needed or no longer needed within that waiver eligibility span, and may be renewed annually.

(5) Community respite provided to individuals enrolled in the individual options waiver is subject to the funding ranges and individual funding levels set forth in rule 5123-9-06 of the Administrative Code.

(6) Payment for community respite does not include payment for room and board or transportation.