POLICY 1900

Home and Community Based Waiver Waiting List

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1900.00 Purpose

The purpose of this Policy is to set forth a process for the Ohio Department of Developmental Disabilities (ODDD) and the county board of developmental disabilities to define requirements for the Home and Community Based Waiver Waiting List.

1900.01 Applicability

This Policy applies to individuals who are seeking a Home and Community-Based Waiver to support their needs that cannot be otherwise supported by local community resources.

1900.02 Definitions

(1) "Adult" means an individual who is eighteen years of age or older.

(2) "Alternative services" means the various programs, funding mechanisms, services, and supports, other than home and community-based services, that exist as part of the developmental disabilities service system and other service systems. "Alternative services" includes, but is not limited to, services offered through Ohio's Medicaid state plan such as home health services and services available at an intermediate care facility for individuals with intellectual disabilities.

(3) "Community-based alternative services" means alternative services in a setting other than a hospital, an intermediate care facility for individuals with intellectual disabilities, or a nursing facility.

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

(5) "Current need" means an unmet need for home and community-based services within twelve months, as determined by a county board based upon assessment of

the individual using the waiting list assessment tool. Situations that give rise to current need include:

(a) An individual is likely to be at risk of substantial harm due to:

(i) The primary caregiver's declining or chronic physical or psychiatric condition that significantly limits his or her ability to care for the individual;

(ii) (ii) Insufficient availability of caregivers to provide necessary supports to the individual

(iii) The individual's declining skills resulting from a lack of supports.

(b) An individual has an ongoing need for limited or intermittent supports to address behavioral, physical, or medical needs, in order to sustain existing caregivers and maintain the viability of the individual's current living arrangement. (c) An individual has an ongoing need for continuous supports to address significant behavioral, physical, or medical needs.

(c) An individual is aging out of or being emancipated from children's services and has needs that cannot be addressed through community-based alternative services.

(d) An individual requires waiver funding for adult day services or employment related supports that are not otherwise available as vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973, 29 U.S.C. 730, as in effect on the effective date of this rule, or as special education or related services as those terms are defined in section 602 of the

Individuals with Disabilities Education Improvement Act of 2004, 20 U.S.C. 1401, as in effect on the effective date of this rule.

(e) An individual is living in an intermediate care facility for individuals with intellectual disabilities or a nursing facility and has a viable discharge plan.

(6) "Date of request" means the earliest date and time of any written or otherwise documented request for home and community-based services made prior to the effective date of this rule September 1, 2018.

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

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

(9) "Immediate need" means a situation that creates a risk of substantial harm to an individual, caregiver, or another person if action is not taken within thirty calendar days to reduce the risk. Situations that give rise to immediate need include:

(a) A resident of an intermediate care facility for individuals with intellectual disabilities has received notice of termination of services in accordance with rule 5123:2-3-05 of the Administrative Code.

(b) A resident of a nursing facility has received thirty-day notice of intent to discharge in accordance with Chapter 5160-3 of the Administrative Code. 5123-9-04 3

(c) A resident of a nursing facility has received an adverse determination in accordance with rule 5123:2-14-01 of the Administrative Code.

(d) An adult is losing his or her primary caregiver due to the primary caregiver's declining or chronic physical or psychiatric condition or due to other

unforeseen circumstances (such as military deployment or incarceration) that significantly limit the primary caregiver's ability to care for the individual when:

(i) Impending loss of the caregiver creates a risk of substantial harm to the individual; and

(ii) There are no other caregivers available to provide necessary supports to the individual.

(e) An adult or child is engaging in documented behavior that creates a risk of substantial harm to the individual, caregiver, or another person.

(f) There is impending risk of substantial harm to the individual or caregiver as a result of:

(i) The individual's significant care needs (i.e., bathing, lifting, high demand, or twenty-four-hour care); or

(ii) The individual's significant or life-threatening medical needs.

(g) An adult has been subjected to abuse, neglect, or exploitation and requires additional supports to reduce a risk of substantial harm to the individual.

(10) “Individual" means a person with a developmental disability.

(11) "Intermediate care facility for individuals with intellectual disabilities" has the same meaning as in section 5124.01 of the Revised Code.

(12) "Locally-funded home and community-based services waiver" means the county board pays the entire nonfederal share of Medicaid expenditures in accordance with sections 5126.059 and 5126.0510 of the Revised Code.

(13) "Nursing facility" has the same meaning as in section 5165.01 of the Revised Code.

(14) "Service and support administration" means the duties performed by a service and support administrator pursuant to section 5126.15 of the Revised Code.

(15) "State-funded home and community-based services waiver" means the department pays, in whole or in part, the nonfederal share of Medicaid expenditures associated with an individual's enrollment in the waiver.

(16) "Status date" means the date on which the individual is determined to have a current need based on completion of an assessment of the individual using the waiting list assessment tool.

(17) "Transitional list of individuals waiting for home and community-based services" means the list maintained in the department's web-based individual data system which shall include the name and date of request for each individual on a list of individuals waiting for home and community-based services on August 31, 2018 established in accordance with rule 5123:2-1-08 of the Administrative Code as that rule existed on August 31, 2018.

(18) "Waiting list assessment tool" means the Ohio assessment for immediate need and current need contained in the appendix to this rule, which shall be used for purposes of making a determination of an individual's eligibility to be added to the waiting list for home and community-based services defined in paragraph (B)(20) of this rule and administered by persons who successfully complete training developed by the department.

(19) "Waiting list date" means, as applicable, either:

(a) The date of request for an individual whose name is included on the transitional list of individuals waiting for home and community-based services; or

(b) The earliest status date for an individual whose name is not included on the transitional list of individuals waiting for home and community-based services.

(20) "Waiting list for home and community-based services" means the list established by county boards and maintained in the department's web-based waiting list management system which shall include the name, status date, date of request (as applicable), waiting list date, and the criteria for current need by which an individual is eligible based on administration of the waiting list assessment tool, for each individual determined to have a current need on or after September 1, 2018.

1900.03 Wait List Assessment Requests

(1) individual, or their guardian, may request a wait list assessment when they think the individual has an immediate or current need by contacting the county board. The wait list assessment is completed within thirty calendar days after the initial request is made by the individual or their guardian.

(2) Results of the wait list assessment are communicated to the individual and/or their guardian and access is given to view the results of the assessment through the Department’s web-based waiting list management system or being provided a paper copy by the county board upon request.

1900.04 Waiver Waiting List

(1) There are three outcomes from a wait list assessment – Immediate Need, Current Need, or No Need Identified. When an individual presents with an Immediate Need or Current Need, the individual is eligible for county board services, and has a need that cannot be met by community-based alternative services (including a need despite the individual's enrollment in a home and community-based services waiver).

(2) Individuals with an assessed Immediate Need are not placed on the waiting list rather they are given two options to meet the individual's needs within thirty (30) calendar days:

  (a) Intermediate Care Facility (ICF) for individuals with intellectual disabilities.

  (b) HCBS Waiver that's appropriate to the individual's needs (Level One, SELF or Individual Options)

(3) Individuals identified with a current need have been determined to have a condition that is:

  (a) Attributable to a mental or physical impairment or combination of mental and physical impairments, other than an impairment caused solely by mental illness.

  (b) Manifested before the individual is age twenty-two; and

  (c) Likely to continue indefinitely; and

  (d) Has a current need which cannot be met by community-based alternative services in the county where the individual resides (including a situation in

which an individual has a current need despite the individual's enrollment in a HCBS waiver).

(4) For individuals who present as having a current need, they are placed on the waiting list for a home and community-based services waiver and their placement on the wait list is based on the weighted results of the answers provided on the assessment. The order for enrolling individuals in locally funded HCBS waivers will be as per the guidelines in OAC 5123-9-04.

(a) Under any circumstances should an individual's status change regarding having an immediate need and/or having a current need or an individual's status date has changed, the Medicaid Manager or designee shall:

(i) Update the individual’s wait list assessment for entry in DODD’s web-based system.

(ii) Update the individual’s record in DODD's web-based waiting list management system.

(b) Annually, a county board shall review the waiting list assessment tool and service needs of everyone whose name is included on the waiting list for HCBS with the individual and the individual’s guardian, as applicable, and assist in identifying and accessing alternative services.

(c) Upon an individual with a current need being identified for a HCBS allocation, the individual (or their guardian) is notified by a phone call which waiver they’re being offered. They are also informed of the two options (ICF or HCBS waiver) to determine which best meets the individual’s needs. A

follow-up letter will be sent to the individual and/or guardian when no response to attempted phone contacts is made.

(d) Once an individual or individual's guardian accepts the waiver allocation, they are notified who the assigned SSA is and that they will be contacted to begin the waiver application process.

1900.05 Due Process

(1) Due Process is given to each individual or their guardian upon initial notification of the wait list assessment results and upon allocation of HCBS for the individual (in accordance with section 5160.31 of the Revised Code and Chapters 5101:6-1 to 5101:6-9 of the Administrative Code) by an action of CCBDD related to:

(a) The approval, denial, withholding, reduction, suspension, or termination of a service funded by the state Medicaid program.

(b) Placement on, denial of placement on, or removal from the waiting list HCBS of individuals waiting for HCBS; or,

(c) A dispute regarding an individual's date of request or status date.

1900.06 Status Changes that Impact Waiting List

(1) Under the following circumstances the Medicaid manager or designee may remove an individual from the waiting list for HCBS:

(a.) When CCBDD determines that the individual no longer has a condition:

(i) Attributable to a mental or physical impairment or combination of mental and physical impairments, other than an impairment caused solely by mental illness.

(ii) Manifested before the individual is age twenty-two; and

(iii) Likely to continue indefinitely; and

(iv) Has a current need which cannot be met by community-based alternative services in the county where the individual resides (including a situation in which an individual has a current need despite the individual's enrollment in a HCBS waiver).

(b) Individual no longer has a current need

(c) Upon request of the individual or the individual's guardian, as applicable

(d) Upon enrollment of the individual in a HCBS waiver that meets the individual's needs

(e) If the individual or the individual's guardian, as applicable, declines enrollment in a HCBS waiver or community-based alternative services that are sufficient to meet the individual's needs

(f) If the individual or the individual's guardian, as applicable, fails to respond to attempts by the Medicaid Manager or designee to contact the individual or the individual's guardian by at least two different methods, one of which shall be certified mail to the last known address of the individual or the individual's guardian, as applicable. Second attempt will be a phone call to the last known phone number on file.

(g) When the Medicaid Manager or designee determines the individual does not have a developmental disabilities level of care in accordance with rule 5123:2-9-04 of the Administrative Code

(h) When the individual is no longer a resident of Ohio, or

(i) Upon the individual's death.

(j) When an individual is not eligible to receive Medicaid.

(2) When an individual on the waiting list for HCBS moves from another county to Clermont, the Medicaid Manager or designee shall review the individual's waiting list assessment tool within 90 calendar days of receiving notice.

(a) The Medicaid Manager or designee shall update the individual's county of residence in DODD's web-based waiting list management system without changing the status date or date of request assigned by the previous county board.

(b) Medicaid Manager or designee determines that the individual has a current need which can be met by community-based alternative services in the receiving county, the Community Services and Support – SSA is notified by email with the request to assist the individual or the individual's guardian, as applicable, in identifying and accessing those services.

1900.07 Administrative Review and Allocation of HCBS Waivers

(1) CCBDD shall, in conjunction with development of its plan described in section 5126.054 of the Revised Code and its strategic plan described in rule 5123-4-01 of the Administrative Code, identify how many individuals the county board plans to enroll in each type of locally funded HCBS waiver during each calendar year. The number of HCBS waivers is based on projected funds available to the county board to pay the nonfederal share of the Medicaid expenditures and the assessed needs of the county's residents on the waiting list for home and community-based services.

(2) Monthly, the Medicaid Waiver Team meets to review the current waiting list and allocate waivers based on the next 90-day cycle of enrollment.

(3) Once an individual is allocated a HCBS waiver, and the individual accepts the waiver, a Waiver SSA is assigned. The Medicaid Manager works with the identified Waiver SSA assigned to complete the Waiver Application for HCBS enrollment within 90-days of the individual's waiver allocation.