

5123:2-9-06

Home and community-based services waivers - payment for waiver services.**(A) Purpose**

The purpose of this rule is to establish the standards governing payment for home and community-based services (HCBS) under components of the medicaid program that the Ohio department of developmental disabilities administers pursuant to section 5111.871 of the Revised Code.

(B) Definitions

- (1) "Agency provider" means an entity, including a county board of developmental disabilities, that employs persons for the purpose of providing services for which the entity must be certified under rules adopted by the department.
- (2) "Cost projection and payment authorization" means the process followed and the form used by county boards of developmental disabilities (including the payment authorization for waiver services or "PAWS," until such time that the PAWS is replaced by the cost projection tool) to communicate the frequency, duration, scope, and amount of payment requested for each HCBS waiver service that is identified in the individual service plan.
- (3) "Cost projection tool" (CPT) means the web-based analytical tool, developed and administered by the department, used to project the cost of HCBS waiver services identified in the individual service plans of individuals enrolled on individual options and level one HCBS waivers. The department shall publish any changes to the CPT thirty days prior to implementation.
- (4) "County board" means a county board of developmental disabilities that performs HCBS waiver administration functions.
- (5) "Department" means the Ohio department of developmental disabilities as established by section 121.02 of the Revised Code.
- (6) "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.
- (7) "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 services for individuals enrolled on the individual options waiver. 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.
- (8) "Guardian" means a guardian appointed by the probate court under Chapter 2111. of the Revised Code. If the individual is a minor, "guardian" means the

individual's parents. If no guardian has been appointed for a minor under Chapter 2111. of the Revised Code 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" 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.

- (9) "Home and community-based services" (HCBS) has the same meaning as in section 5126.01 of the Revised Code.
- (10) "Independent provider" means a self-employed person who provides services for which he or she must be certified under rule 5123:2-2-01 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 mental retardation or other developmental disability. A guardian may take any action on behalf of the individual, may make choices for the individual, or may receive notice on behalf of the individual to the extent permitted by applicable law.
- (12) "Individual funding level" means the total funds, calculated on a twelve-month basis, that result from applying the rates in appendix A to this rule to the units of all waiver services other than adult day services and non-medical transportation services, established by the individual service plan development process to be sufficient in frequency, 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 paid in accordance with this rule shall be within or below the funding range assigned to the individual as the result of administration of the Ohio developmental disabilities profile.
- (13) "Individual service plan" (ISP) means the written description of services, supports, and activities to be provided to an individual in accordance with paragraph (H) of rule 5101:3-40-01 of the Administrative Code or paragraph (H) of rule 5101:3-42-01 of the Administrative Code, as applicable.
- (14) "ODJFS" means the Ohio department of job and family services as established by section 121.02 of the Revised Code.
- (15) "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 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 this rule.

- (16) "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.
- (17) "Provider" means an agency provider or independent provider that:
- (a) Is certified by the department to provide HCBS waiver services; and
 - (b) Has a medicaid provider agreement from ODJFS.
- (18) "Service and support administrator" (SSA) 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.
- (19) "Team" has the same meaning as in rule 5123:2-1-11 of the Administrative Code.
- (20) "Transportation" means an approved waiver service offered in order to enable individuals served on a 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. Transportation services under the waiver shall be offered in accordance with the ISP.
- (21) "Waiver eligibility span" means the twelve-month period following either an individual's initial enrollment date or the subsequent eligibility re-determination date.
- (C) Funding ranges and individual funding levels for individuals enrolled on the individual options waiver
- (1) Individuals shall be assigned to a funding range based on completion and scoring of the ODDP. The ODDP 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 and medical assistance 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) The SSA shall ensure that an ODDP is accurately completed and shall inform the individual of his/her assigned funding range resulting from the ODDP score 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) 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 adult day services and non-medical transportation services, resulting from the completion of the ISP planning process to calculate the individual funding level.
- (5) 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.
- (6) 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 number 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 services available for the individual's use during the remainder of the waiver eligibility span.
- (7) The county board shall complete the cost projection and payment authorization and the SSA shall ensure waiver services are initiated for an individual whose funding level is within the funding range determined by an ODDP assessment. The SSA shall 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.
- (8) When the individual funding level 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 an individual 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 the funding level is approved, the county board shall ensure the cost projection and payment authorization is completed and waiver services are initiated.

- (c) If, through the prior authorization process, the request for the funding level is denied, the SSA shall continue 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 ensure the cost projection and payment authorization is completed and shall ensure waiver services are initiated.
- (ii) If an ISP that meets these conditions cannot 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.
- (9) When the funding level of an individual is below the assigned funding range, the SSA shall:
- (a) Coordinate an ISP planning process to ensure that the services reflected in the ISP are sufficient to meet the health and welfare needs of the individual.
- (b) Ensure waiver services are initiated and ensure completion of the cost projection and payment authorization.
- (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.
- (10) The department shall use the twelve-month period following either an individual's initial enrollment date or the subsequent eligibility 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.
- (11) The department shall periodically re-examine the scoring of the ODDP and the linkage of the scores to the funding ranges.

(D) Payment limitations under the level one waiver

(1) Payment for any one or combination of more than one of the following services under the level one waiver is subject to a five thousand dollar benefit package limitation in twelve-month increments, beginning with the effective date of an individual's enrollment and continuing during each subsequent twelve-month period:

(a) Homemaker/personal care (routine).

(b) Homemaker/personal care (on-site/on-call).

(c) Informal respite.

(d) Institutional respite (ICFMR).

(e) Institutional respite (department-licensed facility).

(f) Transportation.

(2) In accordance with rule 5123:2-8-11 of the Administrative Code, payment for emergency assistance for any one or combination of more than one service shall not exceed eight thousand dollars for three consecutive years, beginning with the effective date of an individual's enrollment and continuing during each subsequent three-year period.

(E) Changes to individual funding levels and funding ranges

(1) The individual funding level may increase or decrease based on the outcome of the ISP planning process. In no instance shall 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 (C) of this rule. Changes to individual funding levels are subject to review by the department. Prior state level review shall not 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) A funding range established for an individual shall change only when changes in assessment variable scores on the ODDP justify assignment of a new funding range. Any or all ODDP variables may 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 pursuant to section 5101.35 of the Revised Code concerning the approval, denial, reduction, or termination of services.

(F) Behavior support and medical assistance rate modifications for homemaker/personal care (HPC) services

(1) Payment rates for routine HPC may be modified to reflect the needs of individuals requiring behavior support and individuals requiring medical assistance. Only individuals meeting criteria established by the department as specified in paragraphs (F)(2)(b) and (F)(3) of this rule shall be eligible for these rate modifications. Upon determination by the county board that the individual meets the criteria, 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 behavior support and/or medical assistance 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 shall be renewed annually at the individual's eligibility re-determination date if the individual continues to meet the criteria. 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.

(2) The behavior support rate modification is applicable to routine HPC services only and shall 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 billing unit of service is contained in appendix A to this rule.

(a) 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) The individual presents a danger to self or others or has been assessed to have the potential to present a danger; and

(ii) A behavior support plan that is a component of the individual's ISP

has been developed in accordance with the requirements in rules established by the department; and

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

(iv) The individual either:

(a) Responds "yes" to at least four items in question number thirty-two of the behavior domain of the ODDP; or

(b) 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 (F)(2)(b) of this rule have been met, the county board shall apply 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 accordance with paragraph (F)(2)(b)(iii) of this rule.

(3) The medical assistance rate modification is applicable to routine HPC services only and shall be paid during all times when routine HPC services are provided to an individual who qualifies for the modification. The amount of the medical assistance rate modification for each fifteen-minute billing unit of service is contained in appendix A to this rule. The county board shall apply the medical assistance rate modification when the following criteria have been met:

(a) An individual requires routine feeding and/or the administration of prescribed medications through gastrostomy and/or jejunostomy tubes, and/or requires the administration of routine doses of insulin through subcutaneous injections and insulin pumps; or

(b) An 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 or topical medication or a health-related activity as defined in rule 5123:2-6-01 of the Administrative Code.

(G) On-site/on-call payment rate for HPC services

(1) 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.

(2) A provider shall be paid at the on-site/on-call rate for HPC services contained in appendix A to this rule when:

(a) 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

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

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

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

(3) 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.

(4) Neither the behavior support nor the medical assistance rate modification is applicable to the on-site/on-call payment rates for HPC services.

(H) Staffing ratios

(1) ISPs shall indicate the typical ratios at which services are to be delivered, as defined in appendix A to this rule, when individuals share services, regardless of funding source.

(2) The base rate paid to a provider for HPC services shall be adjusted to reflect the number 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.

(3) In those situations where more than 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 service codes and payment rates established in appendix A to this rule to indicate both staff size and group size.

- (4) Group size shall be identified on the claim for payment submitted by the provider to the department for each waiver service, other than HPC daily billing unit, delivered.
- (5) Staffing 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.

(I) Projection of the cost of an individual's services

- (1) Prior to the beginning of an individual's waiver eligibility span, the individual's SSA or other county board designee shall prepare a projection of the annual cost of every individual options or level one waiver service that is authorized in the ISP for the waiver eligibility span using the cost projection tool (CPT) developed by the department.
- (2) The cost projection shall be based on staffing ratios and the total estimated number of service units the individual is expected to receive in accordance with his/her ISP during the waiver eligibility span.
- (3) The total number of service units shall be determined with input from the individual's team as part of the ISP development process.
- (4) The CPT shall project the cost of services based on the rates established in Chapters 5123:2-9 and 5123:2-13 of the Administrative Code.
- (5) Rule 5123:2-9-31 of the Administrative Code shall govern the circumstances when an individual receives the HPC daily billing unit.
- (6) The CPT shall be utilized to project costs based on medicaid payment rates for individuals, regardless of funding source, who share services with HCBS waiver enrollees.
- (7) The individual's provider shall have access to the CPT including but not limited to the detail and summary information. At the request of the individual, other persons shall have access to the detail and summary information in the CPT.

- (8) When changes occur that the team determines affect the total estimated direct service hours, the county board shall enter changes to the CPT. These changes shall be made along with any necessary changes to the ISP, daily rate application, cost projection and payment authorization, and prior authorization request (as applicable) for the individual(s) affected by the changes.
- (9) Beginning December 31, 2010, county boards shall complete a cost projection using the CPT when an individual is initially enrolled on an individual options or level one waiver and when an individual is annually re-determined eligible for continued enrollment on an individual options or level one waiver. CPT will be the only authorized cost projection instrument on and after December 31, 2010.

(J) Payment for waiver services

- (1) Providers shall be paid at the lesser of their usual and customary rate (UCR) or the statewide 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 contained 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.
- (2) The billing units, service codes, and payment rates for waiver services are included in appendix A to this rule or in service-specific rules in Chapters 5123:2-9 and 5123:2-13 of the Administrative Code.
- (3) Payment rates for HPC services shall be established separately for services provided through agency providers and for services provided by independent providers. HPC services extend to those times when the individual is not physically present and the provider is performing homemaker activities on behalf of the individual.
- (4) 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 for the preponderance of time. The cost-of-doing-business categories and the counties assigned to each are contained in appendix B to this rule.
- (5) Payment for HPC does not include room and board, items of comfort or convenience, or costs for the maintenance, upkeep, and improvement of the

home.

- (6) Payment rates for interpreter services, nutrition services, and social work services shall be established separately for services provided through agency providers and for services provided by independent providers and shall include an adjustment for geography based on the county cost-of-doing-business category contained in appendix B to this rule.
- (7) Payment rates for transportation services shall be based on the internal revenue service mileage allowance as established in appendix A to this rule. When more than one individual is receiving transportation, the number of individuals in the group shall be determined by totaling the number of individuals, regardless of funding source, for whom transportation is being provided. Transportation services extend to those times when the individual is not physically present and the provider is performing transportation on behalf of the individual.
- (8) The department shall periodically collect payment information 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 rates 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 payment is consistent with efficiency, economy, and quality of care.
- (9) Payment for an HCBS waiver service constitutes payment in full. Payment shall be made for HCBS waiver services when:
- (a) The service is identified in an approved ISP;
 - (b) The service is recommended for payment through the cost projection and payment authorization process; and
 - (c) The service is provided by a provider selected by an individual enrolled on the waiver.
- (10) Payment for waiver services shall not exceed amounts authorized through the cost projection and payment authorization for the individual's corresponding waiver eligibility span.

(K) Claims for payment for HCBS waiver services

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

- (2) Claims for payment for HCBS waiver services shall be submitted to the department in the format prescribed by the department. 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. Claims for payment shall include the number of units of service. Except for claims for HPC daily billing unit, claims for payment shall include the number 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 the HCBS waiver service provider that provides the preponderance of HCBS waiver services. 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.
- (6) Claims for payment for environmental accessibility adaptations and personal

emergency response systems 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 auditor of state 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) Overpayments, duplicate payments, payments for services not rendered, payments for which there is no documentation of services delivered, or payments for services not in accordance with an approved ISP are recoverable by the department, ODJFS, the auditor of state, or the office of the attorney general. All recoverable amounts are subject to the application of interest in accordance with rule 5101:3-1-25 of the Administrative Code.

(9) Providers of HCBS waiver services 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 auditor of state. Providers who fail to produce the records requested within thirty days following the request shall be subject to decertification and/or loss of their medicaid provider agreement.

(L) 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 on or excluded from an ISP or individual behavior plan addendum. A change in staff to waiver recipient service ratios does not automatically result in a change in the level of services received by an individual.

(M) ODJFS authority

ODJFS retains final authority to establish funding ranges for waiver services; to establish payment rates for waiver services; to review, revise, and approve any element of the decision process resulting in a determination to make a behavior support or medical assistance modification to the HPC payment rate; to review and approve each service identified in an ISP that is funded through an HCBS waiver and the payment rate for the service; and to authorize the provision of and payment for waiver services through the cost projection and payment authorization.

Replaces: 5123:2-9-06
Effective: 07/01/2010
R.C. 119.032 review dates: 07/01/2015

CERTIFIED ELECTRONICALLY

Certification

06/21/2010

Date

Promulgated Under: 119.03
Statutory Authority: 5123.04, 5111.871, 5111.873
Rule Amplifies: 5123.04, 5111.871, 5111.873
Prior Effective Dates: 07/01/2005, 07/01/2007, 12/21/2007 (Emer.),
03/20/2008