

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in section 1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The state has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid state plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A state has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Ohio** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:

Self Empowered Life Funding (SELF) Amendment July 1, 2026

C. Waiver Number: OH.0877

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)

07/01/26

Approved Effective Date of Waiver being Amended: 07/01/25

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

Ohio is making changes to the SELF waiver to update how services are described and to update the responsibilities of Service and Support Administrators.

The following changes have been made:

Main Section B Optional Information

Added public comment summary and additional information for I-2-a Rate Methodology for Environmental Accessibility Adaptations.

Appendix B Participant Access and Eligibility

B-6-f Process for level of care evaluation: Modified text to include an in-person review.

Appendix C Participant Services

C-1-a- Service Specification:

Environmental Accessibility Adaptations has been added as a new service.

Services updated:

Adult Day Support

- Added guidelines for where services can take place to meet federal HCBS requirements.
- Added requirements for environmental health and safety to meet federal guidelines.
- Added a definition for “small group”.
- Updated provider qualifications to include required training.

Environmental Accessibility Adaptations

- Clarified that the service includes home modifications inside and outside the home to support community living and safety.
- Repairs to previously approved adaptations are now allowed.
- Specified which types of modifications are not allowed.
- Service must be based on a need identified by a qualified professional.
- Added requirements for submitting a bid.
- Independent providers cannot use subcontractors.
- Providers must confirm work meets local and state codes.

Vehicle Modifications

- Raised doors are now allowed as a modification.
- Clarified what invoice documentation is needed for factory-installed adaptations on new vehicle purchases.
- Added that moving adaptable equipment from one vehicle to another is an allowable cost.

C-4-a Additional Limits on Participant Services:

Added environmental accessibility adaptation to show cost limit of \$15,000.

Appendix C Quality Improvement:

Added a new performance measure that monitors provider non-residential settings for compliance to the HCBS settings rule.

Appendix D Participant-Centered Planning and Service Delivery

D-1-a Responsibility for Service Plan Development:

Updated training requirements for Service and Support Administrators.

D-1-d-i Service Plan Development process:

Added the following requirements:

- Initial assessments and reassessments are to be conducted in person.
- Service plans must include at least one outcome to be achieved within 12 months.
- Requested ISP revisions must be completed within 30 calendar days.

D-2-a Service Plan Implementation and Monitoring:

Added service plan monitoring guidelines including:

- Regular in-person visits at home and day service settings.
- Enhanced monitoring or unscheduled visits when necessary to protect the individual's health and welfare.

Appendix I Financial Accountability

I-2-a- Rate Determination Methods:

Added rate methodology for Environmental Accessibility Adaptations

Appendix J Cost Neutrality Demonstration

J-2-d- Estimate of Factor D:

Updated Waiver Years 2, 3, 4, 5

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
Waiver Application	Main B
Appendix A - Waiver Administration and Operation	
Appendix B - Participant Access and Eligibility	B-6-f
Appendix C - Participant Services	C-1-a, C-4-a, C Quality Improvement
Appendix D - Participant Centered Service Planning and Delivery	D-1-a, D-1-d-i, D-2-a
Appendix E - Participant Direction of Services	
Appendix F - Participant Rights	
Appendix G - Participant Safeguards	
Appendix H	
Appendix I - Financial Accountability	I-2-a
Appendix J - Cost-Neutrality Demonstration	J-2-d

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (*check*

each that applies):

Modify target group(s)

Modify Medicaid eligibility

Add/delete services

Revise service specifications

Revise provider qualifications

Increase/decrease number of participants

Revise cost neutrality demonstration

Add participant-direction of services

Other

Specify:

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Ohio** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of section 1915(c) of the Social Security Act (the Act).

B. Program Title (optional - this title will be used to locate this waiver in the finder):

Self Empowered Life Funding (SELF) Amendment July 1, 2026

C. Type of Request: amendment

Requested Approval Period: (For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)

3 years 5 years

Draft ID: OH.014.03.02

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/25

Approved Effective Date of Waiver being Amended: 07/01/25

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search

existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

Hospital

Select applicable level of care

Hospital as defined in 42 CFR § 440.10

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR § 440.160

Nursing Facility

Select applicable level of care

Nursing Facility as defined in 42 CFR § 440.40 and 42 CFR § 440.155

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR § 440.140

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

Services furnished under the provisions of section 1915(a)(1)(a) of the Act and described in Appendix I

Waiver(s) authorized under section 1915(b) of the Act.

Specify the section 1915(b) waiver program and indicate whether a section 1915(b) waiver application has been submitted or previously approved:

Specify the section 1915(b) authorities under which this program operates (*check each that applies*):

section 1915(b)(1) (mandated enrollment to managed care)

section 1915(b)(2) (central broker)

section 1915(b)(3) (employ cost savings to furnish additional services)

section 1915(b)(4) (selective contracting/limit number of providers)

A program operated under section 1932(a) of the Act.

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

A program authorized under section 1915(i) of the Act.

A program authorized under section 1915(j) of the Act.

A program authorized under section 1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The purpose of the Self-Empowered Life Funding (SELF) 1915c Home and Community-Based Services (HCBS) waiver is to offer eligible individuals a self-directed model service program as an alternative to receiving Medicaid services in an intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care.

The goals and objectives of the waiver include:

1. Serving individuals meeting the following eligibility criteria:

- Determined to meet the criteria for a developmental disabilities level of care in accordance with rule 5123-8-01 of the Administrative Code and, in the absence of the SELF waiver, would require ICF/IID services as defined in 42 C.F.R. 440.150.
- Determined financially eligible for Medicaid.
- The needed waiver services are not readily available through another source at the level required to allow the individual to live in the community.
- Agrees to participate in SELF and while enrolled, shall not be simultaneously enrolled in another medicaid home and community-based program.
- Health related needs can be safely met in a home and community-based setting as determined by DODD's designee.
- Participates in the development of a person-centered services plan in accordance with the process and requirements set forth in rule 5123-4-02 of the Administrative Code.
- Participates in activities of self-directing.
- Requires the provision of at least one waiver service on a monthly basis.

2. Increasing choice and control of HCBS through:

- Self-directing services and supports.
- Identifying and addressing unique needs through the person-centered services planning process.
- Recruitment, enrollment and oversight of waiver service providers.
- Providing education and assistance on all waiver service options.

3. Maintaining cost neutrality.

The organizational structure of the SELF waiver is comprised of the State Medicaid Agency Ohio Department of Medicaid (ODM), the Ohio Department of Developmental Disabilities (DODD), and County Boards of Developmental Disabilities (CBDD). The ODM enters into a biennial interagency agreement (IAA) with the DODD. County Boards of Developmental Disabilities with designated medicaid local administrative authority per Ohio Revised Code 5126.055 operate with DODD oversight.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

Yes. This waiver provides participant direction opportunities. Appendix E is required.

No. This waiver does not provide participant direction opportunities. Appendix E is not required.

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the quality improvement strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in section 1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of section 1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

Not Applicable

No

Yes

C. Statewide. Indicate whether the state requests a waiver of the statewide requirements in section 1902(a)(1) of the Act (*select one*):

No

Yes

If yes, specify the waiver of statewide requirements that is requested (*check each that applies*):

Geographic Limitation. A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state. Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

Limited Implementation of Participant-Direction. A waiver of statewide requirements is requested in order to make participant-direction of services as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state. Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR § 441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in Appendix C, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to section 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR § 441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR § 441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR § 441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR § 431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of section 1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR Part 433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. If a provider certifies that a particular legally liable third-party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR Part 431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR § 431.210.
- H. Quality Improvement.** The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the quality improvement strategy specified in **Appendix H**.
- I. Public Input.** Describe how the state secures public input into the development of the waiver:

For each required public comment period associated with waiver program renewal and amendments, Ohio uses the following methods to notify the public of the opportunity to review and comment on the waiver renewal/amendment: The SELF Waiver Amendment Public Notice is featured on the Ohio Department of Medicaid (ODM) and Department of Developmental Disabilities (DODD) websites until the close of the public comment period.

- Electronic: Ohio posts a public notice, summary of the draft waiver, the draft waiver itself on the ODM website. DODD posts public notices on their websites, which link to the ODM website. The public has the ability to submit electronic comments via email to a mailbox designated by the state. The public may also submit written comments to the state at a mailing address designated to receive written comments.
- The local county boards post a copy of the Public Notice and Request for Comment announcement, which includes information about how to obtain a non-electronic copy of the waiver and the proposed renewals from DODD and local county boards. Individuals are able to obtain the waiver application which is available in both hard copies and online and requests may be through mail or phone.
- Stakeholders, advisory groups, and working committees. Announcements are issued to DODD stakeholders regarding the formal public comment period with a request to disseminate the information to their respective colleagues and distribution lists, which link to the electronic documents.
- Ohio offers four methods for the public to provide input on the proposed waiver renewal and/or request a non-electronic copy:

1) E-mail: waiverfeedback@dodd.ohio.gov

2) Written comments sent to: DODD 30 E. Broad Street, 13th Floor, Columbus, OH 43215

3) Phone: Call to leave a voicemail message at: (614) 466-5990

4) Courier or in-person submission to: Attn: DODD 30 E. Broad Street, 13th Floor, Columbus, OH 43215

Date of the formal public comment period: March 2 to April 1, 2026.

Active links used to post entire waiver applications

Ohio Department of Medicaid link: <https://medicaid.ohio.gov/about-us/notices/public-notices>

Ohio Department of Developmental Disabilities link: Waiver Amendments 2026 | Department of Developmental Disabilities <https://dodd.ohio.gov/waivers-and-services/Waiver+Amendments/waiver-amendments-2026>

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the state of the state's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Sly

First Name:

ShaRhonda

Title:

Section Chief, Home and Community Based Policy

Agency:

Ohio Department of Medicaid

Address:

50 West Town Street, Suite 400

Address 2:

5th floor

City:

Columbus

State:

Ohio

Zip:

43218-2709

Phone:

(380) 215-2063

Ext:

TTY

Fax:

(614) 644-9358

E-mail:

ShaRhonda.Sly@medicaid.ohio.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Showalter

First Name:

Allan

Title:

Deputy Director, Medicaid Development and Administration

Agency:

Ohio Department of Developmental Disabilities

Address:

30 East Broad Street, 13th floor

Address 2:**City:**

Columbus

State:

Ohio

Zip:

43215

Phone:

(614) 387-0375

Ext:

TTY

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under section 1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Ohio

Zip:

Phone:

Ext:

TTY

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

Adding or decreasing limits to a service or a set of services, as specified in Appendix C.

Reducing the unduplicated count of participants (Factor C).

Adding new, or decreasing, a limitation on the number of participants served at any point in time.

Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.

Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

Reduction in capacity for the renewal

The state reviewed quarterly allocation reports and 372 data reports to determine a decrease in reserved capacities would not result in participants experiencing a decrease in or loss of waiver service. Unduplicated participant counts in 372 data reports show for SFY2021, SFY2022 and SFY2023 (submitted) range from 1908 at the lowest to 2169 at the highest. Total approved capacity for the waiver during those years ranged from 2900 to 4300 with the approved capacity in the current WY5 being 5700. The state subtracted unduplicated counts with approved capacity and found unused slots ranged from 888 to 2131. Additionally, the state reviewed quarterly allocation data for SFY2023 to the present. Disenrollments from SFY2023 (604) and SFY2024 (520) compared to enrollments at approximately 115 and 75 respectively indicate a slow rate of enrollment compared to a higher rate of disenrollment. As enrollment data indicates unduplicated slots have not reached more than 2200 at any time, reducing capacity to 4000 for this renewal would provide assurance a decrease in service or a loss of service would not occur. Finally, the state has submitted an increase in capacity for the Level One waiver which provides flexibility for people who do not want to self-direct as required in the SELF waiver. The Level One waiver aligns with services available in the SELF waiver thus allowing flexibility to meet the population needs and not decrease services.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Additional information for I-2-a Rate Methodology July 1, 2026 Amendment

Environmental Accessibility Adaptations (current max rate est. 2026) are based on the current manufacturer's suggested retail price as recommended by the product's manufacturer. If an equipment provider is also the manufacturer, they may set a suggested retail price if it is equal to or lower than the price for the same or a comparable item recommended by other manufacturers. Statewide maximum rates apply with payment being limited to the lower of the provider's usual charge or the established statewide maximum rate. To establish the total cost, DODD reviewed environmental accessibility adaptations claims data from FY 2021 through FY 2025 in the Level One and IO waivers and determined a per-project cap of \$15,000. The cap is based on historically low overall expenditures and the small number of projects that exceeded \$10,000. Environmental Accessibility Adaptation (EAA) was added as a new line in the SELF waiver, previously included in the Participant Goods and Services (PDGS) line. The cost per unit of \$3,605 is reflective of the cost per unit in the prepared Level One waiver renewal for EAA. The number of users was projected based on processed payments noted in the FMS' PDGS Detailed Report submitted to DODD for calendar years 2022, 2023 and 2024.

PDGS values were reduced to reflect the re-categorization of the EAA services now included in a new line, as described above. The total cost of PDGS was reduced by \$288,400, consistent with the \$288,400 that was reflected for EAA.

The changes to the SELF waiver were budget neutral.

** Additional Information from I-2-a for January 1, 2026 Amendment**

New Billing Increments: Support Brokerage and Remote Supports were changed from an hourly billing increment to a 15-minute billing increment for the second half of WY 1 through WY 5 (January 1, 2026 through June 30, 2030). This change in billing increment is intended to be budget neutral.

Public Comment Summary: The proposed January 2026 Individual Options, Level 1 and SELF waiver programs and the simultaneous public comment for associated Ohio Administrative Code regulations received feedback from fifty-nine commenters through the public comment period from August 28, 2025 to September 27, 2025.

The comments included the following topics

- Recommendations for changes that include adjustments to or creation of additional services to be provided through the waiver programs. This includes consideration to add post-secondary education supports, coverage of software and battery-operated educational toys and games, modification to service payment options, increased flexibility with assistive technology and remote supports, increased rates for support brokerage services and expansion of locations remote supports may be delivered.

Changes such as this would require significant time and authority to develop, including stakeholder collaboration, budgetary allocations, legislative authority, as well as approval processes required for state plan amendments and waiver programs. No changes were made to the waiver application as a result of this feedback.

- Request to update language requiring probate court approval for a relative guardian permitted to serve as a direct care worker due to Ohio Rules of Superintendence no longer requiring this of relative guardians. The state removed language referring to court appointed authority for guardians to serve as direct care workers which is no longer applicable according to the Ohio Rules of Superintendence.
- Identification of typographical errors identified within the waiver applications. Typographical errors were corrected.
- Identification of the need for additional clarity within several descriptions of services within the applications.

As a result of this feedback, the state:

- o Clarified language in the Support Broker service definition on assisting the individual in determining budget allocation and effectiveness to meet desired outcomes and self-directed services.
- o Clarified that Assistive Technology must be the least costly alternative that meets the person's needs.
- o Clarified the definition of Remote Supports to define the monitoring base and the continuous nature of the service with the needs of the individual being included in the service plan. Language was added to replace the required shift testing of equipment to be written as protocols for testing and verification of equipment and technology used.
- Comments regarding requirements for parents of individuals requesting to or serving as a direct care worker. No changes were made as a result of this feedback received. Requirements within the waiver applications are in alignment with technical guidance requirements for waiver programs and Ohio Administrative Requirements governing program policy and operations.

***Additional information from I-2-a**

Home Delivered Meal Service: Rates were developed based on aligning with home delivered meal rates and types available through Ohio's 1915(c) nursing-based facility-based waiver programs. This includes the addition of kosher and therapeutic meal types. The State reviewed the methodology to ensure economy, efficiency, quality of care and found it to be sufficient to meet these requirements and ensure sufficient provider capacity. The rate methodology was based on assumptions for three categories of cost: meal preparation, transportation and delivery, and administration and overhead. The methodology was developed as the sum of the following cost components: wages (based upon the Bureau of Labor Statistics data), employment related expenses, transportation costs, supplies, administration, and other overhead expenses. The methodology included a review of Ohio Medicaid claims and enrollment data, research of public resources, and a comparison to similar waiver service offerings in other state Medicaid programs.

The Health Care Assessment rate was based on a pilot project started in 2022 ending 6/30/2024 and then increased by the biennial budget rate increases. The rate for the pilot project was based on the fair market value of the service to be provided. Health Care Assessment waiver rate was based on a pilot project that started February 2022 and ended 6/30/2024. The service rate was established in the biennial budget 7/1/24 with a planned increase set for 2025. The same rate increase that occurred for all services in 1/1/24 and 7/1/24 was then applied to the initial rate which began when the service started in 1/2025.

Rates for service animal training and vehicle modification were developed with input from two stakeholder work groups devoted to each service area. While data was limited as each service was not able to be data-mined individually, it was determined that each service would have a usual and customary rate based on industry standards. Some anecdotal data showed average cost, which is how the estimated number of users and costs were determined. Service Animal Training was separated from the Participant Directed Goods and Services and has been included under the Assistive Technology category using an estimated number of users and average units per user of 1 with an \$8,200 average per person experience as the cost per service. These estimates are based on historical experience dating back to 2017 with a total of 5 service animals representing approximately \$41,000 of cost. Therefore, the state assumed an average of 1 per year at the average cost of the historical experience.

Vehicle modification was separated from the Participant Directed Goods and Services into its own service category. The assumed number of users was established at 1 based on actual experience for vehicle modification in CY 2024 under the SELF waiver in Participant Directed Goods and Services service line. The state utilized units per user of 1 with a cost per unit consistent with the \$10,000 cap established for the vehicle modification service line.

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (*select one*):

The waiver is operated by the state Medicaid agency.

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

The Medical Assistance Unit.

Specify the unit name:

(Do not complete item A-2)

Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.

Specify the division/unit name:

The Ohio Department of Developmental Disabilities (DODD)

In accordance with 42 CFR § 431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the state Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The Ohio Department of Medicaid (ODM), as the single State Medicaid Agency, assures compliance and maintains administrative oversight of operational and policy development at the Ohio Department of Developmental Disabilities (DODD), the operating agency, through an interagency agreement between ODM and DODD. This agreement provides for ODM oversight and review of programmatic compliance with federal and state laws and regulations and in addition to auditing and fiscal compliance.

ODM's oversight of DODD's performance and assurance of compliance occurs through a continuous review process that includes reviews of performance data, quality briefings and meetings, on-going communication and collaboration, resolving individual issues and systemic remediation and fiscal reviews as described below and in further detail in Appendix H.

ODM monitors DODD's compliance and performance by:

- Convening the Quality Steering Committee four times per year;
- Convening the Health Safety and Welfare Committee two times per year.
- Conducting quality briefings with DODD four times per year;
- Performing a targeted review per program year;
- On-going assurance of the resolution of case-specific problems;
- On-going communication with DODD including bi-weekly meetings with DODD Medicaid administration staff, ODM clinical staff and ODM policy.
- Conducting the continuous review of DODD performance measure data (described below and in Appendix H);
- Ensuring systemic remediation (Quality Improvement Plan) whenever a performance measure is not fully met, and falls below a threshold of 86%;
- Conducting fiscal reviews and audits (described below and in Appendix I).
- On-going ODM participation in DODD workgroups, taskforces and other programmatic committees.

Convening the Quality Steering Committee approximately 4 times per year. The Quality Steering Committee provides administrative oversight for Ohio's Medicaid HCBS Waiver Quality Strategy. Using a collaborative process, the QSC reviews and analyzes data across waivers to identify promising practices and opportunities for quality improvement. It uses these discussions to assess and compare performance and innovative data analytics across Ohio's HCBS waivers to support collaborative efforts, improve waiver systems, and help move Ohio toward more unified quality management.

Convening the Health, Safety and Welfare Oversight Committee at least 2 times per year- ODM convenes an internal Health, Safety and Welfare committee to review and aggregate data compiled from a variety of sources to identify trends and systemic issues in waiver program operations and participant outcomes. The output from this group includes technical assistance to the case management agencies and continuous evaluation and updates to the policy. ODM assures case-specific resolution through the oversight of the Health, Safety, and Welfare Committee.

ODM conducts quality briefings with the operating agency at least four times per year to review data generated through the departments' quality processes, including results of any completed targeted reviews, waiver performance measure data, and data presented by the operating agency on the oversight activities conducted by that department. This data includes but is not limited to problems detected, corrective measures taken, and how the operating agency verified, or intends to verify, that the actions were effective.

Performing targeted reviews of HCBS waiver participants. At least once per program year, ODM will identify a target group of waiver participants using data from reporting systems. ODM's staff will perform reviews of the target group to identify best practices as well as areas for improvement in waiver operations, including both service delivery and case management. These reviews will help the State identify and implement system changes that address vulnerabilities and improve individuals' experiences and health outcomes.

On-going assurance of the resolution of case specific issues completed by ODM staff and the Clinical Operations staff to address unmet needs and health and welfare of the waiver participant. Resolution is tracked including any needed remediation. An unmet need is defined as any health and safety risk for the individual, grievance, and/or concerns with case management performance identified. Unmet needs may be identified through constituent inquiries, ODM staff discovery of a situation in which a waiver recipient's health or welfare may be at risk, or when Service and Support Administrator (SSA) deficiencies are identified. The unmet needs are tracked for

response and resolution. Depending on the severity of the situation, staff will take immediate action, coordinate intervention with providers or SSAs, or identify other interventions to assure health and welfare. ODM communicates findings for further review and appropriate intervention, and with explicit variable timeframes within which a report back to ODM is expected. ODM logs and tracks all findings and referrals to assure appropriate case-specific resolution.

On-going communication with DODD including bi-weekly meetings with DODD Medicaid administration staff, ODM clinical staff and ODM policy. These meetings address outstanding individual issues, current projects, updates and any additional items for discussion to assure the waiver program is meeting the needs of persons served. Additional ODM or DODD staff may be included depending on concerns and issues.

Continuous Review of DODD performance measure data. ODM will examine performance data and other information gathered both by ODM and DODD to measure compliance and performance with respect to the federal waiver assurances including service planning, care management, free choice of provider, level of care, health and welfare, participant satisfaction, and validation of service delivery. This data and any remediation (if necessary) will be submitted in accordance with the approved performance measures in the waiver. This information will also be used by ODM to complete the quality sections of the CMS 372 report (submitted to CMS annually) and is included in the Evidence Report submitted for each waiver as part of the renewal process. If areas of non-compliance or opportunities to improve program performance are identified through this process, ODM may require DODD to develop and implement quality improvement plans and monitor their effectiveness at achieving desired outcomes.

To ensure systemic remediation, ODM may require a Quality Improvement Plan. In the event areas of non-compliance or opportunities to improve program performance are identified through ODM monitoring and oversight activities, ODM may require DODD to develop and implement quality improvement plans and monitor their effectiveness at achieving desired outcomes.

Performing fiscal reviews and audits (described in Appendix I). Ongoing fiscal reviews includes desk reviews of administrative costs and A-133 Audits, which occur at least every three years based on risk.

On-going ODM participation in DODD workgroups, taskforces and other programmatic committees. On an ongoing basis, ODM staff participate in quarterly DODD Major Unusual Incident Trends and Patterns reviews and DODD Mortality Reviews. Ongoing committees with ODM staff include waiver redesign workgroups, Assistive Technology Taskforce, Employment First initiative and others as requested.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

The Ohio Department of Medicaid and the Department of Developmental Disabilities have a contractual relationship with an entity to perform the function of Financial Management Services (FMS). The FMS entity will be responsible for utilization management to ensure the payment for waiver services delivered match what is authorized in the Individual Service Plan.

No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

Local/Regional non-state public agencies perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the state and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

County boards of developmental disabilities conduct waiver operational and administrative functions at the local level.

These responsibilities include performing assessments and evaluations, assisting individuals in exercising free choice of provider, monitoring services, investigations of abuse, neglect and major incidents, case management (known as service and support administration) and managing waiting lists in accordance with Section 5126.042 of the Ohio Revised Code.

Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

In accordance with Section 5126.054 of the Ohio Revised Code, each county board of developmental disabilities (county board) develops a plan for Medicaid waiver administration. The plan includes the Planning Implementation Component Tracking document (known as the PICT).

The Ohio Department of Medicaid (ODM), in collaboration with the Department of Developmental Disabilities, hold responsibility for the oversight of the FMS entity's execution of Medicaid provider agreements. Through the competitive bid process, the FMS entity entered into an agreement with ODM and DODD by committing to adhere to the standards established in the request for proposals and the signed contract with DODD. ODM and DODD oversee this process through the quarterly performance measure review as noted in Appendix A-Administration and Oversight.

The Department of Developmental Disabilities (DODD) conducts the following activities:

- Reviews and approves the county board plan for Medicaid waiver administration,
- Reviews county board recommendations regarding whether an individual's application for Home and Community-Based Services (HCBS) waiver services should be approved or denied, including whether the individual meets an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) level of care,
- Retains the authority to review any Individual Service Plan (ISP) recommended by the county board for waiver services, and
- Provides communication, technical assistance and training to county boards regarding their role as local operators for waivers.

Appendix H provides further discussion of the oversight of county boards by DODD.

The Department of Developmental Disabilities (DODD) monitors and assesses the performance of the Financial Management Service (FMS) vendor in the following ways:

1. Annual reviews conducted by DODD Audit staff or by a contract with an audit agency that review a representative sample of participant files including all fiscal and financial records. Expenditures are reviewed for being allowed under the waiver and Ohio Administrative Code, and whether expenditures are accurately and appropriately assigned and reported.
2. All expenditures are reported monthly to DODD from the FMS. DODD staff identifies inconsistencies based on information including utilization, individual budgets, expenditures, dates of service, waiver enrollment date and then follow up with FMS staff to see correction of errors.
3. The FMS will be required by contract to comply with applicable audit requirements and responsibilities of the Office of Management and Budget (OMB) Circular A-133.

Appendix A: Waiver Administration and Operation

- 6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The Operating Agency-Department of Developmental Disabilities (DODD):

- 1) Accredits each county board of developmental disabilities (county board) for a period of one to three years, with better performing boards granted the longer accreditation terms;
- 2) Conducts tiered reviews every 1-3 years (based on performance) of each county board to evaluate Prevention from Harm Systems; and
- 3) On an ongoing basis, investigates Major Unusual Incidents that may be considered a conflict of interest for the local county board to investigate.

The tools used for accreditation contain questions, probes, and requests for evidence that tie directly to federal assurances, including assurances for: service planning & consumer free choice of provider; level of care determination; health and welfare; and hearing rights. The health and welfare sections of the accreditation tool are used for the tiered Protection from Harm evaluations. The Operating Agency produces regular reports on participant-specific Major Unusual Incidents, including county-specific data, and monitors reported data to detect trends and patterns.

Regarding the assessment of the contracted entity, DODD has a review process utilizing the standards of a Financial Management Service entity Readiness Review as its base, as detailed in Appendix E (Oversight of the FMS).

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR § 431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment				
Waiver enrollment managed against approved limits				
Waiver expenditures managed against approved levels				
Level of care waiver eligibility evaluation				
Review of Participant service plans				
Prior authorization of waiver services				
Utilization management				
Qualified provider enrollment				
Execution of Medicaid provider agreements				
Establishment of a statewide rate methodology				

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Rules, policies, procedures and information development governing the waiver program				
Quality assurance and quality improvement activities				

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

A-4: Number and percent of County Board of Developmental Disabilities (CBDD) accreditations completed timely by Ohio Department of Developmental Disabilities.
Numerator: Number of accreditation reviews completed timely. Denominator: Total number of CBDDs due for accreditation review.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DODD's Accreditation Reviews/Office of Provider Standards and Review (OPSR)

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review

Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

A-1: Number and percent of quality briefings conducted timely between Ohio Department of Medicaid and Ohio Department of Developmental Disabilities (DODD) to review DODD performance data as specified in the waiver application. Numerator: Number of quality briefings conducted timely. Denominator: Total number of quality briefings specified in the waiver application.

Data Source (Select one):

Meeting minutes

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

A-2: Number and percent of quarterly performance measure reports that were submitted to Ohio Department of Medicaid (ODM) by Ohio Department of Developmental Disabilities on time and in the correct format. Numerator: Number of quarterly performance measure reports submitted on time and in the correct format. Denominator: Total number of quarterly performance measure reports required by ODM.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:

	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

A-5 Number and percent of reviewed Medicaid provider agreements executed by the contracted FMS entity that meet Ohio Department of Medicaid and Federal requirements.

Denominator: Number of DODD reviewed Medicaid provider agreements executed.

Numerator: Number of those agreements that meet ODM and Federal requirements.

Data Source (Select one):

Other

If 'Other' is selected, specify:

FMS provider enrollment reports

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100%

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

A-3: Number and percent of quality improvement plans required by Ohio Department of Medicaid (ODM) that were submitted on time by Ohio Department of Developmental Disabilities (DODD) and accepted by ODM. Numerator: Number of quality improvement plans required by ODM that were submitted on time by DODD and accepted by ODM. Denominator: Total number of quality improvement plans required by ODM.

Data Source (Select one):

Trends, remediation actions proposed / taken

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Oversight Activities by ODM:

ODM conducts quality briefings with the operating agency at least four times per year to review data generated through the departments' quality processes, including results of any completed targeted reviews, waiver performance measure data, and data presented by the operating agency on the oversight activities conducted by that department. This data includes but is not limited to problems detected, corrective measures taken, and how the operating agency verified, or intends to verify, that the actions were effective.

Performance Measures data reports are submitted to ODM by DODD on a quarterly basis.

The information is gathered from county board and DODD compliance activities. DODD is able to identify and address individual problems as they are discovered and provide technical assistance that may include plans of corrective action. When problems are discovered, the individual county board is notified and technical assistance is provided using e-mail, phone contact and/or letters to county board staff. When issues are noted that are systemic, DODD will provide statewide training and incorporate that corrective action into its monitoring during the next monitoring cycle.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Methods for Remediation/Fixing Individual Problems

Case Specific Resolution: During the course of any review conducted by ODM or DODD, when staff encounter a situation in which a waiver recipients health or welfare is at risk, or when case management deficiencies are identified, the staff follow a protocol to report these observations. Depending on the severity of the situation, the staff will take immediate action, coordinate intervention with providers or case managers, and report the finding to ODM managers. ODM communicates findings to DODD for further review and appropriate intervention, and with explicit variable timeframes within which a report back to ODM is expected. ODM logs and tracks all such findings and referrals to assure appropriate case-specific resolution.

The ODM Clinical Operations section monitors both prevention and outcome activities performed by the Department of Developmental Disabilities (DODD) to protect Medicaid consumers on HCBS waivers from significant incidents impacting their health and welfare. The ODM Clinical Operations reviews incident alerts, track and monitor them until, resolution has been reached, the individual is healthy and safe, the cause has been identified and remedied, and preventive measures have been taken. The discovery of potential Director Incident Alerts may occur through the following means: may be notified by DODD via Director's Alert e-mail or other means; by ODM Clinical Operations; through ODM monitoring of DODD Ohio Incident Tracking and Management System; through other service delivery systems; media; or complaints received directly

by ODM.

The Department of Developmental Disabilities (DODD) receives and acts upon complaints/compliance issues in a variety of ways. DODD's Major Unusual Incident (MUI)/Registry Unit receives complaints through a toll-free number for reporting abuse/neglect and other MUIs. Complaints are also received via email and U.S. mail. Each complaint received is logged and acted upon the same or next day and followed up until the issue is resolved.

Some calls result in MUIs while other calls are assorted complaints which are referred to other department staff, county boards, or outside entities such as the Department of Health. These include medical, behavior, environmental and other miscellaneous subjects. Complaints are resolved by MUI/Registry unit managers when a MUI has occurred, other complaints are resolved by the appropriate DODD unit managers.

DODD employs a Family Outreach & Education Coordinator who works with families to provide technical assistance, including addressing complaints.

DODD Office of Compliance will follow up on any complaints and noncompliance regarding county boards of developmental disabilities (county boards) or certified waiver providers. This could result in citations being issued. Citations require a plan of correction that must be approved by DODD. Individuals may also contact their Service and Support Administrator (SSA) to voice any concerns or complaints. Each county board is required to have a complaint resolution process. Both ODM and DODD received inquiries submitted through the Governor's Office and/or Legislators' offices. Each State Agency manages the submission of these inquiries directly through internal processes, including through the Unmet Need/MUI process, if warranted. Communication between State Agencies is initiated, and all issues received through these venues is remediated individually. This is oftentimes completed through the closure of the constituent inquiry through the unique internal process to each agency, and without rising to the level of an Unmet Need or MUI.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

- a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR § 441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
		Aged			
		Disabled (Physical)			
		Disabled (Other)			
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury			
		HIV/AIDS			
		Medically Fragile			
		Technology Dependent			
Intellectual Disability or Developmental Disability, or Both					
		Autism			
		Developmental Disability	0		
		Intellectual Disability	0		
Mental Illness					
		Mental Illness			
		Serious Emotional Disturbance			

- b. Additional Criteria.** The state further specifies its target group(s) as follows:

To be enrolled on this waiver, an individual (or their representative) must be willing and able to perform the duties associated with Participant Direction. The individual must document what supports will be used for purposes of information and assistance with Participant Direction, and that those supports have received the appropriate training on Participant Direction.

- c. Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

Not applicable. There is no maximum age limit

The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

No Cost Limit. The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

Cost Limit in Excess of Institutional Costs. The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

The limit specified by the state is (*select one*)

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

Institutional Cost Limit. Pursuant to 42 CFR § 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

Cost Limit Lower Than Institutional Costs. The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The incorporation of participant direction and the flexibility of the service package will ensure that an individual has considerable options to obtain the service and supports they would need. In addition, other resources such as natural supports and services funded locally could be accessed to help assure health and welfare of the individual.

The cost limit specified by the state is (*select one*):

The following dollar amount:

Specify dollar amount:

The dollar amount (*select one*)

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Children: \$41,424/year;
Adults: \$62,136/year

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

- b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

The Service and Support Administrator (SSA) will complete an assessment process to ensure that the cost limit is sufficient to assure individual's health and welfare when combined with other paid or unpaid resources. The opportunity to request a fair hearing is provided if enrollment to the waiver is denied.

The SSA will inform the individual of the opportunity to request a Fair Hearing at the time of the initial assessment.

- c. Participant Safeguards.** When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

The participant is referred to another waiver that can accommodate the individual's needs.

Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Other safeguard(s)

Specify:

In the event that an individual’s health and safety can no longer be assured through the SELF Waiver and no alternate waiver is available for the individual to transfer to, the individual will be disenrolled and afforded the opportunity for placement in an ICF-IID facility, accessing other Medicaid State plan services and/or may receive services financed by local, non-Medicaid funds.

The participant will be informed during the initial meeting with SSA when choosing the appropriate waiver for that individual.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	4000
Year 2	4000
Year 3	4000
Year 4	4000
Year 5	4000

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

- ☒ The state does not limit the number of participants that it serves at any point in time during a waiver year.
- ☐ The state limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The state (*select one*):

Not applicable. The state does not reserve capacity.

The state reserves capacity for the following purpose(s).

Purpose(s) the state reserves capacity for:

Purposes	
Emergencies and Hearing Decisions	
HB 287 Provisions	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose (*provide a title or short description to use for lookup*):

Emergencies and Hearing Decisions

Purpose (*describe*):

- a. Emergency: Individuals who require waiver resources to address immediate needs due to circumstances specified in Ohio Administrative Code (OAC) 5123-9-04.
- b. Hearing Decisions: An order for a county board to enroll an individual on the waiver as the result of a Medicaid state hearing decision made in accordance with 5101.35 of the Revised Code.

Describe how the amount of reserved capacity was determined:

A total number of 3% of unduplicated number of participants (listed in Table B-3-a) is reserved to accommodate emergency situations and hearing decisions Reserved capacities during each Waiver Year. The emergency and hearing decisions reserved capacity is less 15% of the proposed total; the 15% is used towards HB287 reserved capacity.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	102
Year 2	102
Year 3	102
Year 4	102
Year 5	102

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose (*provide a title or short description to use for lookup*):

HB 287 Provisions

Purpose *(describe):*

Pursuant to Am Sub HB 287 (133rd Ohio General Assembly), within a reserved capacity established by this waiver, the State targets eligible individuals who have a spouse or parent or a legal guardian who is an active duty military service member and, at the time of the service member’s transfer to Ohio, the individual was receiving similar home and community-based waiver services in another state.

Describe how the amount of reserved capacity was determined:

Reserved capacity for the SELF waiver is projected at 15% of the reserved capacity for emergency and hearing decisions per waiver year as no actual data is available at this time. The State will monitor such enrollments and modify the projection as appropriate.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	18
Year 2	18
Year 3	18
Year 4	18
Year 5	18

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

The waiver is not subject to a phase-in or a phase-out schedule.

The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

Waiver capacity is allocated/managed on a statewide basis.

Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

The Ohio Department of Developmental Disabilities (DODD) allocates waiver capacity for the SELF Waiver to the 88 county boards of developmental disabilities (county boards). The allocation process starts with a waiver allocation request submitted by each county board which is reviewed by DODD in the waiver enrollment system. DODD reviews all requests and approves allocations in a manner that ensures that individuals who are residents of each of Ohio's 88 counties have proportionate access to SELF waiver opportunities. The formula for allocation of waiver capacity is based on demographic information and census data. The selection for entrance onto the waiver does not impact the formula; criteria for selecting entrants onto the waiver is based on the waiting list rule (please see Appendix B-3-f for additional information).

Ohio Revised Code (ORC) 5123.046 requires the State to approve county board plans for waiver enrollment. Each year, county boards submit requests for waiver allocation to DODD through its web-based application, based on both available funding and the needs of people on the waiting list. DODD compares the statewide requests for waiver allocation with the number of unused waivers available for allocation and approves allocation requests through the web-based allocation in a manner that ensures statewide access.

DODD maintains unused waiver capacity and allocates to county boards only the number of waivers requested by each board in accordance with its annual strategic planning process. Additional requests can be made by county boards throughout the year to address needs for increased capacity.

DODD maintains a waiting list management system that manages both allocation and enrollment data. ODM staff members have direct access to the data contained in the waiver management system and can also request reports at any time. Real-time reporting compares the unduplicated number of individuals enrolled and the number of waiver applications in process. A monthly summary is sent by DODD to the Ohio Department of Medicaid (ODM) and Office of Budget Management (OBM). Once the unduplicated count approaches the approved count, the actual enrollments are monitored closely, as well as the number of applications in process to assure that the unduplicated count is not exceeded.

The State's practices do not violate the requirement that individuals have comparable access to waiver services across the state or impede movement among counties. Waiver allocation is managed at the state level by DODD with oversight by ODM. Chapters 5123 and 5126 of the ORC include provisions for the State of Ohio to pay the non-federal share of home and community-based services when a county faces financial hardship to ensure continued statewide access.

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Section 5126.042 of the Ohio Revised Code (ORC) requires the county boards of developmental disabilities (county boards) to establish a waiting list for individuals who are assessed as needing home and community-based services (HCBS) and have requested to receive HCBS through a DODD-administered waiver program.

Ohio Administrative Code (OAC) 5123-9-04 titled Home and community-based services- waiting list policy sets forth requirements for the waiting list established pursuant to section 5126.042 of the Revised Code when a county board of developmental disabilities determines that available resources are insufficient to enroll individuals who are assessed to need and who choose home and community-based services in department-administered home and community-based services waivers.

Planning for locally-funded home and community-based services waivers: A county board will, 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 home and community-based services waiver during each calendar year, based on projected funds available to the county board to pay the nonfederal share of medicaid expenditures and the assessed needs of the county's residents on the waiting list for home and community-based services.

Administration of the waiting list assessment tool:

- (1) A county board will administer the initial waiting list assessment tool to an individual when the individual, the individual's guardian, or a member of the individual's family:
 - (a) Requests the county board administer the waiting list assessment tool;
 - (b) Requests the individual be enrolled in a home and community-based services waiver or placed on the waiting list for home and community-based services; or
 - (c) Identifies an unmet need.
- (2) A county board will re-administer the waiting list assessment tool to an individual when the individual, the individual's guardian, or a member of the individual's family identifies a change in circumstance that may result in the individual having a current need or an immediate need.

Waiting list for home and community-based services

- (1) The county board will place an individual's name on the waiting list for home and community-based services when, based on assessment of the individual using the waiting list assessment tool, the individual:
 - (a) Has been diagnosed with a severe, chronic disability:
 - (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
 - (b) 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 home and community-based services waiver).
- (2) The county board will not place an individual's name on the waiting list for home and community-based services when the individual:
 - (a) Is a child who is subject to a determination under section 121.38 of the Revised Code and requires home and community-based services; or
 - (b) Has an immediate need, in which case the county board will take action necessary to ensure the immediate need is met. The county board will provide the individual or the individual's guardian (which may include a public children services agency), as applicable, with the option of having the individual's needs met in an intermediate care facility for individuals with intellectual disabilities or through community-based alternative services. Once an individual or individual's guardian chooses the preferred setting option, the county board will take action to ensure the individual's immediate need is met, including by enrollment in a home and community-based services waiver, if necessary. Such action may also include assisting the individual or the individual's guardian, as applicable, in identifying and accessing alternative services that are available to meet the individual's needs.
- (3) When a county board places an individual's name on the waiting list for home and community-based services, the county board will:
 - (a) Record, the individual's status date in the waiting list management system;
 - (b) Notify the individual or the individual's guardian, as applicable, that the individual's name has been placed on the waiting list for home and community-based services.
 - (c) Provide contact information to the individual or the individual's guardian, as applicable, for a person at the county board who can assist in identifying and accessing alternative services that address, to the extent possible, the individual's needs. Contact information will include the person's name, title, telephone number and electronic mail address.

(4) Annually, a county board will:

- (a) Review the waiting list assessment tool and service needs of each individual whose name is included on the waiting list for home and community-based services with the individual and the individual's guardian, as applicable; and
- (b) Assist the individual or the individual's guardian, as applicable, in identifying and accessing alternative services.

(5) Under any circumstances, when a county board determines an individual's status has changed with regard to having an immediate need and/or having a current need or an individual's status date has changed, the county board will update the individual's record in the waiting list management system.

Order for enrolling individuals in locally-funded home and community-based services waivers

(1) A county board will select individuals for enrollment in locally-funded home and community-based services waivers in this order:

- (a) Individuals with immediate need who require waiver funding to address the immediate need.
- (b) Individuals who have met multiple criteria for current need for twelve or more consecutive months and who were not offered enrollment in a home and community-based services waiver in the prior calendar year. When two or more individuals meet the same number of criteria for current need, the individual with the earliest status date will be selected for enrollment.
- (c) Individuals who have met multiple criteria for current need for less than twelve consecutive months. When two or more individuals meet the same number of criteria for current need, the individual with the earliest of either the status date or date of request will be selected for enrollment.

(d) Individuals who meet a single criterion for current need. When two or more individuals meet a single criterion for current need, the individual with the earliest status date will be selected for enrollment.

(2) Individuals with immediate need and individuals with current need may be enrolled in locally-funded home and community-based services waivers concurrently.

(3) Meeting the criteria for immediate need and/or current need does not guarantee enrollment in a locally-funded home and community-based services waiver within a specific timeframe.

(4) When an individual is identified as next to be enrolled in a locally-funded home and community-based services waiver, the county board will determine the individual's eligibility for enrollment in a home and community-based services waiver. When the county board determines an individual is eligible for enrollment in a home and community-based services waiver, the county board will determine which type of locally-funded home and community-based services waiver is sufficient to meet the individual's needs in the most cost-effective manner. A county board will respond to the department within ten calendar days when the department request additional information regarding an individual on the waiting list who was passed over for enrollment in locally-funded home and community-based services waiver despite a higher placement on the waiting list. The county board will collaborate with the department to address any impediments to meeting the individual's needs.

Due process

- (1) Due process will be afforded to an individual when a county board takes an action related to placement on, denial of placement on, or removal from the waiting list for home and community-based services.
- (2) The county board will issue and explain due process to the individual or the individual's guardian, as applicable, using a form approved by the Ohio department of job and family services (available at odjfs.state.oh.us/forms/).
- (3) Due process will be provided in accordance with section 5160.31 of the Revised Code and Chapters 5101:6-1 to 5101:6-9 of the Administrative Code.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

- a. **1. State Classification.** The state is a (*select one*):

Section 1634 State

SSI Criteria State

209(b) State

2. Miller Trust State.

Indicate whether the state is a Miller Trust State (*select one*):

No

Yes

- b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR § 435.217)

Parents and Other Caretaker Relatives (42 CFR § 435.110)

Pregnant Women (42 CFR § 435.116)

Infants and Children under Age 19 (42 CFR § 435.118)

SSI recipients

Aged, blind or disabled in 209(b) states who are eligible under 42 CFR § 435.121

Optional state supplement recipients

Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

100% of the Federal poverty level (FPL)

% of FPL, which is lower than 100% of FPL.

Specify percentage:

Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in section 1902(a)(10)(A)(ii)(XIII) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in section 1902(a)(10)(A)(ii)(XV) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in section 1902(a)(10)(A)(ii)(XVI) of the Act)

Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in section 1902(e)(3) of the Act)

Medically needy in 209(b) States (42 CFR § 435.330)

Medically needy in 1634 States and SSI Criteria States (42 CFR § 435.320, § 435.322 and § 435.324)

Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

Specify:

Section 1925: Transitional Medical Assistance
 42 CFR 435.115: Extended Medicaid due to Spousal Support Collections
 42 CFR 435.117: Deemed Newborns
 42 CFR 435.145: Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care
 42 CFR 435.150: Former Foster Care Children
 42 CFR 435.130: Individuals Receiving Mandatory State Supplements
 42 CFR 435.131: Individuals Who Are Essential Spouses
 42 CFR 435.132: Institutionalized Individuals Continuously Eligible Since 1973
 42 CFR 435.133: Blind or Disabled Individuals Eligible in 1973
 42 CFR 435.134: Individuals Who Lost Eligibility for SSI/SSP Due to an Increase in OASDI Benefits in 1972
 42 CFR 435.135: Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA increases since April 1977
 42 CFR 435.137: Disabled Widows and Widowers Ineligible for SSI due to Increase in OASDI
 42 CFR 435.138: Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security Section 1619(b): Working Disabled under 1619(b)
 1634(c): Disabled Adult Children
 42 CFR 435.222: Reasonable Classifications of Individuals under Age 21
 42 CFR 435.227: Children with Non-IV-E Adoption Assistance
 42 CFR 435.226: Independent Foster Care Adolescents
 42 CFR 435.229: Optional Targeted Low Income Children
 42 CFR 435.213: Certain Individuals Needing Treatment for Breast or Cervical Cancer
 42 CFR 435.210: Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash Assistance
 42 CFR 435.119: Adult Group - Individuals at or below 133% FPL Age 19 through 64 - newly eligible for all states

Special home and community-based waiver group under 42 CFR § 435.217 Note: When the special home and community-based waiver group under 42 CFR § 435.217 is included, Appendix B-5 must be completed

No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217. Appendix B-5 is not submitted.

Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217.

Select one and complete Appendix B-5.

All individuals in the special home and community-based waiver group under 42 CFR § 435.217

Only the following groups of individuals in the special home and community-based waiver group under 42 CFR § 435.217

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

A percentage of FBR, which is lower than 300% (42 CFR § 435.236)

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR § 435.121)

Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR § 435.320, § 435.322 and § 435.324)

Medically needy without spend down in 209(b) States (42 CFR § 435.330)

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR § 441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR § 435.217 group.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR § 435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR § 435.217 group effective at any point during this time period.

Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under section 1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.

In the case of a participant with a community spouse, the state elects to (select one):

Use spousal post-eligibility rules under section 1924 of the Act.

(Complete Item B-5-b (SSI State) and Item B-5-d)

Use regular post-eligibility rules under 42 CFR § 435.726 (Section 1634 State/SSI Criteria State) or under § 435.735 (209b State)

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Spousal impoverishment rules under section 1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules at 42 CFR § 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state plan

Specify:

The following dollar amount

Specify dollar amount: If this amount changes, this item will be revised.

The following formula is used to determine the needs allowance:

Specify:

65% of 300% of the Social Security Income Federal Benefit Rate (SSI/FBR).

Other

Specify:

ii. Allowance for the spouse only (select one):

Not Applicable

The state provides an allowance for a spouse who does not meet the definition of a community spouse in section 1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

Specify the amount of the allowance (select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR § 435.811 for a family of the same size. If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

Other

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726:

a. Health insurance premiums, deductibles and co-insurance charges

- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions) *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

- c. **Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).**

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

- d. **Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)**

The state uses the post-eligibility rules of section 1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under section 1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

- i. **Allowance for the personal needs of the waiver participant**

(select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised

The following formula is used to determine the needs allowance:

Specify formula:

65% of 300% of the Social Security Income Federal Benefit Rate (SSI/FBR).

Other

Specify:

- ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR § 435.726 or 42 CFR § 435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

- iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726 or 42 CFR § 435.735:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions) Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.

The state does not establish reasonable limits.

The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

- e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State – January 1, 2014 through September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

- f. Regular Post-Eligibility Treatment of Income: 209(b) State – January 1, 2014 through September 30, 2027 (or other date as required by law).**

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

- g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules – January 1, 2014 through September 30, 2027 (or other date as required by law).**

The state uses the post-eligibility rules of section 1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR § 441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

- a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

ii. Frequency of services. The state requires (select one):

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

The minimum number of waiver services that an individual must require in order to be determined to need this waiver is one (1). The Support Broker, in conjunction with the Service and Support Administrator (SSA), will provide day-to-day oversight of implementation of the services used by the individual according to the Individual Service Plan (ISP). Should the individual not use services for thirty consecutive calendar days, the SSA will initiate a conversation with the family to determine why the individual is not utilizing the waiver and perform an assessment to determine if the individual still needs the waiver.

Pursuant to Ohio Revised Code (ORC) 5126.15, county boards of developmental disabilities (county boards) have primary responsibility in monitoring ISP implementation and service use by individuals on the waiver. When an individual does not use any waiver service every thirty consecutive days, the county board must assess the individual's need for continued waiver services. If, through the assessment, it is determined that the individual does not need any waiver services, the county board must recommend to the Department of Developmental Disabilities (DODD) that individual be disenrolled from the waiver.

If an individual is anticipated to need waiver services less frequently than every thirty calendar days, the SSA is to indicate in the ISP the method of monitoring they will employ to assure that the individual's health and welfare is not in jeopardy. Monitoring by the county board is to occur no less frequently than once each calendar month. Completion of this monitoring activity and the outcomes of the reviews are to be documented, and the documentation is to be maintained in the individual's file.

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By an entity under contract with the Medicaid agency.

Specify the entity:

Other

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR § 441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Initial Levels of Care are recommended by an evaluator. Evaluator means a person assigned by the county board who coordinates or performs the evaluations and assessments of an individual to make a recommendation to the department as to whether or not the individual meets the criteria for the developmental disabilities level of care. (a) Each evaluator will complete department-approved on line training, which includes a competency check prior to completing evaluations or assessments and recommending level of care. (b) An evaluator shall be a person: (i) Employed by or under contract with a county board for the purpose of recommending level of care for an individual seeking enrollment in home and community-based services; (ii) Employed by an ICFIID in which an individual is seeking placement or currently resides; or (iii) Designated by the department of developmental disabilities.

Initial Levels of Care are then determined by Qualified Intellectual Disabilities Professional staff, as defined in 42 CFR 483.430(a):

(a) Qualified intellectual disability professional:

(1) Has at least one year of experience working directly with persons with intellectual disability or other developmental disabilities; and

(2) Is one of the following:

(i) A doctor of medicine or osteopathy.

(ii) A registered nurse.

(iii) An individual who holds at least a bachelor's degree in a human services field (including, but not limited to: sociology, special education, rehabilitation counseling, and psychology).

- d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

As a condition of waiver eligibility, applicants must meet an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) Level of Care.

The criteria used to make this determination is defined below and is outlined in Ohio Administrative Code (OAC) rule 5123-8-01 Developmental disabilities level of care.

Criteria for ICF-IID level of care:

(1) For individuals' birth through age nine, the criteria for a developmental disabilities level of care is met when:

- (a) -The individual has a substantial developmental delay or specific congenital or acquired condition other than an impairment caused solely by mental illness; and
- (b) -In the absence of individually planned supports, the individual has a high probability of having substantial functional limitations in at least three areas of major life activities later in life:
 - self- care,
 - receptive and expressive communication,
 - learning,
 - mobility,
 - self-direction,
 - capacity for independent living or
 - economic self- sufficiency.

(2) For individuals age ten and older, the criteria for a developmental disabilities level of care is met when:

- (a) -The individual has been diagnosed with a severe, chronic disability that:
 - (i) Is attributable to a mental or physical impairment or combination of mental and physical impairments, other than an impairment caused solely by mental illness;
 - (ii)-Is manifested before the individual is age twenty-two; and
 - (iii)-Is likely to continue indefinitely.

The severe chronic disability described above results in substantial functional limitations in three or more of the following areas of major life activities, as determined through use of the standardized level of care assessment instrument approved by the Ohio Department of Medicaid:

- self-care,
- receptive and expressive communication,
- learning,
- mobility,
- self-direction,
- capacity for independent living and
- economic self-sufficiency.

-The severe chronic disability reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance of lifelong or extended duration that are individually planned and coordinated.

The Department of Developmental Disabilities uses a standardized functional assessment, which is part of the department's web-based applications to ensure all required information has been submitted.

The assessment includes:

- (a) Current diagnoses, including an indication of whether the individual has been diagnosed with a severe, chronic disability as described above;
- (b) An in-person review of current functional capacity; and
- (c) Supporting documentation which will be maintained in the individual's record and made available for state and federal quality assurance and audit purposes.

Supporting documentation includes:

- (a) Verification of the presence of a substantial developmental delay or congenital condition for an individual birth through age nine as described above or the presence of a severe, chronic disability for an individual age ten and older as

described above. The verification will be submitted in a format prescribed by the department and include:

- (i) The results of a medical evaluation performed by a physician or certified nurse practitioner which includes etiology of the condition leading to a developmental disability, diagnoses, and dates of onset; or
 - (ii) For a child birth through age five, the results of an evaluation performed by a qualified professional using appropriate diagnostic instruments and/or procedures; or
 - (iii) The results of a psychological evaluation completed by a psychologist or a psychiatric evaluation completed by a psychiatrist which includes the current diagnoses as specified in the "Diagnostic and Statistical Manual of Mental Disorders" (fifth edition), axes I, II, and III.
- (b) A completed developmental disabilities level of care assessment.

- e. Level of Care Instrument(s).** Per 42 CFR § 441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

The same instrument is used in determining the level of care for the waiver and for institutional care under the state plan.

A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

- f. Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR § 441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The detailed information for this section can also be found in Appendix B-6-d. The requirements and processes for Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) level of care (LOC) determinations and redetermination is prescribed in OAC rule 5123-8-01. The LOC initial evaluation and annual reevaluation is completed using the standardized assessment maintained in the Department of Developmental Disabilities' (DODD) LOC application. In order for the ICF-IID LOC request to be approved, each initial LOC recommendation must include:

- a) Current diagnoses, including an indication of whether the individual has been diagnosed with a severe, chronic disability as described in Ohio Administrative Code (OAC) rule 5123-8-01;
- b) An in-person review of current functional capacity. This review shall be documented using a standardized functional assessment tool that is approved by the Ohio Department of Medicaid (ODM); and
- c) The assessment documentation shall be maintained in the individual's record and made available for state and federal quality assurance and audit purposes.

Initial LOC recommendations for individuals seeking enrollment in a Medicaid home and community-based services waiver must be approved by DODD prior to enrollment in the waiver. LOC recommendations may be submitted to DODD up to ninety days in advance of the proposed enrollment date.

For reevaluations, the county boards of developmental disabilities (county boards) will submit an ICF-IID LOC redetermination to DODD within twelve months of the previous LOC determination and whenever the individual experiences a significant change of condition as described in paragraph (D)(8)(a-b) in OAC rule 5123-8-01.

- g. Reevaluation Schedule.** Per 42 CFR § 441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

- h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.

The qualifications are different.

Specify the qualifications:

- i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR § 441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care (*specify*):

The Department of Developmental Disabilities (DODD) staff receive alerts from the level of care (LOC) system which gives the waiver participants names (by county), and the level of care due date for all redeterminations due within 90 days and 15 days prior to the redetermination due date. A Prior Notice letter (named such as it provides the individual their rights to a prior notice for a pending action) is issued to the individual and/or guardian and to the county board of developmental disabilities (county board) alerting them of the pending timelines, and encourages collaboration with the county board to ensure all necessary documentation is submitted to DODD prior to the due date. The information generated from these reports is monitored by DODD staff for the purpose of working with county board partners to ensure the timely submittal of the redetermination.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR § 441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR § 92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Electronically retrievable documentation of all level of care evaluations and reevaluations are maintained in accordance with state and federal regulations.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

- a. Sub-assurance:** *An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

B-1: Number and percent of new enrollees who had a LOC indicating need for institutional LOC prior to receipt of services. Numerator: Number of new enrollees who had a LOC indicating need for institutional LOC prior to receipt of services. Denominator: Total number new enrollees.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DODD's Waiver Management System (WMS)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: County boards of DD	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

- b. Sub-assurance:** *The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.*

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

B-2: Number and percent of level of care redetermination completed within 12 months of the previous level of care determination. Numerator: Number of level of care redetermination completed within 12 months of the previous level of care determination. **Denominator:** Total number of waiver participants with redetermination needed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DODD's Waiver Management System (WMS)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: County boards of DD	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other	Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Specify: 	
	Continuously and Ongoing
	Other Specify:

- c. **Sub-assurance:** *The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

B-3: Number and percent of participants that initial LOC determinations reviewed were completed using the process required by the approved waiver. Numerator: Number of participants with initial LOC determinations that were completed using the process required by the approved waiver. **Denominator:** Total number of participants with initial LOC determinations.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DODD's Waiver Management System (WMS)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review

Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

ODM conducts quality briefings with the operating agency at least four times per year to review data generated through the departments' quality processes, including results of any completed targeted reviews, waiver performance measure data, and data presented by the operating agency on the oversight activities conducted by that department. This data includes but is not limited to problems detected, corrective measures taken, and how the operating agency verified, or intends to verify, that the actions were effective.

Performance Measures data reports are submitted to ODM by DODD on a quarterly basis.

The information is gathered from county board and DODD compliance activities. DODD is able to identify and address individual problems as they are discovered and provide technical assistance that may include plans of corrective action. When problems are discovered, the individual county board is notified and technical assistance is provided using e-mail, phone contact and/or letters to county board staff. When issues are noted that are systemic, DODD will provide statewide training and incorporate that corrective action into its monitoring during the next monitoring cycle.

Case Specific Resolution: During the course of any review conducted by ODM or DODD, when staff encounter a situation in which a waiver recipients health or welfare is at risk, or when case management deficiencies are identified, the staff follow a protocol to report these observations. Depending on the severity of the situation, the staff will take immediate action, coordinate intervention with providers or case managers, and report the finding to ODM managers. ODM communicates findings to DODD for further review and appropriate intervention, and with explicit variable timeframes within which a report back to ODM is expected. ODM logs and tracks all such findings and referrals to assure appropriate case-specific resolution.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

DODD becomes aware of problems through a variety of mechanisms including, but not limited to, formal & informal complaints, technical assistance requests, and routine & special regulatory review processes (accreditation, licensure, provider compliance, etc). As problems are discovered, the individual County Board is notified and technical assistance is provided using email, phone contact and/or letters to the County Board Superintendent. During the DODD regulatory review process citations may be issued and plans of correction required as needed and appropriate. When issues are noted that are systemic, DODD will provide statewide training and additional technical assistance and monitor for improvement during subsequent monitoring cycles.

ICF-IID Level of Care is determined by a DODD QIDP. Per rule they must make a determination within 30 days of receipt of the application. If Level of Care cannot be determined based on the documentation submitted by the county board with the application, the QIDP is required to perform a Face to Face interview prior to denial of Level of Care. If the QIDP determines the individual does not meet level of care, prior notice of denial with hearing rights is provided to all concerned parties.

DODD staff receive alerts from the Level of Care system which gives the waiver participants names (by county), their LOC due dates 90 days prior and 15 days prior to the redetermination due date. County boards are again notified and prior notices with hearing rights are provided to all concerned parties. If redeterminations are not received prior to the waiver end date, county boards are solicited to provide a reason for the delay and if continued waiver services are not planned they are instructed to submit the proper paperwork to recommend disenrollment or suspension of the waiver per rule. Application received after the due date will result in a gap in waiver services and a resetting of the annual redetermination date.

DODD central office staff review each application for completion upon receipt. If application upon that review are found to be on the incorrect form or missing required information to determine level of care, we initiate our incomplete application procedure which results in a 15-day prior notice to deny or disenroll along with hearing rights. The specific reason for the notice is included in the body of the letter. If the requested information or proper documents are not submitted within the 15-day time limit, the county board can request one extension. If at that time, the incomplete application has not been rectified, the application will be denied if an initial application or the individual will be disenrolled if a redetermination. All initial applications are reviewed prior to archival by central office waiver management for completeness and correctness.

DODD will measure the percentage of people whose annual level of care evaluation occurs within 12 months of their previous or initial level of care evaluation (but not more than 90 days before the due date).

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify: Semi-annually

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR § 441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

At the time the individual requests home and community-based services (HCBS) waiver services, the county board of developmental disability (county board) in the county in which the individual resides is responsible for explaining the services available under the Level One waiver and the alternative of services delivered in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). Additionally, per Ohio Revised Code (ORC) prior to placement on the HCBS waitlist, the county board is responsible for:

- a.) Informing the individual of the option to receive ICF-IID services;
- b.) Providing the individual with the contact information for all ICFs/IID located in the county the board serves and contiguous counties;
- c.) Directing the individual to the searchable database of vacancies in licensed residential facilities include on the Department of Developmental Disabilities' (DODD) website pursuant to section 5123.193 of the ORC.

The county boards use the Freedom of Choice form to document that the individual has chosen to enroll on the waiver as an alternative to services in an ICF-IID. When the Freedom of Choice form is signed by the individual, the county board shall provide a copy of the Medicaid Fair Hearings Right to the individual using the Ohio Department of Jobs and Family Services (ODJFS) 4074.

- b. Maintenance of Forms.** Per 45 CFR § 92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The completed Freedom of Choice forms are maintained by the 88 county boards of developmental disabilities.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Individuals with limited English proficiency have access to a range of supportive services at the time of application and throughout their participation in the waiver program. The need for language accommodation is determined by the county board of developmental disability. The county board Service and Support Administrator (SSA) makes arrangements for individuals to receive interpretation services as needed to ensure individuals can access services. The Department of Developmental Disabilities (DODD) will monitor access to services by persons with limited English proficiency through its ongoing monitoring and technical assistance process.

The Ohio Department of Job and Family Services (ODJFS) makes interpretation services available at the county and state levels. A variety of ODJFS forms have been translated into Spanish and Somali, including the Medicaid Consumer guide and state hearing forms. The County Departments of Job and Family Services (CDJFS) also make interpreter services available to individuals when needed during the eligibility determination process.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

- a. Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Statutory Service	Participant-Directed Homemaker/Personal Care		
Statutory Service	Residential Respite		
Supports for Participant Direction	Participant-Directed Goods and Services		
Supports for Participant Direction	Participant/Family Stability Assistance		
Supports for Participant Direction	Support Brokerage		
Other Service	Assistive Technology		
Other Service	Career Planning		

Service Type	Service		
Other Service	Clinical/Therapeutic Intervention		
Other Service	Community Respite		
Other Service	Environmental Accessibility Adaptations		
Other Service	Functional Behavioral Assessment		
Other Service	Group Employment Support		
Other Service	Habilitation - Adult Day Support		
Other Service	Habilitation - Vocational Habilitation		
Other Service	Health Care Assessment		
Other Service	Home Delivered Meals		
Other Service	Individual Employment Support		
Other Service	Non-Medical Transportation		
Other Service	Remote Supports		
Other Service	Transportation		
Other Service	Vehicle Modification		
Other Service	Waiver Nursing Delegation		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Participant-Directed Homemaker/Personal Care

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Participant-directed Homemaker/personal care (HPC) means the coordinated provision of a variety of services, supports and supervision necessary for the health and welfare of an individual which enables the individual to live in the community.

These are tasks directed at increasing the independence of the individual within his/her home or community.

This service will help the individual meet daily living needs, and without this service, alone or in combination with other waiver services, the individual would require institutionalization.

Homemaking and personal tasks are combined into a single service titled homemaker/personal care because, in actual practice, a single person provides both services and does so as part of the natural flow of the day. For example, the provider may prepare a dish and place it in the oven to cook (homemaking), assist the individual in washing up before a meal and assist him/her to the table (personal care), put the prepared meal on the table (homemaking), and assist the individual in eating (personal care). Segregating these activities into discrete services is impractical.

Participant Directed Homemaker/personal care may be provided to an individual in an acute care hospital to address the individual's intensive personal care, behavioral support/stabilization, or communication needs when the following conditions are met:

- i. The service is identified in the person-centered service plan.
- ii. The participant directed homemaker/personal care is provided to meet the needs of the individual that are not met through the provision of acute care hospital services.
- iii. Participant Directed Homemaker/personal care is necessary to ensure smooth transition between the acute care hospital and the individual's home ensuring the individual is able to return to their community home preserving the individual's functional abilities.
- iv. The service is not duplicative nor a substitute for service the acute care hospital provides or is obligated to provide through its conditions of participation, federal law, state law, or other applicable requirement.
- v. The person providing homemaker personal care is awake.
- vi. A maximum of 16 hours per day of participant directed homemaker/personal care and a maximum total of no more than thirty days per waiver span may be provided to an individual in an acute care hospital.
- vii. The cost of participant directed homemaker/personal care provided to an individual in an acute care hospital can be accommodated by the individual's authorized budget in the medicaid billing system.

Services included in the provision of Participant-Directed HPC are as follows:

1. Self-advocacy training may include training to assist in the expression of personal preferences, self-representation, self-protection from and reporting of abuse, neglect and exploitation, individual rights and to make increasingly responsible choices.
2. Self-direction, including the identification of and response to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements of life activities.
3. Daily living skills including training in accomplishing routine household tasks, meal preparation, personal care, self-administration of medication, and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid, and communication skills such as using the telephone.
4. Money management services may include training involving money management and personal finances, planning and decision making and may only be provided under HPC if provided in conjunction with other homemaker or personal care tasks.
5. Implementation of recommended follow-up counseling or other therapeutic interventions under the direction of a professional or extension of therapeutic services, which consist of reinforcing physical, occupational, speech and other therapeutic programs. Services are aimed at increasing the overall effective functioning of the individual.
6. Behavior support strategies includes training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors; or extension of therapeutic services. Services are aimed at increasing the overall effective functioning of the individual.
7. Medical and health care services that are integral to meeting the daily needs of the individual (e.g. routine administration of medications or tending to the needs of individuals who are ill or require attention to their medical needs on an ongoing basis).
8. Emergency assistance training includes developing responses in case of emergencies, prevention planning, and training in the use of equipment or technologies used to access emergency response systems.
9. Community access services that explore community services available to all people, natural supports available to the individual, and develop methods to access additional services/supports/activities needed by the individual to be integrated in and have full access to the community.
10. Mobility including training or assistance aimed at enhancing movement within the individual's home, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or other means of providing transportation.

The individual/designee responsibilities and authority to direct the delivery of homemaker/personal care are identified in

OAC 5123-9-32.

Individuals or their representatives will direct/supervise individual providers of participant-directed homemaker/personal care.

In addition to the day-to-day supervision by the individual/designee, Appendix D-1-d identifies the continuous review process implemented by the service and support administrator in accordance with Ohio Administrative Code 5123-5-02.

The type and frequency of supervision and review are tailored to each person's unique needs and specified in the Individual Support Plan.

The individual provider shall comply with the requirements of rule 5123-2-06 regarding behavior supports. If there is an individual behavior support strategy, the individual provider shall be trained in the components of the plan. The individual provider shall maintain documentation of such training in accordance with 5123-9-32 and present such documentation upon request by ODM, DODD, or the county board.

On Site/On Call is a subservice of Participant-Directed Homemaker Personal Care. The on-site/on-call rate is paid when no need for supervision or supports is anticipated for a minimum continuous period of no less than five hours, and a provider must be on-site and available to provide homemaker/personal care if an unanticipated need arises but is not required to remain awake. This service must be documented in the Individual Service Plan. The on-site/on-call rate and service may only be authorized in the residence of the individual or at another location in the community selected by the individual other than the residence of the provider of the service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Due to the scope of services available, Participant-directed HPC may not be provided at the same time the individual is receiving non-residential adult day support, group employment support, individual employment support, or vocational habilitation, non-medical transportation or residential respite. A provider of Participant-directed Homemaker/personal care cannot also provide money management to the same individual. Participant-directed Homemaker/personal care service may not be provided in schools, other educational settings, or in preschool. Billing for participant directed HPC services while an individual is in an acute care hospital will be at the same rate as other HPC.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Provider of Participant-directed Homemaker/personal care
Individual	Independent Provider of Participant-directed Homemaker/personal care

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Participant-Directed Homemaker/Personal Care

Provider Category:

Agency

Provider Type:

Agency Provider of Participant-directed Homemaker/personal care

Provider Qualifications

License (specify):

Certificate (specify):

Participant-directed homemaker/personal care provided to an individual enrolled in the self-empowered life funding waiver will be provided by a common law employee or an agency with choice. A provider of participant-directed homemaker/personal care will meet the requirements below and have a medicaid provider agreement with the Ohio department of medicaid. A provider of participant-directed homemaker/personal care is subject to the following: (a) A common law employee need not hold a high school diploma or certificate of high school equivalence, "American Red Cross" or equivalent certification in first aid, or "American Red Cross" or equivalent certification in cardiopulmonary resuscitation unless specifically required to do so by the individual receiving services; and (b) A common law employee need not complete the eight hours of annual training described in the Homemaker Personal Care service, unless specifically required to do so by the individual receiving services, but in any case will annually complete training in accordance with standards established by the department in: (i) The rights of individuals set forth in section 5123.62 of the Revised Code; and (ii) addressing major unusual incidents and unusual incidents to ensure health, welfare, and continuous quality improvement, including a review of health and welfare alerts issued by the department since the previous year's training. A provider of participant-directed homemaker/personal care will not administer medication or perform health-related activities unless the provider meets the applicable requirements of Chapters 4723., 5123., and 5126. of the Revised Code and rules adopted under those chapters. An applicant seeking certification to provide participant-directed homemaker/ personal care will complete and submit an application through DODD. (8) The individual receiving participant-directed homemaker/personal care will determine training to be completed by the common law employee or staff of the agency with choice as necessary to meet the individual's unique needs.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Developmental Disabilities (DODD).

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Participant-Directed Homemaker/Personal Care

Provider Category:

Individual

Provider Type:

Independent Provider of Participant-directed Homemaker/personal care

Provider Qualifications

License (specify):

Certificate (specify):

Participant-directed homemaker/personal care provided to an individual enrolled in the self-empowered life funding waiver will be provided by a common law employee or an agency with choice. A provider of participant-directed homemaker/personal care will meet the requirements below and have a medicaid provider agreement with the Ohio department of medicaid. A provider of participant-directed homemaker/personal care is subject to the following: (a) A

common law employee need not hold a high school diploma or certificate of high school equivalence, "American Red Cross" or equivalent certification in first aid, or "American Red Cross" or equivalent certification in cardiopulmonary resuscitation unless specifically required to do so by the individual receiving services; and (b) A common law employee need not complete the eight hours of annual training described in the Homemaker Personal Care service, unless specifically required to do so by the individual receiving services, but in any case will annually complete training in accordance with standards established by the department in: (i) The rights of individuals set forth in section 5123.62 of the Revised Code; and (ii) addressing major unusual incidents and unusual incidents to ensure health, welfare, and continuous quality improvement, including a review of health and welfare alerts issued by the department since the previous year's training. A provider of participant-directed homemaker/personal care will not administer medication or perform health-related activities unless the provider meets the applicable requirements of Chapters 4723., 5123., and 5126. of the Revised Code and rules adopted under those chapters. An applicant seeking certification to provide participant-directed homemaker/ personal care will complete and submit an application through DODD. (8) The individual receiving participant-directed homemaker/personal care will determine training to be completed by the common law employee or staff of the agency with choice as necessary to meet the individual's unique needs.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD).

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Residential Respite

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09011 respite, out-of-home

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:**Sub-Category 4:**

Service Definition (Scope):

Residential Respite is a service provided to individuals unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the individuals. Residential Respite shall only be provided in the following locations:

An intermediate care facility for individuals with intellectual disabilities (ICF/IID); or

A residential facility, other than an intermediate care facility for individuals with intellectual disabilities, licensed by the department under section 5123.19 of the Revised Code; or

A residence, other than an intermediate care facility for individuals with intellectual disabilities or a facility licensed by the department under section 5123.19 of the Revised Code, where Residential Respite is provided by an agency provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

See cost limitations as defined in C-4.

Residential Respite is limited to 90 calendar days per waiver eligibility span which is the twelve-month period following either an individual's initial waiver enrollment date or a subsequent eligibility redetermination date. The cost for Residential Respite services does not include room and board.

Only one provider of Residential Respite or Community Respite shall use a daily billing unit on any given day.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Facilities licensed by DODD under section 5123.19 of the Revised Code
Agency	Facilities certified as ICFs/IID
Agency	Agency Providers of Residential Respite

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service

Service Name: Residential Respite

Provider Category:

Agency

Provider Type:

Facilities licensed by DODD under section 5123.19 of the Revised Code

Provider Qualifications**License (specify):**

Licensed by the Ohio Department of Developmental Disabilities under 5123.19 of the Revised Code. All licensed facilities are awarded term licenses of one to three years based upon the results of a licensure survey. The reviews measure compliance with provider standards, including the physical environment, quality of services and areas that ensure the individual's health and welfare. At the end of each term, a review is conducted and a new term is issued (OAC 5123-2-04).

Certificate (specify):

Residential Respite will be provided by a residential facility or an agency provider that meets the requirements below and that has a medicaid provider agreement with the Ohio department of medicaid. An applicant seeking approval to provide residential respite will complete and submit an application through the department.

Prior to providing direct services, each direct support professional who is employed by an agency will successfully complete: (1) Training provided or arranged by the agency provider in: (a) Mission, vision, values, and organizational structure of the agency provider (b) Policies, procedures, and work rules of the agency provider (c) Overview of specific services provided by the agency provider (d) Service documentation that supports billing for services provided (2) Training provided by the department or by an entity using department provided curriculum in: (a) Empathy-based care (b) Role of a direct support professional including "National Alliance for Direct Support Professionals" code of ethics (c) Rights of individuals set forth in section 5123.62 of the Revised Code (d) Implementation of individual service plans and service outcomes (e) Recognizing and reporting major unusual incidents and unusual incidents (f) Universal precautions for infection .

Training provided or arranged by the agency provider specific to the individual service plan of each individual the direct support professional will support regarding what is important to the individual and what is important for the individual (examples include but are not limited to: health and safety; community integration; employment goals; behavioral support strategy; management of the individual's funds; or medication administration/delegated nursing needs) (B) Within thirty calendar days of hire, each direct support professional will successfully complete training provided or arranged by the agency provider in: (1) Person-centered planning and provision of services (2) Facilitating community participation and integration for individuals served (3) how to address major unusual incidents and unusual incidents to ensure health, welfare, and continuous quality improvement, including a review of health and welfare alerts issued by the department (4) Empathy-based care (C) On an annual basis, each direct support professional will successfully complete: (1) Two hours of training provided by the department or by an entity using department-provided curriculum in topics relevant to the direct support professional's duties including: (a) "National Alliance for Direct Support Professionals" code of ethics (b) Rights of individuals set forth in section 5123.62 of the Revised Code (c) Empathy-based care (2) Six hours of training provided or arranged by the agency provider in: (a) Recognizing and reporting major unusual incidents and unusual incidents, agency-specific data regarding major unusual incidents, and strategies for preventing major unusual incidents (b) Review of health and welfare alerts issued by the department since previous year's training (c) Topics selected from the following list that are relevant to services provided and people served by the agency provider: (i) Components of quality care (examples include but are not limited to: interpersonal relationships and trust; cultural competency; effective communication; person-centered philosophy, planning, and practice; implementing individual service plans; trauma-informed care; or empathy-based care) (ii) Health and safety (examples include but are not limited to: signs and symptoms of illness or injury and procedure for response; or transportation safety) (iii) Positive behavioral support (examples include but are not limited to: creating positive culture; general requirements for intervention and behavioral support strategies and role of the direct support professional including documentation; or crisis intervention techniques)

Other Standard (specify):**Verification of Provider Qualifications****Entity Responsible for Verification:**

Ohio Department of Developmental Disabilities

Frequency of Verification:

All licensed facilities are awarded term license of one to three years based upon the results of a licensure survey. The reviews measure compliance with provider standards, including the physical environment, quality of services and areas that ensure the individual's health and welfare. At the end of each term, a review is conducted and a new term is issued (OAC 5123-2-04). Initial certification for providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Residential Respite

Provider Category:

Agency

Provider Type:

Facilities certified as ICFs/IID

Provider Qualifications

License (specify):

Licensed by the Ohio Department of Health as an ICF/IID under Chapter 3721 of the Revised Code. All licensed facilities are awarded term licenses of one to three years based upon the results of a licensure survey. The reviews measure compliance with provider standards, including the physical environment, quality of services and areas that ensure the individual's health and welfare. At the end of each term, a review is conducted and a new term is issued (OAC 5123:-2-04).

Certificate (specify):

Residential Respite will be provided by a residential facility or an agency provider that meets the requirements below and that has a medicaid provider agreement with the Ohio department of medicaid. An applicant seeking approval to provide residential respite will complete and submit an application through the department.

Prior to providing direct services, each direct support professional who is employed by an agency will successfully complete: (1) Training provided or arranged by the agency provider in: (a) Mission, vision, values, and organizational structure of the agency provider (b) Policies, procedures, and work rules of the agency provider (c) Overview of specific services provided by the agency provider (d) Service documentation that supports billing for services provided (2) Training provided by the department or by an entity using department provided curriculum in: (a) Empathy-based care (b) Role of a direct support professional including "National Alliance for Direct Support Professionals" code of ethics (c) Rights of individuals set forth in section 5123.62 of the Revised Code (d) Implementation of individual service plans and service outcomes (e) Recognizing and reporting major unusual incidents and unusual incidents (f) Universal precautions for infection .

Training provided or arranged by the agency provider specific to the individual service plan of each individual the direct support professional will support regarding what is important to the individual and what is important for the individual (examples include but are not limited to: health and safety; community integration; employment goals; behavioral support strategy; management of the individual's funds; or medication administration/delegated nursing needs) (B) Within thirty calendar days of hire, each direct support professional will successfully complete training provided or arranged by the agency provider in: (1) Person-centered planning and provision of services (2) Facilitating community participation and integration for individuals served (3) how to address major unusual incidents and unusual incidents to ensure health, welfare, and continuous quality improvement, including a review of health and welfare alerts issued by the department (4) Empathy-based care (C) On an annual basis, each direct support professional will successfully complete: (1) Two hours of training provided by the department or by an entity using department-provided curriculum in topics relevant to the direct support professional's duties including: (a) "National Alliance for Direct Support Professionals" code of ethics (b) Rights of individuals set forth in section 5123.62 of the Revised Code (c) Empathy-based care (2) Six hours of training provided or arranged by the agency provider in: (a) Recognizing and reporting major unusual incidents and unusual incidents, agency-specific data regarding major unusual incidents, and strategies for preventing major unusual incidents (b) Review of health and welfare alerts issued by the department since previous year's training (c) Topics selected from the following list that are relevant to services provided and people served by the agency provider: (i) Components of quality care (examples include but are not limited to: interpersonal relationships and trust; cultural competency; effective communication; person-centered philosophy, planning, and practice; implementing individual service plans; trauma-informed care; or empathy-based care) (ii) Health and safety (examples include but are not limited to: signs and symptoms of illness or injury and procedure for response; or transportation safety) (iii) Positive behavioral support (examples include but are not limited to: creating positive culture; general requirements for intervention and behavioral support strategies and role of the direct support professional including documentation; or crisis intervention techniques)

Other Standard (specify):

Verification of Provider Qualifications**Entity Responsible for Verification:**

Ohio Department of Developmental Disabilities

Frequency of Verification:

All licensed facilities are awarded term license of one to three years based upon the results of a licensure survey. The reviews measure compliance with provider standards, including the physical environment, quality of services and areas that ensure the individual's health and welfare. At the end of each term, a review is conducted and a new term is issued (OAC 5123-2-04). Initial certification for providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Residential Respite****Provider Category:**

Agency

Provider Type:

Agency Providers of Residential Respite

Provider Qualifications**License (specify):****Certificate (specify):**

Residential Respite will be provided by a residential facility or an agency provider that meets the requirements below and that has a medicaid provider agreement with the Ohio department of medicaid. An applicant seeking approval to provide residential respite will complete and submit an application through the department.

Prior to providing direct services, each direct support professional who is employed by an agency will successfully complete: (1) Training provided or arranged by the agency provider in: (a) Mission, vision, values, and organizational structure of the agency provider (b) Policies, procedures, and work rules of the agency provider (c) Overview of specific services provided by the agency provider (d) Service documentation that supports billing for services provided (2) Training provided by the department or by an entity using department provided curriculum in: (a) Empathy-based care (b) Role of a direct support professional including "National Alliance for Direct Support Professionals" code of ethics (c) Rights of individuals set forth in section 5123.62 of the Revised Code (d) Implementation of individual service plans and service outcomes (e) Recognizing and reporting major unusual incidents and unusual incidents (f) Universal precautions for infection .

Training provided or arranged by the agency provider specific to the individual service plan of each individual the direct support professional will support regarding what is important to the individual and what is important for the individual (examples include but are not limited to: health and safety; community integration; employment goals; behavioral support strategy; management of the individual's funds; or medication administration/delegated nursing needs) (B) Within thirty calendar days of hire, each direct support professional will successfully complete training provided or arranged by the agency provider in: (1) Person-centered planning and provision of services (2) Facilitating community participation and integration for individuals served (3) how to address major unusual incidents and unusual incidents to ensure health, welfare, and continuous quality improvement, including a review of health and welfare alerts issued by the department (4) Empathy-based care (C) On an annual basis, each direct support professional will successfully complete: (1) Two hours of training provided by the department or by an entity using department-provided curriculum in topics relevant to the direct support professional's duties including: (a) "National Alliance for Direct Support Professionals" code of ethics (b) Rights of individuals set forth in section 5123.62 of the Revised Code (c) Empathy-based care (2) Six hours of training provided or arranged by the agency provider in: (a) Recognizing and reporting major unusual incidents and unusual incidents, agency-specific data regarding major unusual incidents, and strategies for preventing major unusual incidents (b) Review of health and welfare alerts issued by the department since previous year's training (c) Topics selected from the following list that are

relevant to services provided and people served by the agency provider: (i) Components of quality care (examples include but are not limited to: interpersonal relationships and trust; cultural competency; effective communication; person-centered philosophy, planning, and practice; implementing individual service plans; trauma-informed care; or empathy-based care) (ii) Health and safety (examples include but are not limited to: signs and symptoms of illness or injury and procedure for response; or transportation safety) (iii) Positive behavioral support (examples include but are not limited to: creating positive culture; general requirements for intervention and behavioral support strategies and role of the direct support professional including documentation; or crisis intervention techniques)

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

DODD

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Participant-Directed Goods and Services

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17010 goods and services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Participant-directed goods and services means services, equipment, or supplies not otherwise provided through the individual's waiver or through the Medicaid state plan that are purchased through the individual budget, address a need clearly identified through assessment of the individual, are specified in the individual service plan, and meet all of the following requirements:

- (a) The services, equipment, or supplies are required to at least one of the following objectives:
 - (i) Decrease the individual's need for other Medicaid home and community-based services;
 - (ii) Advance the individual's participation in the community;
 - (iii) Increase the individual's safety in his or her home;
 - (iv) Increase the individual's independence;
 - (v) Improve the individual's cognitive, social, or behavioral functions; or
 - (vi) Assist the individual to develop or maintain personal, social, or physical skills.
- (b) The individual does not have funds to purchase the services, equipment, or supplies, and they are not available through another source.
- (c) The services, equipment, or supplies support the health and welfare of the individual.
- (d) The services, equipment, or supplies are directly linked in the individual service plan as addressing a need clearly identified through assessment of the individual.
- (e) The services, equipment, or supplies are for the direct medical or remedial benefit of the individual.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limits:

Participant-directed goods and services shall not be specialized services.

Participant directed goods and services shall not include:

- (a) Experimental treatments including items considered by the federal food and drug administration as experimental or investigational or not approved to treat a specific condition;
- (b) Items used solely for entertainment or recreational purposes;
- (c) Pools, spas, or saunas;
- (d) Tobacco products or alcohol;
- (e) Food;
- (f) Internet service;
- (g) Items of general utility;
- (h) New equipment or supplies or repair of previously approved equipment or supplies that have been damaged as a result of confirmed misuse, abuse, or negligence;
- (i) Equipment, supplies, and devices of the same type for the same individual, unless there is a documented change in the individual's condition that warrants the replacement;
- (j) Home modifications that are of general utility or that add to the total square footage of the home; or
- (k) Items that are illegal or otherwise prohibited through federal or state regulations.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Financial management services entity

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Participant-Directed Goods and Services

Provider Category:

Agency

Provider Type:

Financial management services entity

Provider Qualifications

License (specify):

Certificate (specify):

Certification standards do not apply to providers of participant directed goods and services. Provision of participant directed goods and services will be coordinated by a financial management services (FMS) entity. The FMS assures that a medicaid provider agreement is signed by any entity providing a service. Providers of "goods" do not require a medicaid agreement.

Other Standard (specify):

See additional information provided in Appendix E-1-i.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Developmental Disabilities (DODD).

Frequency of Verification:

DODD audits the FMS each 'review cycle' for the SELF Waiver which typically spans a 3-year period.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Participant/Family Stability Assistance

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09020 caregiver counseling and/or training

Category 2:

13 Participant Training

Sub-Category 2:

13010 participant training

Category 3:**Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Participant/Family Stability Assistance means services that enable the participant/family to understand how best to support the individual in their home and/or to enhance the individual's ability to direct their own services. Participant/family stability assistance is intended to support both the participant and the family to live as much like other families as possible in order to prevent or delay unwanted out-of-home placement. The service can only be utilized by the individual or by family members who reside with the individual and must be outcomes-based, meaning that there must be a goal for the service which is listed in the individual's individual service plan (ISP).

Participant/Family Stability Assistance includes training and/or counseling in the following areas:

- (1) Accommodating the individual's disability in the home;
- (2) Accessing supports offered in the community;
- (3) Effectively supporting the individual so that he or she may be fully engaged in the life of the family; and
- (4) Supporting the unique needs of the individual.

Participant/Family Stability Assistance includes the cost of enrollment fees and materials, but does not cover travel expenses.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The service can only be utilized by the participant or family members who reside with the participant.

Experimental treatments are excluded.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Providers of Participant/Family Stability Assistance Training
Agency	Agency Providers of Participant/Family Stability Assistance Training
Agency	Agency Providers of Participant/Family Stability Assistance - Counseling
Individual	Independent Providers of Participant/Family Stability Assistance - Counseling

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Participant/Family Stability Assistance

Provider Category:

Individual

Provider Type:

Independent Providers of Participant/Family Stability Assistance Training

Provider Qualifications

License (specify):

Certificate (specify):

Participant/family stability assistance-training will be provided by an independent provider or an agency provider that meets the requirements below and has a medicaid provider agreement with the Ohio department of medicaid; and has completed and submitted an application through DODD. An individual may determine additional qualifications for a provider of participant/family stability assistance-training; additional qualifications determined by the individual will be recorded in the individual service plan. Participant/family stability assistance-training shall not be provided to an individual by the individual's family member.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Developmental Disabilities (DODD).

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Participant/Family Stability Assistance

Provider Category:

Agency

Provider Type:

Agency Providers of Participant/Family Stability Assistance Training

Provider Qualifications

License (specify):

Certificate (specify):

Participant/family stability assistance-training will be provided by an independent provider or an agency provider that meets the requirements below and has a medicaid provider agreement with the Ohio department of medicaid; and has completed and submitted an application through DODD. An individual may determine additional qualifications for a provider of participant/family stability assistance-training; additional qualifications determined by the individual will be recorded in the individual service plan. Participant/family stability assistance-training shall not be provided to an individual by the

individual's family member.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Developmental Disabilities (DODD).

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Participant/Family Stability Assistance

Provider Category:

Agency

Provider Type:

Agency Providers of Participant/Family Stability Assistance - Counseling

Provider Qualifications

License (specify):

Certificate (specify):

Participant/family stability assistance-training will be provided by an independent provider or an agency provider that meets the requirements below and has a medicaid provider agreement with the Ohio department of medicaid; and has completed and submitted an application through DODD. An individual may determine additional qualifications for a provider of participant/family stability assistance-training; additional qualifications determined by the individual will be recorded in the individual service plan. Participant/family stability assistance-training shall not be provided to an individual by the individual's family member.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Developmental Disabilities (DODD).

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Participant/Family Stability Assistance

Provider Category:

Individual

Provider Type:

Independent Providers of Participant/Family Stability Assistance - Counseling

Provider Qualifications**License (specify):****Certificate (specify):**

Participant/family stability assistance-training will be provided by an independent provider or an agency provider that meets the requirements below and has a medicaid provider agreement with the Ohio department of medicaid; and has completed and submitted an application through DODD. An individual may determine additional qualifications for a provider of participant/family stability assistance-training; additional qualifications determined by the individual will be recorded in the individual service plan. Participant/family stability assistance-training shall not be provided to an individual by the individual's family member.

Other Standard (specify):**Verification of Provider Qualifications****Entity Responsible for Verification:**

The Department of Developmental Disabilities (DODD).

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Support Brokerage

HCBS Taxonomy:**Category 1:**

12 Services Supporting Self-Direction

Sub-Category 1:

12020 information and assistance in support of self-direction

Category 2:**Sub-Category 2:**

Category 3:**Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

A Support Broker is responsible for coaching and mentoring an individual choosing to self-direct waiver services. The support broker empowers an individual to live more independently by presenting person-centered tools and guidance that enable the individual to make informed choices about services, supports and staff. A support broker is responsible, on a continuing or as needed basis, for providing the individual with creative advocacy, advice and assistance related to the individual's waiver services (particularly those associated with self-direction) in accordance with the individual's choices and preferences. The Support Broker assists the individual with the individual's responsibilities regarding self-direction, including understanding employer authority and budget authority, negotiating rates, locating and selecting providers, and keeping the focus of the services and support delivery on the individual and his/her desired outcomes. Support Broker is provided at a ratio of one support broker to one individual.

The Support Broker, working in conjunction with the service and support administrator, will assist the individual with determining how the individual's waiver budget can be most effectively allocated to achieve the individual's desired outcomes and reviewing the provision of self-directed services as specified in the individual service plan.

Support brokerage may extend to those times when an individual is not physically present and the support broker is performing support brokerage activities on behalf of the individual, including times when the support broker is driving to and from locations where support brokerage activities are performed. The nature and duration of support brokerage activities that may be provided on behalf of the individual, including parameters for driving time, will be specified in the individual service plan. Support brokerage may be provided through virtual support under the following conditions: virtual support does not have the effect of isolating an individual from the individual's community or preventing the individual from interacting with people with or without disabilities; the use of virtual support has been agreed to by an individual and the individual's team and is specified in the individual service plan; the use of virtual support complies with applicable laws governing an individual's right to privacy and the individual's protected health information.

Support Brokerage is not duplicative of services available under the Medicaid State Plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Cost Limitation for this service: \$8,000 per waiver eligibility span which is the twelve-month period following either an individual's initial waiver enrollment date or a subsequent eligibility redetermination date.

This service cannot be provided by any of the following entities or any of their employees:

- a. A county board, or its affiliated housing or adult service non-profit corporations
- b. A provider of another HCBS Waiver service, or any related entities affiliated with that provider (including, but not limited to, contractors of providers).

In addition, this waiver service cannot be provided on a paid basis by the parents of a minor child, spouse of an individual, legal guardian, or relative that resides with the individual. Persons enrolled in department-administered home and community-based services waivers will not be paid for providing support brokerage to themselves.

When the costs of Support Brokerage exceeds the identified service limit and as described in C-4 of the application, the department and the county board will collaborate with the individual and the individual's team to ensure the individual's health and welfare needs are met either through waiver funding or non-medicare funds. When waiver funding is necessary, the county board will submit documentation to the department establishing how the additional service cost will ensure the individual's health and welfare.

Service Delivery Method (check each that applies):**Participant-directed as specified in Appendix E****Provider managed****Remote/via Telehealth**

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Provider of Support Brokerage
Individual	Independent Provider of Support Brokerage

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Support Brokerage

Provider Category:

Agency

Provider Type:

Agency Provider of Support Brokerage

Provider Qualifications

License (specify):

Certificate (specify):

Support brokerage will be provided by one of the following: (a) An independent provider or an agency provider that: Meets the requirements noted below and has a medicaid provider agreement with the Ohio department of Medicaid, and has completed and submitted an application through DODD. Support brokerage will be provided by a person who has at least an associate's degree from an accredited college or university, has at least two years of experience providing support for a person with a developmental disability; or is a person enrolled in a department-administered home and community-based services waiver that has been self-directing waiver services for at least two years without utilizing support brokerage services. A person who has successfully completed the department-approved support broker training prior to providing support brokerage. An individual may determine additional qualifications for a provider of support brokerage; additional qualifications determined by the individual will be recorded in the individual service plan.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Developmental Disabilities (DODD).

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Support Brokerage

Provider Category:

Individual

Provider Type:

Independent Provider of Support Brokerage

Provider Qualifications**License (specify):****Certificate (specify):**

Support brokerage will be provided by one of the following: (a) An independent provider or an agency provider that: Meets the requirements noted below and has a medicaid provider agreement with the Ohio department of Medicaid, and has completed and submitted an application through DODD. Support brokerage will be provided by a person who has at least an associate's degree from an accredited college or university, has at least two years of experience providing support for a person with a developmental disability; or is a person enrolled in a department-administered home and community-based services waiver that has been self-directing waiver services for at least two years without utilizing support brokerage services. A person who has successfully completed the department-approved support broker training prior to providing support brokerage. An individual may determine additional qualifications for a provider of support brokerage; additional qualifications determined by the individual will be recorded in the individual service plan.

Other Standard (specify):**Verification of Provider Qualifications****Entity Responsible for Verification:**

The Department of Developmental Disabilities (DODD).

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Technology

HCBS Taxonomy:**Category 1:**

14 Equipment, Technology, and Modifications

Sub-Category 1:

14031 equipment and technology

Category 2:**Sub-Category 2:**

Category 3:**Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

“Assistive technology” means an item, piece of equipment, device, product system, engineered solution, or training of a service animal that addresses an individual’s needs and outcomes identified in his or her individual service plan. The service is for the direct benefit of the individual in maintaining or improving independence, functional capabilities, vocational skills, community involvement or physical skills. Assistive technology has four distinct components:

1. “Assistive technology consultation” means an evaluation of the assistive technology needs of an individual, including a functional evaluation of technologies available to address the individual’s assessed needs and support the individual to achieve outcomes identified in his or her individual service plan.

2. “Assistive technology equipment” means the cost of equipment comprising the assistive technology and may include engineering, designing, fitting, customizing, or otherwise adapting the equipment to meet an individual’s specific needs. Assistive technology equipment may include equipment used for remote support such as motion sensing system, radio frequency identification, live video feed, live audio feed, or web-based monitoring. Assistive technology-equipment may include the cost of software applications or monthly recurring fees, such as subscriptions, necessary to use an item, piece of equipment, device or product system. Assistive technology equipment does not include items otherwise available as environmental accessibility adaptations or specialized medical equipment and supplies, internet service, items or equipment used solely for entertainment or recreational purposes, items or equipment used solely for the purpose of general utility, new equipment or repair of previously approved equipment that has been damaged as a result of confirmed misuse, abuse, or negligence, or purchase or lease of a personal computing device such as a desktop, laptop, or tablet that duplicates any similar equipment in the possession of, or service currently used by, the individual.

The individual service plan or written agreement will note whether the equipment has been purchased outright or if the equipment is being rented from the provider of assistive technology – equipment. This will include that the rental agreement between the provider or assistive technology – equipment and the individual will not exceed the useful life of the equipment and whether the individual will own the equipment or return the equipment to the provider, or renew a rental agreement beyond the useful life of the equipment when that best meets the individual’s needs. Assistive technology-equipment must be the least costly alternative that meets the person’s needs.

When an individual and the team determine assistive technology equipment that has exceeded its useful life requires repair or replacement, the individual and team will authorize the most cost-effective approach – repair or replacement. The amount billed for repair of an item will be the cost of the parts plus associated labor and will not exceed twenty-five per cent of the cost of replacing an item.

3. “Assistive technology support” means education and training that aids an individual in the use of assistive technology equipment as well as training for the individual’s family members, guardians, staff, or other persons who provide natural supports or paid services, employ the individual, or who are otherwise substantially involved in activities being supported by the assistive technology equipment. Assistive technology support may include, when necessary, coordination with complementary therapies or interventions and adjustments to existing assistive technology to ensure its ongoing effectiveness.

4. “Assistive technology - service animal training” means training of an animal to perform a specific job or task for an individual. The job or task performed by the animal must be directly related to the individual’s disability. An animal that provides emotional support, therapy, comfort, or companionship but does not perform a specific job or task for the individual is not a service animal for the purposes of this rule. Assistive technology - service animal training may [include] an annual examination and routine vaccinations of a fully trained service animal.

Assistive technology - service animal training does not include:

- costs of purchasing or otherwise acquiring an animal;

- veterinary care of an animal other than an annual exam and routine vaccinations;
- grooming of an animal;
- food, equipment, or supplies consumed or utilized by an animal;
- modifications to an individual's home or vehicle necessary to accommodate an animal;
- licensing or registering an animal; or
- costs associated with delivery, transport, or boarding of an animal.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Assistive technology support is limited to 40 hours per year which is the twelve-month period following either an individual's initial waiver enrollment date or a subsequent eligibility redetermination date.

The cost of all components of assistive technology equipment shall not exceed five thousand dollars per year.

The cost for initial training of a service animal will not exceed ten thousand dollars per year.

The cost for additional training, following the initial training will not exceed two thousand dollars per waiver eligibility span which is the twelve-month period following either an individual's initial waiver enrollment date or a subsequent eligibility redetermination date.

The cost for annual exam and routine vaccinations will not exceed five hundred dollars per waiver eligibility span which is the twelve-month period following either an individual's initial waiver enrollment date or a subsequent eligibility redetermination date.

When the costs of assistive technology exceeds any of these limits and as described in C-4 of the application, the department and the county board will collaborate with the individual and the individual's team to ensure the individual's health and welfare needs are met either through waiver funding or non-medicaid funds.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Provider of Assistive Technology

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Agency Provider of Assistive Technology

Provider Qualifications

License (specify):

Certificate (specify):

Assistive technology will be provided only by an agency provider that meets the requirements listed below and that has a

medicaid provider agreement with the Ohio department of medicaid. (2) An applicant seeking approval to provide assistive technology will complete and submit an application and maintain DODD certification. (3) An applicant seeking approval to provide assistive technology - consultation will submit documentation to the department demonstrating that persons who deliver the service: (a) Hold a license in occupational therapy or physical therapy issued in accordance with Chapter 4755. of the Revised Code; or (b) Hold a license in speech-language pathology issued in accordance with Chapter 4753. of the Revised Code; or (c) Hold assistive technology professional certification issued by the "Rehabilitation Engineering and Assistive Technology Society of North America;" or (d) Have at least two years of full-time (or part-time equivalent), paid work experience in the developmental disabilities services delivery system and hold a bachelor's degree from an accredited college or university in: (i) Biomedical, computer, electrical, or mechanical engineering; (ii) Health and rehabilitation sciences including, but not limited to, occupational therapy, physical therapy, speech-language pathology, or rehabilitation counseling; or (iii) Engineering technology, special education, or a related program. (4) An applicant seeking approval to provide assistive technology - equipment will provide written assurance that the applicant has experience related to interactive electronic items, devices, product systems, or engineered solutions that directly benefit individuals in maintaining or improving independence, functional capabilities, vocational skills, community involvement, or physical skills. (5) An applicant seeking approval to provide assistive technology - support will meet any of the above requirements. An applicant seeking approval to provide assistive technology - service animal training will submit documentation to the department demonstrating that: Persons or entities that train service animals are reputable and experienced in providing structured training for animals to perform specific jobs or tasks for an individual that are directly related to the individual's disability. Persons who perform or administer an annual examination and routine vaccinations to a fully-trained service animal are licensed to practice veterinary medicine in accordance with Chapter 4741. of the Revised Code.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities

Frequency of Verification:

Initial certification for agency providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Career Planning

HCBS Taxonomy:

Category 1:

03 Supported Employment

Sub-Category 1:

03030 career planning

Category 2:

03 Supported Employment

Sub-Category 2:

03010 job development

Category 3:**Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Career Planning means individualized, person-centered, comprehensive employment planning and support that provides assistance for individuals to attain or advance in competitive integrated employment. Career planning is a focused and time-limited engagement of an individual in identification of a career direction, and development of a plan for achieving competitive integrated employment, and the supports needed to achieve that employment.

Activities that constitute career planning include:

- (a) Situational observation and assessment. Situational observation and assessment is a time-limited (i.e., thirty days for each experience) service that involves observation and assessment of the individual's interpersonal skills, work behaviors, and vocational skills through practical, experiential, community integrated, paid work experiences related to the individual's preferences as established in the individual service plan. Information gathered through situational observation and assessment provides a context to further determine the skills or behaviors to be developed by the individual to ensure his or her success in the individual's preferred work environment.
- (b) Career exploration. Career exploration assists an individual to interact with job holders and observe jobs and job tasks. Career exploration may include informational interviews with and/or shadowing persons who are actually performing the job duties of the identified occupation. When possible, the job seeker shall be given an opportunity to perform actual job duties as well.
- (c) Benefits education and analysis. Benefits education and analysis provides information to job seekers, families, guardians, advocates, service and support administrators, and educators about the impact of paid employment on a range of public assistance and benefits programs, including but not limited to supplemental security income, social security disability insurance, Medicaid buy-in for workers with disabilities, Medicare continuation benefits, veteran's benefits, supplemental nutrition assistance program, and housing assistance.
- (d) Career discovery. Career discovery is an individualized, comprehensive process to help a person, who is pursuing individualized integrated employment or self-employment, reveal how interests and activities of daily life may be translated into possibilities for integrated employment. Career discovery results in identification of the individual's interests in one or more specific aspects of the job market; the individual's skills, strengths, and other contributions likely to be valuable to employers or valuable to the community if offered through self-employment; and conditions necessary for the individual's successful employment or self-employment. Career discovery culminates in development of a written career discovery profile summarizing the process, revelations, and recommendations for next steps which shall be used to develop the individual's vocational portfolio.
- (e) Employment/self-employment plan. Employment/self-employment plan is an individualized service to create a clear plan for employment or the start-up phase of self-employment and includes a planning meeting involving the job seeker and other key people who will be instrumental in supporting the job seeker to become employed in competitive integrated employment. This service may include career advancement planning for individuals who are already employed. This service culminates in a written employment plan directly tied to the results of career exploration, if previously authorized, situational observation and assessment, and/or career discovery. For individuals seeking self-employment, this service results in the development of a self-employment business plan that identifies training and technical assistance needs and potential supports and resources for those services as well as potential sources of business financing given that Medicaid funds may not be used to defray the capital expenses associated with starting up a business.
- (f) Job development. Job development is an individualized service to develop a strategy to attain competitive integrated employment. The job development strategy shall reflect best practices. The service may include analyzing a job site, identifying necessary accommodations, and negotiating with an employer for customized employment. This service is intended to result in achievement of a competitive integrated employment outcome consistent with the job seeker's or job holder's personal and career goals as identified in the individual service plan, as determined through career exploration, situational observation and assessment, career discovery, and/or the employment planning process. This service shall not be provided to an individual on place four of the path to community employment as described in rule 5123-2-05 of the Administrative Code.

(g) Self-employment launch. Self-employment launch is support to implement a self-employment business plan and launch a business. This service is intended to result in the achievement of an integrated employment outcome consistent with the job seeker's or job holder's personal and career goals as identified in the individual service plan, as determined through career exploration, situational observation and assessment, career discovery, and/or the employment planning process. This service shall not be provided to an individual on place four of the path to community employment as described in rule 5123-2-05 of the Administrative Code.(h) Worksite accessibility. Worksite accessibility includes:

(i) Time spent identifying the need for and ensuring the provision of reasonable worksite accommodations that allow the job seeker or job holder to gain, retain, and enhance employment or self-employment;

(ii) Time spent ensuring the provision of reasonable worksite accommodations through partnership efforts with the employer and, where appropriate, the opportunities for Ohioans with disabilities agency; and

(iii) Purchasing or modifying equipment that will be retained by the individual at the current employment site and/or in other settings, when documented that funding from the opportunities for Ohioans with disabilities agency or any other source is not available.

Requirements for service delivery:

The expected outcome of career planning is the individual's attainment of competitive integrated employment and/or career advancement in competitive integrated employment. 2) Career planning shall be provided pursuant to a person-centered individual service plan that conforms to the requirements of rules 5123-4-02 and 5123-2-05 of the Administrative Code and shall be coordinated with other services and supports set forth in the individual service plan.

3) Career planning may be provided in a variety of settings but shall not be furnished in the individual's residence or other living arrangement except for a home visit conducted as part of career discovery or when the individual is self-employed, and the residence is the site of self-employment.

4) Career planning shall be provided at a ratio of one staff to one individual.

5) Career planning services may extend to those times when the individual is not physically present while the provider is performing career planning activities on behalf of the individual.

6) A provider of career planning shall recognize changes in the individual's condition and behavior as well as safety and sanitation hazards

A provider of the job development component of career planning may be eligible for an outcome-based payment following an individual's achievement of competitive integrated employment.

a) A provider may obtain either or both of two possible outcome-based payments for each individual served:

i) One payment when the individual secures competitive integrated employment.

ii) One payment when the individual secures competitive integrated employment that: Pays at least twelve dollars per hour; and/or employs the individual for an average of at least thirty hours per week as determined over the course of at least four weeks.

b) To obtain an outcome-based payment, a provider will secure one or more pay stubs from the individual served sufficient to document the competitive integrated employment and/or hourly wage or average hours worked following provision of the job development component of career planning. The provider will submit the pay stub or pay stubs to the individual's service and support administrator, who will authorize the outcome-based payment in the individual service plan. When pay stubs cannot be secured, the provider will instead submit an attestation that the outcome has been achieved.

c) The amount of the outcome-based payment is determined by the nature of the competitive integrated employment and the acuity assessment group assignment of the individual at the time the individual secures competitive integrated employment.

d) No more than two outcome-based payments will be made during an individual's waiver eligibility span which is the twelve-month period following either an individual's initial waiver enrollment date or a subsequent eligibility redetermination date.

e) The service codes and payment rates for outcome-based payments are contained in the appendix to Ohio Administrative rule 5123-9-13.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Payment for adult day support, career planning, group employment support, individual employment support, and vocational habilitation alone or in combination, shall not exceed the budget limitations contained in appendix B to rule 5123:2-9-19 of the Administrative Code.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	For profit and non-profit private providers of career planning service
Individual	Independent provider of career planning

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Career Planning

Provider Category:

Agency

Provider Type:

For profit and non-profit private providers of career planning service

Provider Qualifications

License (specify):

Certificate (specify):

Career planning will be provided by an agency provider that is certified by the Department of Developmental Disabilities and has a medicaid provider agreement with the Ohio Department of Medicaid.

An agency provider will ensure that direct support professionals who provide career planning successfully complete, no later than thirty calendar days after hire, training in: (a) Services that comprise career planning including the expectation that career planning will eventually lead to competitive integrated employment; (b) Signs and symptoms of illness or injury and procedure for response; (c) Building/site-specific emergency response plans; and (d) Program-specific transportation safety.

An agency provider will ensure that: (a) Direct support professionals who perform the benefits education and analysis component of career planning have successfully completed nationally approved or accredited training in benefits education and analysis. (b) Direct support professionals who perform the worksite accessibility component of career planning hold an appropriate license (e.g., occupational therapist) or certification (e.g., certified professional ergonomist issued by the "Board of Certification in Professional Ergonomics"), or have successfully completed appropriate training by an accredited college or university.

An agency provider will ensure that direct support professionals who provide career planning (other than those who have at least one year of experience providing career planning at the point of hire), during the first year after hire, are assigned and have access to a mentor.

An agency provider will ensure that direct support professionals who provide career planning (other than those who have at least one year of experience providing career planning at the point of hire), no later than one year after hire, successfully complete at least eight hours of training specific to the provision of career planning that includes, but is not limited to: (a) Skill building in advancement of individuals on the path to competitive integrated employment and development of individuals' strengths and skills necessary for competitive integrated employment; and (b) Self-determination which includes assisting the individual to develop self-advocacy skills, to exercise civil rights, to exercise control and responsibility over the services received, and to acquire skills that enable becoming more independent, productive, and integrated within the community.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Developmental Disabilities (DODD)

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Career Planning

Provider Category:

Individual

Provider Type:

Independent provider of career planning

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Career planning will be provided by an independent provider that is certified by the Department of Developmental Disabilities and has a medicaid provider agreement with the Ohio Department of Medicaid.

An independent provider will have: (a) At least one year of full-time (or part-time equivalent), paid work experience related to employment planning and support that assists individuals to achieve competitive integrated employment; or (b) Thirty hours of formal training related to employment planning and support that assists individuals to achieve competitive integrated employment.

Additionally, an independent provider of the benefits education and analysis component of career planning will have successfully completed nationally approved or accredited training in benefits education and analysis. An independent provider of the worksite accessibility component of career planning will hold an appropriate license (e.g., occupational therapist) or certification (e.g., certified professional ergonomist issued by the "Board of Certification in Professional Ergonomics"), or have successfully completed appropriate training by an accredited college or university.

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Developmental Disabilities (DODD)

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Clinical/Therapeutic Intervention

HCBS Taxonomy:

Category 1:

10 Other Mental Health and Behavioral Services

Sub-Category 1:

10040 behavior support

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Clinical/Therapeutic Intervention means services that assist unpaid caregivers and/or paid support staff in carrying out individual treatment/support plans, that are not covered by the Medicaid State Plan, and are necessary to improve the individuals independence and inclusion in their community. Clinical/Therapeutic Intervention includes consultation activities that are provided by professionals in psychology, counseling and behavior management. The service includes the development of a treatment/support plan, training and technical assistance to carry out the plan, delivery of the services described in the plan, and monitoring of the individual and the provider in the implementation of the plan. This service may be delivered in the individuals home or in the community, as described in the individual service plan (ISP).

Clinical/Therapeutic Intervention is not duplicative of services available under the Medicaid State Plan. Early Periodic Screening, Diagnosis and Treatment (EPSDT) services, as applicable, must be exhausted prior to accessing Clinical/Therapeutic Intervention services under the waiver.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Experimental treatments are prohibited.

This service must be deemed necessary to reduce an individuals intensive behaviors. A determination of whether or not this service will provide the desired benefit, in the form of a Functional Behavioral Assessment (which may be pre-existing or supplied as a waiver service), will be determined on an individual basis by one of the following: Licensed Professional Clinical Counselor (per OAC 4757.22), Licensed Professional Counselor (per OAC 4757.23), Licensed Independent Social Worker (LISW) (per OAC 4757.27), or Licensed Social Worker under supervision of an LISW (per OAC 4757.28).

A Clinical/Therapeutic Interventionist must work under supervision of a Specialized Clinical/Therapeutic Interventionist or a Senior Level Specialized Clinical/Therapeutic Interventionist.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Specialized Clinical/Therapeutic Interventionist
Agency	Clinical/Therapeutic Interventionist
Individual	Senior Level Specialized Clinical/Therapeutic Interventionist
Individual	Clinical/Therapeutic Interventionist
Individual	Specialized Clinical/Therapeutic Interventionist
Agency	Senior Level Specialized Clinical/Therapeutic Interventionist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Clinical/Therapeutic Intervention

Provider Category:

Agency

Provider Type:

Specialized Clinical/Therapeutic Interventionist

Provider Qualifications

License (specify):

Certificate (specify):

For both agency and individual providers, the person/entity must have a medicaid provider agreement with the Ohio department of medicaid and submit an application to DODD. Clinical/therapeutic intervention shall will be provided by senior level specialized clinical/therapeutic interventionists, specialized clinical/ therapeutic interventionists, and clinical/therapeutic interventionists. (a) A senior level specialized clinical/therapeutic interventionist shall will have a doctoral degree in psychology, special education, medicine, or a related discipline; be licensed or certified under the laws of the state to practice in that field; and have at least three months of experience and/or training in the implementation and oversight of comprehensive interventions for individuals with developmental disabilities who need significant behaviorally-focused interventions. (b) A specialized clinical/therapeutic interventionist shall will : (i) Have a master's degree in psychology, special education, or a related discipline and be licensed or certified under the laws of the state to practice in that field or be registered with the state board of psychology as an aide or a psychology aide working under psychological work supervision in accordance with standards of the state board of psychology; and (ii) Have at least three months of experience and/or training in the implementation and oversight of comprehensive interventions for individuals with developmental disabilities who need significant behaviorally-focused interventions. A clinical/therapeutic interventionist shall will work under the supervision of a senior level specialized clinical/therapeutic interventionist or a specialized clinical/therapeutic interventionist and shall : (i) Have experience providing one-to-one care for an individual with developmental disabilities who needs significant behaviorally focused interventions; (ii) Have undergone two monitored sessions with an individual with developmental disabilities who needs significant behaviorally focused interventions; (iii) Hold a "Registered Behavior Technician" credential issued by the behavior analyst certification board; or (iv) Hold a "Board Certified Assistant Behavior Analyst" credential issued by the behavior analyst certification board.) (4) Clinical/therapeutic intervention shall not be provided to an individual by the individual's family member.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Developmental Disabilities (DODD).

Frequency of Verification:

Initial certification for agency providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Clinical/Therapeutic Intervention

Provider Category:

Agency

Provider Type:

Clinical/Therapeutic Interventionist

Provider Qualifications

License (specify):

Certificate (specify):

For both agency and individual providers, the person/entity must have a medicaid provider agreement with the Ohio department of medicaid and submit an application to DODD. Clinical/therapeutic intervention shall will be provided by senior level specialized clinical/therapeutic interventionists, specialized clinical/ therapeutic interventionists, and clinical/therapeutic interventionists. (a) A senior level specialized clinical/therapeutic interventionist shall will have a doctoral degree in psychology, special education, medicine, or a related discipline; be licensed or certified under the laws of the state to practice in that field; and have at least three months of experience and/or training in the implementation and oversight of comprehensive interventions for individuals with developmental disabilities who need significant behaviorally-focused interventions. (b) A specialized clinical/therapeutic interventionist shall will : (i) Have a master's degree in psychology, special education, or a related discipline and be licensed or certified under the laws of the state to practice in that field or be registered with the state board of psychology as an aide or a psychology aide working under psychological work supervision in accordance with standards of the state board of psychology; and (ii) Have at least three months of experience and/or training in the implementation and oversight of comprehensive interventions for individuals with developmental disabilities who need significant behaviorally-focused interventions. A clinical/therapeutic interventionist shall will work under the supervision of a senior level specialized clinical/therapeutic interventionist or a specialized clinical/therapeutic interventionist and shall : (i) Have experience providing one-to-one care for an individual with developmental disabilities who needs significant behaviorally focused interventions; (ii) Have undergone two monitored sessions with an individual with developmental disabilities who needs significant behaviorally focused interventions; (iii) Hold a "Registered Behavior Technician" credential issued by the behavior analyst certification board; or (iv) Hold a "Board Certified Assistant Behavior Analyst" credential issued by the behavior analyst certification board.) (4) Clinical/therapeutic intervention shall not be provided to an individual by the individual's family member.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Developmental Disabilities.

Frequency of Verification:

Initial certification for agency providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Clinical/Therapeutic Intervention

Provider Category:

Individual

Provider Type:

Senior Level Specialized Clinical/Therapeutic Interventionist

Provider Qualifications

License (specify):

Certificate (specify):

For both agency and individual providers, the person/entity must have a medicaid provider agreement with the Ohio department of medicaid and submit an application to DODD. Clinical/therapeutic intervention shall will be provided by senior level specialized clinical/therapeutic interventionists, specialized clinical/ therapeutic interventionists, and clinical/therapeutic interventionists. (a) A senior level specialized clinical/therapeutic interventionist shall will have a doctoral degree in psychology, special education, medicine, or a related discipline; be licensed or certified under the laws of the state to practice in that field; and have at least three months of experience and/or training in the implementation and oversight of comprehensive interventions for individuals with developmental disabilities who need significant behaviorally-focused interventions. (b) A specialized clinical/therapeutic interventionist shall will : (i) Have a master's degree in psychology, special education, or a related discipline and be licensed or certified under the laws of the state to practice in that field or be registered with the state board of psychology as an aide or a psychology aide working under psychological work supervision in accordance with standards of the state board of psychology; and (ii) Have at least three months of experience and/or training in the implementation and oversight of comprehensive interventions for individuals with developmental disabilities who need significant behaviorally-focused interventions. A clinical/therapeutic interventionist shall will work under the supervision of a senior level specialized clinical/therapeutic interventionist or a specialized clinical/therapeutic interventionist and shall : (i) Have experience providing one-to-one care for an individual with developmental disabilities who needs significant behaviorally focused interventions; (ii) Have undergone two monitored sessions with an individual with developmental disabilities who needs significant behaviorally focused interventions; (iii) Hold a "Registered Behavior Technician" credential issued by the behavior analyst certification board; or (iv) Hold a "Board Certified Assistant Behavior Analyst" credential issued by the behavior analyst certification board.) (4) Clinical/therapeutic intervention shall not be provided to an individual by the individual's family member.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Developmental Disabilities.

Frequency of Verification:

Initial certification for agency providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Clinical/Therapeutic Intervention

Provider Category:

Individual

Provider Type:

Clinical/Therapeutic Interventionist

Provider Qualifications

License (specify):

Certificate (specify):

For both agency and individual providers, the person/entity must have a medicaid provider agreement with the Ohio department of medicaid and submit an application to DODD. Clinical/therapeutic intervention shall will be provided by senior level specialized clinical/therapeutic interventionists, specialized clinical/ therapeutic interventionists, and clinical/therapeutic interventionists. (a) A senior level specialized clinical/therapeutic interventionist shall will have a doctoral degree in psychology, special education, medicine, or a related discipline; be licensed or certified under the laws of the state to practice in that field; and have at least three months of experience and/or training in the implementation and oversight of comprehensive interventions for individuals with developmental disabilities who need significant behaviorally-focused interventions. (b) A specialized clinical/therapeutic interventionist shall will : (i) Have a master's degree in psychology, special education, or a related discipline and be licensed or certified under the laws of the state to practice in that field or be registered with the state board of psychology as an aide or a psychology aide working under psychological work supervision in accordance with standards of the state board of psychology; and (ii) Have at least three months of experience and/or training in the implementation and oversight of comprehensive interventions for individuals with developmental disabilities who need significant behaviorally-focused interventions. A clinical/therapeutic interventionist shall will work under the supervision of a senior level specialized clinical/therapeutic interventionist or a specialized clinical/therapeutic interventionist and shall : (i) Have experience providing one-to-one care for an individual with developmental disabilities who needs significant behaviorally focused interventions; (ii) Have undergone two monitored sessions with an individual with developmental disabilities who needs significant behaviorally focused interventions; (iii) Hold a "Registered Behavior Technician" credential issued by the behavior analyst certification board; or (iv) Hold a "Board Certified Assistant Behavior Analyst" credential issued by the behavior analyst certification board.) (4) Clinical/therapeutic intervention shall not be provided to an individual by the individual's family member.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Developmental Disabilities.

Frequency of Verification:

Initial certification for agency providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Clinical/Therapeutic Intervention

Provider Category:

Individual

Provider Type:

Specialized Clinical/Therapeutic Interventionist

Provider Qualifications

License (specify):

Certificate (specify):

For both agency and individual providers, the person/entity must have a medicaid provider agreement with the Ohio department of medicaid and submit an application to DODD. Clinical/therapeutic intervention shall will be provided by

senior level specialized clinical/therapeutic interventionists, specialized clinical/ therapeutic interventionists, and clinical/therapeutic interventionists. (a) A senior level specialized clinical/therapeutic interventionist shall will have a doctoral degree in psychology, special education, medicine, or a related discipline; be licensed or certified under the laws of the state to practice in that field; and have at least three months of experience and/or training in the implementation and oversight of comprehensive interventions for individuals with developmental disabilities who need significant behaviorally-focused interventions. (b) A specialized clinical/therapeutic interventionist shall will : (i) Have a master's degree in psychology, special education, or a related discipline and be licensed or certified under the laws of the state to practice in that field or be registered with the state board of psychology as an aide or a psychology aide working under psychological work supervision in accordance with standards of the state board of psychology; and (ii) Have at least three months of experience and/or training in the implementation and oversight of comprehensive interventions for individuals with developmental disabilities who need significant behaviorally-focused interventions. A clinical/therapeutic interventionist shall will work under the supervision of a senior level specialized clinical/therapeutic interventionist or a specialized clinical/therapeutic interventionist and shall : (i) Have experience providing one-to-one care for an individual with developmental disabilities who needs significant behaviorally focused interventions; (ii) Have undergone two monitored sessions with an individual with developmental disabilities who needs significant behaviorally focused interventions; (iii) Hold a "Registered Behavior Technician" credential issued by the behavior analyst certification board; or (iv) Hold a "Board Certified Assistant Behavior Analyst" credential issued by the behavior analyst certification board.) (4) Clinical/therapeutic intervention shall not be provided to an individual by the individual's family member.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Developmental Disabilities.

Frequency of Verification:

Initial certification for agency providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Clinical/Therapeutic Intervention

Provider Category:

Agency

Provider Type:

Senior Level Specialized Clinical/Therapeutic Interventionist

Provider Qualifications

License (specify):

Certificate (specify):

For both agency and individual providers, the person/entity must have a medicaid provider agreement with the Ohio department of medicaid and submit an application to DODD. Clinical/therapeutic intervention shall will be provided by senior level specialized clinical/therapeutic interventionists, specialized clinical/ therapeutic interventionists, and clinical/therapeutic interventionists. (a) A senior level specialized clinical/therapeutic interventionist shall will have a doctoral degree in psychology, special education, medicine, or a related discipline; be licensed or certified under the laws of the state to practice in that field; and have at least three months of experience and/or training in the implementation and oversight of comprehensive interventions for individuals with developmental disabilities who need significant behaviorally-focused interventions. (b) A specialized clinical/therapeutic interventionist shall will : (i) Have a master's degree in psychology, special education, or a related discipline and be licensed or certified under the laws of the state to practice in that field or be registered with the state board of psychology as an aide or a psychology aide working under psychological work supervision in accordance with standards of the state board of psychology; and (ii) Have at least three months of

experience and/or training in the implementation and oversight of comprehensive interventions for individuals with developmental disabilities who need significant behaviorally-focused interventions. A clinical/therapeutic interventionist shall will work under the supervision of a senior level specialized clinical/therapeutic interventionist or a specialized clinical/therapeutic interventionist and shall : (i) Have experience providing one-to-one care for an individual with developmental disabilities who needs significant behaviorally focused interventions; (ii) Have undergone two monitored sessions with an individual with developmental disabilities who needs significant behaviorally focused interventions; (iii) Hold a "Registered Behavior Technician" credential issued by the behavior analyst certification board; or (iv) Hold a "Board Certified Assistant Behavior Analyst" credential issued by the behavior analyst certification board.) (4) Clinical/therapeutic intervention shall not be provided to an individual by the individual's family member.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Developmental Disabilities.

Frequency of Verification:

Initial certification for agency providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Respite

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09011 respite, out-of-home

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Community Respite means services provided to individuals unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the individuals. Community Respite shall only be provided outside of an individual's home in a camp, recreation center, or other place where an organized community program or activity occurs.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Community Respite shall not be provided to an individual at the same time by the same provider as Participant-Directed Homemaker/Personal Care (PD-HPC). Only one provider of Residential Respite or Community Respite shall use a daily billing unit on any given day. Community respite shall not be simultaneously provided at the same location where adult day services are being provided.

Payment for Community Respite does not include room and board.

Community Respite is limited to 60 calendar days of service per waiver eligibility span which is the twelve-month period following either an individual's initial waiver enrollment date or a subsequent eligibility redetermination date.

Community Respite is part of the overall cost limitation for the SELF waiver of \$41,424/year for children and \$61,136/year for adults.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Community Respite Providers

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Community Respite

Provider Category:

Agency

Provider Type:

Agency Community Respite Providers

Provider Qualifications

License (specify):

Certificate (specify):

Community respite will be provided by an agency provider that meets the requirements below and that has a medicaid provider agreement with the Ohio department of medicaid. An applicant seeking approval to provide community respite will complete and submit an application through DODD. A provider of community respite will provide written assurance and ensure that all employees, contractors, and employees of contractors delivering community respite shall 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.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Developmental Disabilities (DODD).

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Accessibility Adaptations

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Environmental accessibility adaptations means those physical modifications to the inside or outside of an individual's home (e.g., installation of ramps or grab bars, widening of doorways, modification of bathroom facilities, or installation of specialized electrical systems to operate an individual's medical equipment). The physical modification to the individual's home must be determined by the individual's team necessary to support the individual to reside in a community-based setting and either ensure the health, welfare and safety of the individual or enable the individual to function with greater independence while at home and noted in the individual's individual services plan (ISP).

Environmental accessibility adaptations includes repair of previously approved environmental accessibility adaptations funded by the individual's waiver when repair is more cost effective than replacement and the repair is not necessary as a result of apparent misuse, abuse, or negligence.

Excluded are those modifications to the home that are of general utility (i.e., not specifically related to the individual's disability and assessed needs), are not of direct medical or remedial benefit to the individual, such as roof repair, central air conditioning, modifications that add to the total square footage of the home or are a typical homeowner's responsibility (e.g., complying with a local building code).

Environmental accessibility adaptations do not include modifications to a residential facility, modifications to a home owned or leased by a provider of home and community-based services except when the home is owned or leased by a provider who is providing shared living to the individual, construction of a new home or an addition to a home (i.e., building walls where no walls exist), repair or replacement of previously approved environmental accessibility adaptations damaged as a result of apparent misuse, abuse, or negligence and restoring a home to its prior state – as it existed prior to installation of environmental accessibility adaptations.

An individual's need for environmental accessibility adaptations will be identified through an assessment conducted by a qualified professional (e.g., occupational therapist or physical therapist) acting within the scope of practice. A provider of environmental accessibility adaptations will comply with all applicable state and local regulations that apply to the operation of the provider's business or trade. Whenever possible, an individual's service and support administrator will secure at least two bids from department-certified providers of environmental accessibility adaptations that meet the individual's needs as identified in the assessment described in OAC rule 5123-9-23.

A bid submitted by a provider of environmental accessibility adaptations will include:

- (a) An itemized quote of the physical modification to be made including a description of each component of the project (such as demolition, permit fees, installation of new materials, cleanup, and debris removal), specific materials (such as brand name and item number) to be installed, and associated costs for materials and labor.
- (b) A detailed scale drawing depicting the physical modification to be made.
- (c) A timeline with anticipated dates for starting and completing the project which must fall within a single waiver eligibility span.
- (d) Documentation demonstrating the provider is bonded, licensed, and/or insured for the nature of work to be performed.
- (e) A description of any warranties of materials or labor.

The individual and the individual's team will evaluate the bids to identify the lowest cost alternative available that meets the individual's assessed needs.

The services under the Environmental Accessibility Adaptations service are limited to additional services not otherwise covered under the state plan, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT), but consistent with waiver objectives of avoiding institutionalization.

When an individual is moving from an institutional setting, environmental accessibility adaptations may be authorized for up to one hundred eighty calendar days prior to the date on which the individual enrolls in the individual options.

Environmental accessibility adaptations begun while the individual is living in the institutional setting are not considered complete and the service may not be billed until the date the individual leaves the institution and enrolls in the waiver.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

When the cost of needed environmental accessibility adaptations exceeds fifteen thousand dollars per project, the department and the county board will collaborate with the individual and the individual's team to ensure the individual's health and welfare needs are met either through waiver funding or non-medicaid funds. When waiver funding is necessary, the county board will submit documentation to the department establishing how the project will ensure the individual's health and welfare.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Environmental Accessibility Providers
Agency	Agency Environmental Accessibility Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Independent Environmental Accessibility Providers

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Environmental accessibility adaptations will be provided by an independent provider or an agency provider that has a medicaid provider agreement with the Ohio department of medicaid. An independent provider may not employ, either directly or through contract, anyone else to provide the services. An applicant seeking approval to provide environmental accessibility adaptations will complete and submit an application to DODD and submit to the department documentation verifying the applicant's experience in providing environmental accessibility adaptations and attest that the applicant will complete environmental accessibility adaptations in accordance with applicable state and local building codes

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Developmental Disabilities

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Agency Environmental Accessibility Provider

Provider Qualifications

License (specify):

02/13/2026

Certificate (specify):

Other Standard (specify):

Environmental accessibility adaptations will be provided by an independent provider or an agency provider that has a medicaid provider agreement with the Ohio department of medicaid. An independent provider may not employ, either directly or through contract, anyone else to provide the services. An applicant seeking approval to provide environmental accessibility adaptations will complete and submit an application to DODD and submit to the department documentation verifying the applicant's experience in providing environmental accessibility adaptations and attest that the applicant will complete environmental accessibility adaptations in accordance with applicable state and local building codes

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Developmental Disabilities

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Functional Behavioral Assessment

HCBS Taxonomy:

Category 1:

10 Other Mental Health and Behavioral Services

Sub-Category 1:

10040 behavior support

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Functional Behavioral Assessment is an assessment not otherwise available under the state Medicaid program to determine why an individual engages in intensive behaviors and how the individual's behaviors relate to the environment. Functional Behavioral Assessments describe the relationship between a skill or performance problem and the variables that contribute to its occurrence. Functional Behavioral Assessments can provide information to develop a hypothesis as to why the individual engages in the behavior; when the individual is most likely to demonstrate the behavior; and situations in which the behavior is least likely to occur.

Functional Behavioral Assessment is not duplicative of services available under the Medicaid State Plan. Early Periodic Screening, Diagnosis and Treatment (EPSDT) services, as applicable, must be exhausted prior to accessing Functional Behavioral Assessment services under the waiver.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Cost Limitation for this service: \$1,500 per waiver eligibility span which is the twelve-month period following either an individual's initial waiver enrollment date or a subsequent eligibility redetermination date.

Limit of 1 Functional Behavioral Assessment per waiver eligibility span which is the twelve-month period following either an individual's initial waiver enrollment date or a subsequent eligibility redetermination date.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Provider of Functional Behavioral Assessment
Individual	Independent Provider of Functional Behavioral Assessment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Functional Behavioral Assessment

Provider Category:

Agency

Provider Type:

Agency Provider of Functional Behavioral Assessment

Provider Qualifications

License (specify):

Must be licensed as one of the following: Licensed Professional Clinical Counselor per OAC 4757.22; Licensed Professional Counselor per OAC 4757.23; Licensed Independent Social Worker per OAC 4757.27; or Licensed Social Worker (under the supervision of an LISW) per OAC 4757.28, Psychologist licensed pursuant to Chapter 4732. of the Revised Code; Certified Ohio behavior analyst certified pursuant to section 4783.04 of the Revised Code.

Certificate (specify):

This service may be provided by an independent provider who meets the below or an agency who employees staff who meet the following criteria:

Functional behavioral assessment will be provided by a person who has the experience necessary to perform psychometric tests that assess an individual's functional behavioral level and who is a: (a) Psychologist licensed pursuant to Chapter 4732.

of the Revised code, b) Professional clinical counselor licensed pursuant to 4757.22 of the Revised Code; (c) Professional counselor licensed pursuant to section 4757.23 of the Revised Code; (d) Independent social worker licensed pursuant to 4757.27 of the Revised Code; (e) Social worker licensed pursuant to section 4757.28 of the Revised Code working under the supervision of a licensed independent social worker; or (f) Certified Ohio behavior analyst certified pursuant to 4783.04 of the Revised Code.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Developmental Disabilities.

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Functional Behavioral Assessment

Provider Category:

Individual

Provider Type:

Independent Provider of Functional Behavioral Assessment

Provider Qualifications

License (specify):

Must be licensed as one of the following: Licensed Professional Clinical Counselor per OAC 4757.22; Licensed Professional Counselor per OAC 4757.23; Licensed Independent Social Worker per OAC 4757.27; or Licensed Social Worker (under the supervision of an LISW) per OAC 4757.28; Psychologist licensed pursuant to Chapter 4732. of the Revised Code; Certified Ohio behavior analyst certified pursuant to section 4783.04 of the Revised Code.

Certificate (specify):

This service may be provided by an independent provider who meets the below or an agency who employees staff who meet the following criteria:

Functional behavioral assessment will be provided by a person who has the experience necessary to perform psychometric tests that assess an individual's functional behavioral level and who is a: (a) Psychologist licensed pursuant to Chapter 4732. of the Revised code, b) Professional clinical counselor licensed pursuant to 4757.22 of the Revised Code; (c) Professional counselor licensed pursuant to section 4757.23 of the Revised Code; (d) Independent social worker licensed pursuant to 4757.27 of the Revised Code; (e) Social worker licensed pursuant to section 4757.28 of the Revised Code working under the supervision of a licensed independent social worker; or (f) Certified Ohio behavior analyst certified pursuant to 4783.04 of the Revised Code.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Developmental Disabilities.

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

HCBS Taxonomy:
Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Group employment support means services and training activities provided in regular business, industry, and community settings for groups of two or more workers with disabilities such as mobile work crews and other business-based work groups engaging workers with disabilities in employment in the community.

(a) Activities that constitute group employment support include any combination of the following as necessary and appropriate to meet the community employment goals of the individual:

(i) Person-centered employment planning;

(ii) Work adjustment;

(iii) Job analysis;

(iv) Training and systematic instruction;

(v) Job coaching; and

(vi) Training in independent planning, arranging, and using transportation.

(b) Group employment support is provided in two distinct service arrangements:

(i) Dispersed enclaves in which individuals work in a self-contained unit within a company or service site in the community or perform multiple jobs in the company, but are not integrated with non-disabled employees of the company.

(ii) Mobile work crews comprised solely of individuals operating as distinct units and/or self-contained business working in

several locations within the community.

Requirements for service delivery:

- (1) The expected outcome of group employment support is paid employment and work experience leading to further career development and competitive integrated employment.
- (2) Group employment support shall be provided pursuant to a person-centered individual service plan that conforms to the requirements of rules 5123:2-1-11 and 5123:2-2-05 of the Administrative Code and shall be coordinated with other services and supports set forth in the individual service plan.
- (3) The service and support administrator shall ensure that documentation is maintained to demonstrate that the service provided as group employment support to an individual enrolled in a waiver is 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.
- (4) Group employment support shall be provided in an integrated setting and support individuals' access to the greater community, including opportunities to seek competitive, integrated employment, to engage in community life, and to have control over earned income.
- (5) Group employment support may be provided in a variety of settings in the community but shall not be furnished in the individual's residence or other residential living arrangement.
- (6) Individuals receiving group employment support shall be compensated in accordance with applicable federal and state laws and regulations. A determination that an individual receiving group employment support is eligible to be paid at special minimum wage rates in accordance with 29 C.F.R. Part 525, "Employment of Workers with Disabilities under Special Certificates," shall be based on documented evaluations and assessments.
- (7) A provider of group employment support shall ensure the appropriate staff are knowledgeable about the Workforce Innovation and Opportunity Act, wage and hour laws, benefits, work incentives, and employer tax credits for individuals with developmental disabilities and ensure that individuals served receive this information.
- (8) A provider of group employment support shall, in accordance with paragraph (F)(1) of rule 5123:2-2-05 of the Administrative Code, submit to each individual's team at least once every twelve months, or more frequently as decided upon by the individual's team, a written progress report. The written progress report shall outline the anticipated time-frame for each desired outcome of group employment support. If no progress is reported, the individual service plan shall be amended to identify the barriers toward achieving desired outcomes and the action steps to overcome the identified barriers.
- (9) A provider of group employment support shall provide the service in a manner that presumes all participants are capable of working in competitive, integrated employment. The provider shall encourage individuals receiving the service, on an ongoing basis, and as part of the annual person-centered planning process, to explore their interests, strengths, and abilities relating to community competitive integrated employment. The provider shall, as a component of this service, assist individuals to explore, identify, and pursue career advancement opportunities that advance them toward competitive, integrated employment with individual employment support as necessary.
- (10) A provider of group employment support shall recognize changes in the individual's condition and behavior, report to the service and support administrator, and record the changes in the individual's written record.
- (11) A provider of group employment support shall report identified safety and sanitation hazards that occur at the work site to employers having the responsibility to remedy the condition.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

See Appendix C-4, "Other Type of Limit"

Payment for adult day support, career planning, group employment support, individual employment support, and vocational habilitation alone or in combination, shall not exceed the budget limitations contained in appendix B to rule 5123:2-9-19 of the Administrative Code.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	For profit and non-profit private providers of group employment support

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Group Employment Support

Provider Category:

Agency

Provider Type:

For profit and non-profit private providers of group employment support

Provider Qualifications

License (specify):

Certificate (specify):

Group employment support 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. Group employment support will not be provided by an independent provider. An agency seeking approval to provide group employment support will complete and submit an application to DODD. An agency provider shall will ensure that direct support professionals who provide group employment support successfully complete, no later than thirty calendar days after hire, training in: (a) Services that comprise group employment support; (b) Signs and symptoms of illness or injury and procedure for response; (c) Building/site-specific emergency response plans; and (d) Program-specific transportation safety. (5) An agency provider will ensure that direct support professionals who provide group employment support (other than those who have at least one year of experience providing group employment support at the point of hire), during the first year after hire, are assigned and have access to a mentor. An agency provider shall will ensure that direct support professionals who provide group employment support (other than those who have at least one year of experience providing group employment support at the point of hire), no later than one year after hire, successfully complete at least eight hours of training specific to the provision of group employment support that includes, but is not limited to: a) Skill-building in advancement of individuals on the path to community competitive integrated employment and development of individuals' strengths and skills necessary for competitive integrated employment; and (b) Self-determination which includes assisting the self-advocacy skills, to exercise his or her an individual to develop civil rights, to exercise control and responsibility over the services he or she receives received , to acquire skills that enable him or her to become becoming and more independent, productive, and integrated within the community.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Developmental Disabilities (DODD).

Frequency of Verification:

Initial certification for both agency providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Habilitation - Adult Day Support

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04020 day habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Adult day support (ADS) means the provision of regularly scheduled activities in a non-residential setting, such as assistance with acquisition, retention, or improvement of self-help, socialization, and adaptive skills that enhance the individual's social development and performance of daily community living skills. ADS activities and environments shall be designed to foster the acquisition of skills, build community membership and independence, and expand personal choice. ADS enables the individual to attain and maintain his or her maximum potential. Activities that constitute ADS include, but are not limited to:

- (a) Supports to participate in community activities and build community membership consistent with the individual's interests, preferences, goals, and outcomes.
- (b) Supports to develop and maintain a meaningful social life, including social skill development which offers opportunities for personal growth, independence, and natural supports through community involvement, participation, and relationships.
- (c) Supports and opportunities that increase problem-solving skills to maximize an individual's ability to participate in

integrated community activities independently or with natural supports.

(d) Personal care including supports and supervision in the areas of personal hygiene, eating, communication, mobility, toileting, and dressing to ensure an individual's ability to experience and participate in community living.

(e) Skill reinforcement including the implementation of behavioral support strategies, assistance in the use of communication and mobility devices, and other activities that reinforce skills learned by the individual that are necessary to ensure his or her initial and continued participation in community life.

(f) Training in self-determination which includes assisting the individual to develop self-advocacy skills; to exercise his or her civil rights; to exercise control and responsibility over the services he or she receives; and to acquire skills that enable him or her to become more independent, productive, and integrated within the community.

(g) Recreation and leisure including supports identified in the person-centered individual service plan as being therapeutic in nature, rather than merely providing a diversion, and/or as being necessary to assist the individual to develop and/or maintain social relationships and family contacts.

(h) Assisting the individual with self-medication or provision of medication administration for prescribed medication and assisting the individual with or performing health-related activities in accordance with Chapter 5123:2-6 of the Administrative Code.

Requirements for service delivery:

(1) The expected outcome of ADS is building on the individual's strengths and fostering the development of skills that lead to greater independence, community membership, relationship-building, self-direction, and self-advocacy whether the service is delivered in person or remotely.

(2) ADS is available to individuals who are no longer eligible for educational services based on their graduation and/or receipt of a diploma or equivalency certificate and/or their permanent discontinuation of educational services within parameters established by the Ohio Department of Education.

(3) ADS shall be provided pursuant to a person-centered individual service plan that conforms to the requirements of rule 5123-4-02 of the Administrative Code and shall be coordinated with other services and supports set forth in the individual service plan.

(4) ADS may be provided in a variety of settings in the community and shall not be located on the same parcel of land as any individual's home. A non-residential setting authorized for provision of adult day support on the day immediately prior July 1, 2026, may continue to operate. An individual participating in adult day support provided through virtual support may do so from the individual's home as described below.

(5) Adult Day Support may be provided through virtual support under the following conditions:

a. Virtual support does not have the effect of isolating an individual from the individual's community or preventing the individual from interacting with people with or without disabilities.

b. The use of virtual support has been agreed to by an individual and the individual's team and is specified in the individual service plan.

c. The provider ensures the use of virtual support complies with applicable laws governing an individual's right to privacy and the individual's protected health information.

d. Teams should consider that the provision of adult day support through virtual support does not include the following, therefore teams should assure that the person's needs are able to be met with this service:

i. Personal care including supports and supervision in the areas of personal hygiene, eating communication, mobility, toileting, and dressing to ensure an individual's ability to experience and participate in community living; or

ii. Assisting an individual with self-medication or health-related activities or performing medication administration or health-related activities in accordance with Chapter 5123-6 of the Administrative Code

e. Virtual support does not require an in-person visit but it does require the provision of services be by a direct support professional at a distant site who engages with an individual using interactive technology that has the capability for two-way, real-time audio and video communication. A person needs to be present through interactive technology and it must be live audio or video communication.

f. ADS shall be provided pursuant to a person-centered individual service plan that conforms to the requirements of rule 5123-4-02 of the Administrative Code and shall be coordinated with other services and supports set forth in the individual service plan. During this process, service and support administrators (SSAs) are responsible to complete an assessment of the individual, identify supports needed, and develop an individual service plan that includes services and supports that ensure health and welfare, assist the individual to engage in meaningful and productive activities; support community connections and networking, assist the individual to improve self-advocacy skills, ensure achievement of outcomes that are important to the individual and outcomes that are important for the individual, and identify risks and include supports to prevent minimize risks.

g. If technology or technology support is needed within the home to participate in remote virtual habilitation, the SSA could authorize one or more components of the assistive technology service. This service could provide assistive technology consultation, assistive technology equipment, or assistive technology support.

- h. The Adult Day Support Rule, 5123-9-17, requires all employees and contractors who provide adult day support to comply with rule 5123-17-02 of the Administrative Code relating to incidents affecting health and safety.
- (6) A provider of adult day support will ensure adult day support is delivered in a manner that:
- Supports an individual's access to and full participation in the greater community with consideration of the individual's choices, preferences, and needs.
 - Optimizes an individual's personal initiative and independence.
 - Presents opportunities for an individual to:
 - Make informed choices about how to access available services, supports, and staff;
 - Independently choose daily activities; and
 - Change or update preferences at any time.
 - Protects an individual's rights to privacy, respect, freedom from intimidation, and freedom from restraint.
- (7) A provider of adult day support will:
- Maintain sufficient environmental conditions to ensure the safety of individuals served, including electrical systems and wiring, heating and cooling systems, private well and sewer systems, and secure access to mechanical rooms. Walls, ceilings, windows, doors, and screens will be free of damage.
 - b) Store all cleaning supplies, flammables, combustibles, or potentially hazardous chemicals in a secure location. The secure location will not be near a furnace, hot water heater, open flame, or food.
 - Store potentially harmful items not intended for participants' use, including tools, knives, and personal items of staff, in a secure location.
 - Store all medications and biohazard/sharp containers in a secure location inaccessible to participants.
 - Maintain evidence of passing a fire safety inspection completed by the local or state fire marshal upon application to become a provider of adult day support and at least annually thereafter.
 - Maintain working fire pull stations, fire extinguishers, smoke detectors, and carbon monoxide detectors on each level of the building. Smoke detectors and carbon monoxide detectors will be tested at least monthly. Fire extinguishers will be serviced at least annually. The provider will maintain records of testing and service.
 - Maintain an emergency preparedness plan to be used in instances of weather-related (e.g., tornado), fire, and other emergencies. The plan will include a pre-determined tornado shelter area and evacuation site.
 - Conduct at least three fire drills and one tornado drill in a twelve-month period. The provider will maintain documentation of the date and type of drills conducted.
 - Ensure emergency exits are readily available and unobstructed.
 - Ensure areas used for toileting afford individuals sufficient privacy.
 - Ensure individuals who elect, on occasion, to disengage from activities or to be alone have access to an area of privacy.
- (8) A provider of ADS shall comply with applicable laws, rules, and regulations of the federal, state, and local governments pertaining to the physical environment (building and grounds) where adult day support is provided. A provider of adult day support shall be informed of and comply with standards (e.g., Americans with Disabilities Act of 1990) applicable to the service setting.
- (9) ADS includes both individual activities and group activities. The nature of group activities and the number of staff providing adult day support to a group of individuals shall be appropriate to meet the needs and achieve the outcomes identified in each group member's person-centered individual service plan. Small group means a service arrangement with corresponding payment rates when one direct support professional provides adult day support to no more than four participants in order to deliver more individualized and intensive services based on the participants' assessed needs.
- (10) When meals are provided as part of adult day support, they shall not constitute a full nutritional regimen (i.e., three meals per day).
- (11) A provider of ADS shall recognize changes in the individual's condition and behavior as well as safety and sanitation hazards, report to the service and support administrator, and record the changes in the individual's written record.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

See Appendix C-4, "Other Type of Limit".

Payment for adult day support, career planning, group employment support, individual employment support, and vocational habilitation alone or in combination, shall not exceed the budget limitations contained in appendix B to rule 5123-9-19 of the Administrative Code.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person**Relative****Legal Guardian****Provider Specifications:**

Provider Category	Provider Type Title
Agency	For profit and not-for-profit private providers of Adult Day Support

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Habilitation - Adult Day Support****Provider Category:**

Agency

Provider Type:

For profit and not-for-profit private providers of Adult Day Support

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Adult day support will be provided by an agency provider that meets the requirements below and that has a medicaid provider agreement with the Ohio department of medicaid. Adult day support will not be provided by an independent provider.

An applicant seeking approval to provide adult day support will complete and submit an application to DODD.

An agency provider will ensure that direct support professionals who provide adult day support successfully complete, no later than thirty calendar days after hire, training in:

- (a) Services that comprise adult day support;
- (b) The agency provider's policies and procedures governing provision of adult day support, including:
 - (i) Ensuring services support individuals' full participation in the greater community;
 - (ii) Engaging individuals who receive services in developing, planning, and scheduling activities based on their interests, skills, talents, and needs;
 - (iii) Ensuring individuals' rights to privacy, respect, freedom from intimidation, and freedom from restraint;
 - (iv) Signs and symptoms of illness or injury and procedure for response;
 - (v) Site-specific emergency response plans; and
 - (vi) Program-specific transportation safety.

An agency provider will ensure that direct support professionals who provide adult day support (other than those who have at least one year of experience providing adult day support at the point of hire), during the first year after hire, are assigned and have access to a mentor. An agency provider will ensure that direct support professionals who provide adult day support (other than those who have at least one year of experience providing adult day support at the point of hire), no later than one year after hire, successfully complete at least eight hours of training specific to the provision of adult day support that includes, but is not limited to: (a) Skill building in the necessary activities and environments that build on the strengths of individuals served and foster the development of skills that lead to greater independence, community membership, relationship building, and self-direction; (b) Developing natural supports; and (c) Self-determination which includes assisting the individual to develop self-advocacy skills, to exercise civil rights, to exercise control and responsibility over the

services received, and to acquire becoming more independent, productive, and integrated within the community.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Developmental Disabilities.

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Habilitation - Vocational Habilitation

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04020 day habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Vocational habilitation means services that provide learning and work experiences, including volunteer work, where the individual develops general skills that lead to competitive integrated employment such as ability to communicate effectively with supervisors, coworkers, and customers; generally-accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem-solving skills and strategies; and workplace safety and mobility training. Services are expected to occur over a defined period of time with specific outcomes to be achieved determined by the individual and his or her team.

Activities that constitute vocational habilitation include, but are not limited to:

- Ongoing support that may be provided in-person or through virtual support which includes direct supervision, telephone and/or in-person monitoring and/or counseling, and the provision of some or all of the following supports to promote the

development of general work skills.

- Developing a systematic plan of instruction and support, including task analyses to prepare the individual for competitive integrated employment.
- Assisting the individual to perform activities that result in increasing his or her social integration with other individuals and persons employed at the worksite.
- Supporting and training the individual in the use of individualized or community-based transportation services.
- Providing services and training that assist the individual with problem-solving and meeting job-related expectations.
- Assisting the individual to use natural supports and community resources.
- Providing training to the individual to maintain current skills, enhance personal hygiene, learn new work skills, attain self-determination goals, and improve social skills.
- Developing and implementing a plan to assist the individual to transition from his or her vocational habilitation setting to competitive integrated employment emphasizing the use of natural supports.
- Assisting the individual with self-medication or provision of medication administration for prescribed medication and assisting the individual with or performing health-related activities in accordance with Chapter 5123-6 of the Administrative Code.
- Provision of information about or referral to career planning services, disability benefits services, or other appropriate consultative services.

Requirements for service delivery:

- The expected outcome of vocational habilitation is the advancement of an individual on his or her path to community employment and the individual's achievement of competitive integrated employment in a job well-matched to the individual's interests, strengths, priorities, and abilities whether the service is delivered in person or remotely.
- Vocational habilitation is available to individuals who are no longer eligible for educational services based on their graduation and/or receipt of a diploma or equivalency certificate and/or their permanent discontinuation of educational services within parameters established by the Ohio department of education.
- Vocational habilitation shall be provided pursuant to a person-centered individual service plan (ISP) that conforms to the requirements of rules 5123-4-02 and 5123-2-05 of the Administrative Code and shall be coordinated with other services and supports set forth in the individual service plan.
- Individuals receiving vocational habilitation shall have community employment outcomes in their ISP; vocational habilitation activities shall be designed to support the individual's community employment outcomes.
- Vocational habilitation may be provided in a variety of settings in the community but shall not be furnished in the individual's residence or other residential living arrangement except for virtual ADS support as described below.
- Vocational habilitation may be provided through virtual support under the following conditions:
 - o Virtual support does not have the effect of isolating an individual from the individual's community or preventing the individual from interacting with people with or without disabilities.
 - o The use of virtual support has been agreed to by an individual and the individual's team and is specified in the individual service plan.
 - o The provider ensures the use of virtual support complies with applicable laws governing an individual's right to privacy and the individual's protected health information.

Teams should consider that the provision of vocational habilitation through virtual support does not include the following, therefore teams should assure that the person's needs are able to be met with this service:

- Personal care including supports and supervision in the areas of personal hygiene, eating communication, mobility, toileting, and dressing to ensure an individual's ability to experience and participate in community living; or
- Assisting an individual with self-medication or health-related activities or performing medication administration or health-related activities in accordance with Chapter 5123-6 of the Administrative Code.

Virtual support does not require an in-person visit but it does require the provision of services be by a direct support professional at a distant site who engages with an individual using interactive technology that has the capability for two-way, real-time audio and video communication. A person needs to be present through interactive technology and it must be live audio or video communication.

Vocational habilitation shall be provided pursuant to a person-centered individual service plan that conforms to the requirements of rule 5123-4-02 of the Administrative Code and shall be coordinated with other services and supports set forth in the individual service plan. During this process, service and support administrators (SSAs) are responsible to complete an assessment of the individual, identify supports needed, and develop an individual service plan that includes services and supports that ensure health and welfare, assist the individual to engage in meaningful and productive activities; support community connections and networking, assist the individual to improve self-advocacy skills, ensure achievement of outcomes that are important to the individual and outcomes that are important for the individual, and identify risks and include supports to prevent minimize risks.

If technology or technology support is needed within the home to participate in remote virtual habilitation, the SSA could

authorize one or more components of the assistive technology service. This service could provide assistive technology consultation, assistive technology equipment, or assistive technology support.

The Vocational Habilitation Rule, 5123-9-14, requires all employees and contractors who provide vocational habilitation to comply with rule 5123-17-02 of the Administrative Code relating to incidents affecting health and safety.

A provider of vocational habilitation shall, in accordance with paragraph (F)(1) of rule 5123-2-05 of the Administrative Code, submit to each individual's team at least once every twelve months, or more frequently as decided upon by the individual's team, a written progress report. The written progress report shall outline the anticipated time-frame for each desired outcome of vocational habilitation. If no progress is reported, the individual service plan shall be amended to identify the barriers toward achieving desired outcomes and the action steps to overcome the identified barriers.

The service and support administrator shall ensure that documentation is maintained to demonstrate that the service provided as vocational habilitation to an individual enrolled in a waiver is 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.

Individuals receiving vocational habilitation shall be compensated in accordance with applicable federal laws and state laws and regulations. A determination that an individual receiving vocational habilitation is eligible to be paid at special minimum wage rates in accordance with 29 C.F.R. Part 525, "Employment of Workers with Disabilities Under Special Certificates," shall be based on documented evaluations and assessments.

A provider of vocational habilitation shall ensure that appropriate staff are knowledgeable in the Workforce Innovation and Opportunity Act, wage and hour laws, benefits, work incentives, and employer tax credits for individuals with developmental disabilities and ensure that individuals served receive this information.

A provider of vocational habilitation shall comply with applicable laws, rules, and regulations of the federal, state, and local governments pertaining to the physical environment (building and grounds) where vocational habilitation is provided. A provider of vocational habilitation shall be informed of and comply with standards (e.g., Americans with Disabilities Act of 1990) applicable to the service setting.

A provider of vocational habilitation shall recognize changes in the individual's condition and behavior as well as safety and sanitation hazards, report to the service and support administrator, and record the changes in the individual's written record.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

See Appendix C-4, "Other Type of Limit"

Payment for adult day support, career planning, group employment support, individual employment support, and vocational habilitation alone or in combination, shall not exceed the budget limitations contained in appendix B to rule 5123-9-19 of the Administrative Code.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	For-profit and not-for profit private providers of Vocational Habilitation

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Habilitation - Vocational Habilitation

Provider Category:

Agency

Provider Type:

For-profit and not-for profit private providers of Vocational Habilitation

Provider Qualifications**License (specify):****Certificate (specify):**

Vocational habilitation will be provided by an agency provider that meets the requirements listed below and that has a medicaid provider agreement with the Ohio department of medicaid. Vocational habilitation will not be provided by an independent provider. An applicant seeking approval to provide vocational habilitation will complete and submit an application through DODD. An agency provider will ensure that direct support professionals who provide vocational habilitation successfully complete, no later than thirty calendar days after hire, training in: (a) Services that comprise vocational habilitation including the expectation that vocational habilitation will eventually lead to competitive integrated employment; (b) Signs and symptoms of illness or injury and procedure for response; (c) Site-specific emergency response plans; and (d) Program-specific transportation safety. An agency provider will ensure that direct support professionals who provide vocational habilitation (other than those who have at least one year of experience providing vocational habilitation at the point of hire), during the first year after hire, are assigned and have access to a mentor. An agency provider shall will ensure that direct support professionals who provide vocational habilitation (other than those who have at least one year of experience providing vocational habilitation at the point of hire), no later than one year after hire, successfully complete at least eight hours of training specific to the provision of vocational habilitation that includes, but is not limited to: (a) Skill building in advancement of individuals on the path to community competitive integrated employment and development of individuals' strengths and skills necessary for competitive integrated employment; and (b) Self-determination which includes assisting the individual to develop self advocacy skills, to exercise his or her civil rights, to exercise control and responsibility over the services he or she receives skills that enable him or her to become received , and to acquire becoming more independent, productive, and integrated within the community.

Other Standard (specify):**Verification of Provider Qualifications****Entity Responsible for Verification:**

The Ohio Department of Developmental Disabilities.

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Health Care Assessment

HCBS Taxonomy:

Category 1:

11 Other Health and Therapeutic Services

Sub-Category 1:

11020 health assessment

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Health Care Assessment means using technology to facilitate real-time consultation and support provided by a physician, a physician assistant, or an advanced practice nurse to assist an individual and/or the individual's caregivers to understand the individual's presenting health symptoms and identify appropriate next steps. This service allows the provider to coordinate care with the local emergency departments, urgent care facilities and primary care physicians directly, ensuring advance preparation for the emergency department and potentially decreasing the need for inpatient admission. The goal of the service is not to replace services provided by an individual's primary care physician but rather to provide right-on-time health assessment to determine the best clinical course of action, often avoiding unnecessary emergency room visits. Health Care Assessment services will be available twenty-four hours a day, seven days per week and three hundred sixty-five days per year and includes immediate evaluations, video-assisted examinations, treatment plans and discussion and coordination with individuals and/or caregivers by professionals with extensive specialized expertise in supporting individuals with I/DD.

The service is consultative in nature, reflects the presentations and treatments unique to individuals with developmental disabilities and provides disability-specific guidance on when best to seek additional or in-person medical treatment. The service includes support, which is based on an expertise in I/DD, to an individual and/or the individual's paid and unpaid caregivers, seeking to empower the individual and build the capacity of caregivers to better understand the best approach for supporting the individual based on the individual's symptom presentation. The participant receiving the health care assessment service must have capacity and have access to participate in two-way audio and video interactions with the provider of Telehealth Assessment so that immediate evaluations, video-assisted examinations and development of plans of care may occur. The waiver does not pay for any internet or cellular charges.

The Health Care Assessment service includes clinical transition of care, conducted immediately after conclusion of the consultation, from the provider of health care assessment to the receiving provider to help guide care and provide coordination, when the provider of health care assessment recommends the individual go to the emergency room, urgent care facility, or primary care physician. Includes follow-up and aftercare, as needed, via follow-up consultation with the treated individual and/or caregiver, within eighteen hours after the initial consultation.

The Health Care Assessment service includes a comprehensive quality review and provides a quarterly report of aggregated findings. •This service will not duplicate or replace other home and community-based services or medical services available to an individual through the Medicaid state plan, including in-person examinations as needed.

•Telemedicine is available under the state plan. However, the service is different from state plan telehealth as it enables waiver enrollees immediate access to healthcare consultation at any time of day from a practitioner specializing in working with the DD population. It may be unscheduled, after hours and although it is covered using telehealth modality, the service is unique.

•Individuals will be informed of the right to choose from among all qualified providers in accordance with section OAC 5123-9-11 Home and community based services waivers-free choice of providers and as outlined in Appendix D-1-b Service Planning Safeguards. One unit of service constitutes one month of assessment and consultation from the provider.

•The services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This is a monthly subscription service.

No more than 1 unit per month per person.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	For Profit and not for Profit Agency Providers of Telehealth Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Health Care Assessment

Provider Category:

Agency

Provider Type:

For Profit and not for Profit Agency Providers of Telehealth Services

Provider Qualifications

License (specify):

Certificate (specify):

Health care assessment will be provided only by an agency provider that meets the requirements below and that has a medicaid provider agreement with the Ohio department of medicaid. An applicant seeking approval to provide health care assessment will complete and submit an application to DODD. The application will include documented evidence of: (a) The applicant's demonstration of at least four years of experience providing medical care to individuals with developmental disabilities as well as capability to address, and as necessary triage, medical needs of individuals with developmental disabilities. (b) The applicant's achievement of positive outcomes for individuals with developmental disabilities served (e.g., reducing emergency room visits or individual/caregiver satisfaction with services provided). At the point of application for certification and upon request by the department, a provider of health care assessment will provide a certificate of a continuing policy of professional liability insurance in an amount of at least one million dollars. A provider of health care assessment will ensure the person providing health care assessment is a physician, a physician assistant, or an advanced practice nurse who: (a) Is properly credentialed and in good standing in accordance with Ohio law or laws of other states that govern the person's practice. (b) Has successfully completed, prior to delivering health care assessment, twenty-five hours of training specifically related to serving individuals with developmental disabilities.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1:

06 Home Delivered Meals

Sub-Category 1:

06010 home delivered meals

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Home delivered meals means the preparation, packaging, and delivery of one or more meals to individuals who are unable to prepare or obtain nourishing meals. A maximum of two meals per day shall be provided. Home-delivered meals shall be provided pursuant to an individual service plan that conforms to the requirements of rule 5123-4-02 of the Ohio Administrative Code and specifies what type of home-delivered meals (i.e., standard meals, kosher meals, or therapeutic meals) are to be provided, the number of noontime and/or evening meal to be provided, the location for meal delivery, which will be the individual's residence or an alternative location chosen by the individual and the range of time in which the meals are to be delivered.

The service includes the preparation, packaging, and delivery of a safe and nutritious meal(s) to an individual. There are three types of home-delivered meals:

- (1) Standard meal, meaning a meal that is not a kosher meal or a therapeutic meal.
- (2) Kosher meal, meaning a meal certified as kosher by a recognized kosher certification or a kosher establishment under orthodox rabbinic supervision.
- (3) Therapeutic meal, meaning a meal that is part of a therapeutic diet ordered by a licensed healthcare professional whose scope of practice includes ordering therapeutic diets:
 - (a) As part of the treatment for a disease or clinical condition;
 - (b) To modify, eliminate, decrease, or increase certain substances in the diet; or
 - (c) To provide mechanically altered food (i.e., the texture of food is altered by chopping, grinding, mashing, or pureeing so that it can be successfully chewed and safely swallowed) when indicated.

Providers of home delivered meals shall:

Be able to provide two meals per day, seven days per week;

1. Ensure that each meal:

- (a) contains at least one-third of the daily recommended dietary allowance as established by the food and nutrition board of the national academy of sciences national research council; and
- (b) Includes clear instructions on how to maintain, heat, reheat, and/or assemble the meal.

2. Ensure that a licensed dietitian approves and signs all menus and develops all therapeutic meal menus in accordance with the individual service plan;
3. Unless the provider uses a common carrier for meal delivery, maintain a roster of delivery drivers who are trained and have available backup staff for scheduled meal deliveries; and
4. Initiate new orders for home-delivered meals within seventy-two hours of referral or as otherwise specified in the individual service plan.
5. Ensure delivery of home-delivered meals is verified by signature of the individual or the individual's representative upon delivery, attestation by the delivery driver, which may be made via an electronic system, that delivery occurred, or retaining the common carrier's tracking statement or returned postage-paid delivery invoice.
6. Replace any home delivered meal or portion thereof that is lost or stolen between the time of delivery and intended receipt by the individual at no cost to the individual, the Ohio department of medicaid or the department.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency
Individual	Independent

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License (specify):

Certificate (specify):

Home-delivered meals will be provided by an independent provider or an agency provider that is certified by the DODD and that has a medicaid provider agreement with the Ohio department of medicaid. Home-delivered meals will not be provided by a county board or a regional council of governments formed under section 5126.13 of the Revised Code by two or more county boards. An applicant seeking approval to provide home-delivered meals will complete and submit an application through the Ohio department of medicaid provider network management system.

Other Standard (specify):

Verification of Provider Qualifications**Entity Responsible for Verification:**

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type:** Other Service**Service Name:** Home Delivered Meals**Provider Category:**

Individual

Provider Type:

Independent

Provider Qualifications**License (specify):****Certificate (specify):**

Home-delivered meals will be provided by an independent provider or an agency provider that is certified by the DODD and that has a medicaid provider agreement with the Ohio department of medicaid. Home-delivered meals will not be provided by a county board or a regional council of governments formed under section 5126.13 of the Revised Code by two or more county boards. An applicant seeking approval to provide home-delivered meals will complete and submit an application through the Ohio department of medicaid provider network management system.

Other Standard (specify):**Verification of Provider Qualifications****Entity Responsible for Verification:**

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Individual Employment Support

HCBS Taxonomy:**Category 1:**

03 Supported Employment

Sub-Category 1:

03021 ongoing supported employment, individual

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Individual employment support means individualized support for an individual to maintain competitive integrated employment. Activities that constitute individual employment support include but are not limited to:

- (a) Job coaching. Job coaching is identification and provision of services and supports, utilizing task analysis and systematic instruction that assist the individual in maintaining employment and/or advancing his or her career. Job coaching includes supports provided to the individual and his or her supervisor or coworkers on behalf of the individual, either in-person or remotely via technology. Job coaching may include the engagement of natural supports in the workplace to provide additional supports that allow the job coach to maximize his or her ability to fade. Examples of job coaching strategies include job analysis, job adaptations, instructional prompts, verbal instruction, self-management tools, physical assistance, role playing, coworker modeling, written instruction. Job coaching for self-employment includes identification and provision of services and supports, including counseling and guidance, which assist the individual in maintaining self-employment through the operation of a business. When job coaching is provided, a plan outlining the steps to reduce job coaching over time shall be in place within thirty days.
- (b) Benefits and work incentive management.
- (c) Training in assistive or other technology utilized by the individual while on the job.
- (d) Other workplace support services including services not specifically related to job skill training that enable the individual to be successful in integrating into the job setting.
- (e) Personal care and assistance, which may be a component of individual employment support but shall not comprise the entirety of the service.

Requirements for service delivery

- (1) The expected outcome of individual employment support is sustained competitive integrated employment in a job that is well-matched to the individual's interests, strengths, priorities, and abilities, and that meets the individual's personal and career goals.
- (2) Individual employment support shall be provided pursuant to a person-centered individual service plan that conforms to the requirements of rules 5123-4-02 and 5123-2-05 of the Administrative Code and shall be coordinated with other services and supports set forth in the individual service plan.
- (3) The service and support administrator shall ensure that documentation is maintained to demonstrate that the service provided as individual employment support to an individual enrolled in a waiver is 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.

- (4) Individual employment support shall be provided at a ratio of one staff to one individual.
- (5) Individual employment support services may extend to those times when the individual is not physically present and the provider is performing individual employment support on behalf of the individual (e.g., developing coworker supports or meeting with a supervisor).
- (6) A provider of individual employment support shall recognize changes in the individual's condition and behavior, report to the service and support administrator, and record the changes in the individual's written record.
- (7) A provider of individual employment support shall report identified safety and sanitation hazards that occur at the worksite to employers having the responsibility to remedy the condition.
- E. A provider of individual employment support may be eligible for an outcome-based payment following an individual's achievement of a job retention milestone.
- (a) A provider may obtain either or both of two possible outcome-based payments for each individual served:
- (i) One payment when the individual retains competitive integrated employment for ninety calendar days following the first date the provider delivered individual employment support to the individual.
- (ii) One payment when the individual retains competitive integrated employment for one hundred eighty calendar days following the first date the provider delivered individual employment support to the individual.
- (b) To obtain an outcome-based payment, a provider will secure one or more pay stubs from the individual served sufficient to document the date span of the individual's competitive integrated employment (i.e., ninety or one hundred eighty calendar days, as applicable) following the first date the provider was authorized to deliver individual employment support to the individual. The provider will submit the pay stub or pay stubs to the individual's service and support administrator, who will authorize the outcome-based payment in the individual service plan. When pay stubs cannot be secured, the provider will instead submit an attestation that the outcome has been achieved.
- (c) The amount of an outcome-based payment is determined by the job retention milestone and the acuity assessment group assignment of the individual at the time the individual achieves the milestone.
- (d) No more than two outcome-based payments will be made during an individual's waiver eligibility span which is the twelve-month period following either an individual's initial waiver enrollment date or a subsequent eligibility redetermination date.
- (e) The service codes and payment rates for outcome-based payments are contained in the appendix to rule 5123-9- 15.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

See Appendix C-4, "Other Type of Limit"

Payment for adult day support, career planning, group employment support, individual employment support, and vocational habilitation alone or in combination, shall not exceed the budget limitations contained in appendix C to rule 5123:2-9-19 of the Administrative Code.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent providers of individual employment support
Agency	For profit and non-profit private providers of individual employment support

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Individual Employment Support

Provider Category:

Individual

Provider Type:

Independent providers of individual employment support

Provider Qualifications

License (specify):

Certificate (specify):

Individual employment support will be provided by an agency provider or an independent provider that meets the requirements listed below and that has a medicaid provider agreement with the Ohio department of medicaid. An applicant seeking approval to provide individual employment support will complete and submit an application. An applicant seeking independent provider certification to provide individual employment support must have: (a) At least one year of full-time (or part-time equivalent), paid work experience related to supporting individuals to maintain jobs in the general workforce; or (b) Thirty hours of formal training related to supporting individuals to maintain jobs in the general workforce. An agency provider will ensure that direct support professionals who provide individual employment support successfully complete, no later than thirty calendar days after hire, training in: (a) Services that comprise individual employment support; (b) Signs and symptoms of illness or injury and procedure for response; (c) Building/site-specific emergency response plans; and (d) Program-specific transportation safety.

An agency provider will ensure that direct support professionals who provide individual employment support (other than those who have at least one year of experience providing individual employment support at the point of hire), during the first year after hire, are assigned and have access to a mentor. An agency provider will ensure that direct support professionals who provide individual employment support (other than those who have at least one year of experience providing individual employment support at the point of hire), no later than one year after hire, successfully complete at least eight hours of training specific to the provision of individual employment support that includes, but is not limited to: (a) Skill-building in job training and systematic instruction that assists an individual in maintaining employment and or advancing the individual's career; and (b) Self-determination which includes assisting an individual to develop self-advocacy skills, to exercise civil rights, to exercise control and responsibility over the services received, and to acquire skills that enable becoming more independent, productive, and integrated within the community.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Development Disabilities (DODD).

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Individual Employment Support

Provider Category:

02/13/2026

Agency

Provider Type:

For profit and non-profit private providers of individual employment support

Provider Qualifications

License (specify):

Certificate (specify):

Individual employment support will be provided by an agency provider or an independent provider that meets the requirements listed below and that has a medicaid provider agreement with the Ohio department of medicaid. An applicant seeking approval to provide individual employment support will complete and submit an application. An applicant seeking independent provider certification to provide individual employment support must have: (a) At least one year of full-time (or part-time equivalent), paid work experience related to supporting individuals to maintain jobs in the general workforce; or (b) Thirty hours of formal training related to supporting individuals to maintain jobs in the general workforce. An agency provider will ensure that direct support professionals who provide individual employment support successfully complete, no later than thirty calendar days after hire, training in: (a) Services that comprise individual employment support; (b) Signs and symptoms of illness or injury and procedure for response; (c) Building/site-specific emergency response plans; and (d) Program-specific transportation safety.

An agency provider will ensure that direct support professionals who provide individual employment support (other than those who have at least one year of experience providing individual employment support at the point of hire), during the first year after hire, are assigned and have access to a mentor. An agency provider will ensure that direct support professionals who provide individual employment support (other than those who have at least one year of experience providing individual employment support at the point of hire), no later than one year after hire, successfully complete at least eight hours of training specific to the provision of individual employment support that includes, but is not limited to: (a) Skill-building in job training and systematic instruction that assists an individual in maintaining employment and or advancing the individual's career; and (b) Self-determination which includes assisting an individual to develop self-advocacy skills, to exercise civil rights, to exercise control and responsibility over the services received, and to acquire skills that enable becoming more independent, productive, and integrated within the community.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Development Disabilities (DODD).

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Non-Medical Transportation

HCBS Taxonomy:**Category 1:**

15 Non-Medical Transportation

Sub-Category 1:

15010 non-medical transportation

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Non-Medical Transportation (NMT) as a waiver service is available to enable waiver participants to get to/from a place of competitive integrated employment or to access Adult Day Support, Career Planning, Group Employment Support, Individual Employment Support, and/or Vocational Habilitation, as specified by the Individual Service Plan (ISP). NMT may also be authorized to allow individuals access to volunteer opportunities and college or post-secondary activities. This is aligned with Ohio's mission of having all individuals who express an interest in competitive employment create their own unique path to employment. NMT will help support individuals in attaining their employment goals.

Whenever possible, family, friends, neighbors, or community agencies that can provide this service without charge shall be used. Transportation services that are not provided free of charge and are required by enrollees in HCBS waivers administered by the Department to access one or more of these five waiver services and/or the above community activities shall be considered to be NMT services and the payment rates, service limitations and provider qualifications associated with the provision of this service shall be applicable.

NMT is available in addition to the Transportation services described in Ohio Administrative Code 5123-9-06, which will be used primarily in connection with the provision of Homemaker/Personal Care Services.

Special per-trip payment rates for NMT apply when an agency provider or an independent provider transports an individual to or from competitive integrated employment. The special NMT per-trip payment rates are established on a per-person basis, depending on the length of the trip and whether the service is provided in a modified vehicle or a non-modified vehicle.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The maximum service limitation for NMT services will not exceed budget limitations in OAC 5123-9-19.

As outlined in Appendix D-1-b Service Planning Safeguards: County boards providing TCM will not be eligible to provide any of the new adult day services, unless no other qualified provider is available in the geographic area. It is anticipated that all individuals will be safely transitioned from their existing adult day services, many of which are operated by county boards, to the newly designed services according to Ohio's Transition Plan. County Boards are prohibited from providing direct services to new individuals, unless no other qualified and willing provider is available.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual private providers of non-medical transportation per mile
Agency	Public bus transit system, public light rail transit system and taxicabs per trip
Individual	Individual private providers of non-medical transportation per trip
Agency	County board of DD providers of non-medical transportation per trip
Agency	For profit and non-profit private providers of non-medical transportation per trip
Agency	For profit and non-profit private providers of non-medical transportation per mile
Agency	County board of DD providers of non-medical transportation per mile
Agency	Public bus transit system, public light rail transit system and taxicabs per mile

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Non-Medical Transportation

Provider Category:

Individual

Provider Type:

Individual private providers of non-medical transportation per mile

Provider Qualifications

License (specify):

Certificate (specify):

Non-medical transportation will be provided by an independent provider, an agency provider, or an operator of commercial transportation that meets the requirements noted below, and, with the exception of a bus or rail system owned or operated by a government authority, that has a medicaid provider agreement with the Ohio department of medicaid. An applicant seeking approval to provide non-medical transportation will complete and submit an application to DODD. An applicant seeking approval to provide non-medical transportation as an independent provider will present the applicant's driving record prepared by the bureau of motor vehicles no earlier than fourteen calendar days prior to the date of application for initial or renewal provider certification. A person having six or more points on the person's driving record is prohibited from providing non-medical transportation.

An agency provider of non-medical transportation will: (a) Ensure that each driver holds a valid driver's license as specified by Ohio law. (b) Ensure that each driver is covered by valid liability insurance as specified by Ohio law. (c) Obtain, for each driver, a driving record prepared by the bureau of motor vehicles no earlier than fourteen calendar days prior to the date of initial employment as a driver and at least once every three years thereafter. A person having six or more points on the person's driving record is prohibited from providing non-medical transportation. (d) Require each driver to immediately notify the agency provider, in writing, if the driver accumulates six or more points on the driver's driving record or has a driver's license suspended or revoked. (e) Ensure that each driver completes testing for controlled substances by a laboratory certified for such testing within thirty-two hours and completes testing for blood alcohol level by an entity certified for such testing within eight hours of a motor vehicle accident involving the driver while the driver was providing non-medical transportation when: (i) The accident involves the loss of human life; or (ii) The driver receives a citation under state or local law for a moving traffic violation arising from the accident, if the accident involved: (a) Bodily injury to any person who, as a result of the injury, immediately receives medical treatment away from the scene of the accident; or (b) One or more motor vehicles incurred disabling damage as a result of the accident, requiring the motor vehicle to be 5123-9-18 8 transported away from the scene by a tow truck or other motor vehicle. (f) Develop and implement written policies and

02/13/2026

procedures regarding vehicle accessibility, vehicle maintenance, and requirements for vehicle drivers.

Other Standard (specify):

Providers of transportation that is not available to the general public are eligible to bill on a per mile or per trip basis when the vehicles/providers/drivers meet the certification standards of the Department. The service type is determined by the team and individual choice and authorized in the individual's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Developmental Disabilities (DODD).

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

Public bus transit system, public light rail transit system and taxicabs per trip

Provider Qualifications

License (specify):

Certificate (specify):

Non-medical transportation will be provided by an independent provider, an agency provider, or an operator of commercial transportation that meets the requirements noted below, and, with the exception of a bus or rail system owned or operated by a government authority, that has a medicaid provider agreement with the Ohio department of medicaid. An applicant seeking approval to provide non-medical transportation will complete and submit an application to DODD. An applicant seeking approval to provide non-medical transportation as an independent provider will present the applicant's driving record prepared by the bureau of motor vehicles no earlier than fourteen calendar days prior to the date of application for initial or renewal provider certification. A person having six or more points on the person's driving record is prohibited from providing non-medical transportation.

An agency provider of non-medical transportation will: (a) Ensure that each driver holds a valid driver's license as specified by Ohio law. (b) Ensure that each driver is covered by valid liability insurance as specified by Ohio law. (c) Obtain, for each driver, a driving record prepared by the bureau of motor vehicles no earlier than fourteen calendar days prior to the date of initial employment as a driver and at least once every three years thereafter. A person having six or more points on the person's driving record is prohibited from providing non-medical transportation. (d) Require each driver to immediately notify the agency provider, in writing, if the driver accumulates six or more points on the driver's driving record or has a driver's license suspended or revoked. (e) Ensure that each driver completes testing for controlled substances by a laboratory certified for such testing within thirty-two hours and completes testing for blood alcohol level by an entity certified for such testing within eight hours of a motor vehicle accident involving the driver while the driver was providing non-medical transportation when: (i) The accident involves the loss of human life; or (ii) The driver receives a citation under state or local law for a moving traffic violation arising from the accident, if the accident involved: (a) Bodily injury to any person who, as a result of the injury, immediately receives medical treatment away from the scene of the accident; or (b) One or more motor vehicles incurred disabling damage as a result of the accident, requiring the motor vehicle to be 5123-9-18 8 transported away from the scene by a tow truck or other motor vehicle. (f) Develop and implement written policies and procedures regarding vehicle accessibility, vehicle maintenance, and requirements for vehicle drivers.

Other Standard (specify):

Non-Medical transportation providers whose services are available to the general public will not be subject to certification when the transportation service is subcontracted by or purchased on behalf of a waiver recipient by a waiver provider

certified to provide Adult Day Support, Vocational Habilitation, and/or group employment.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Developmental Disabilities (DODD).

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Non-Medical Transportation

Provider Category:

Individual

Provider Type:

Individual private providers of non-medical transportation per trip

Provider Qualifications

License (specify):

Certificate (specify):

Non-medical transportation will be provided by an independent provider, an agency provider, or an operator of commercial transportation that meets the requirements noted below, and, with the exception of a bus or rail system owned or operated by a government authority, that has a medicaid provider agreement with the Ohio department of medicaid. An applicant seeking approval to provide non-medical transportation will complete and submit an application to DODD. An applicant seeking approval to provide non-medical transportation as an independent provider will present the applicant's driving record prepared by the bureau of motor vehicles no earlier than fourteen calendar days prior to the date of application for initial or renewal provider certification. A person having six or more points on the person's driving record is prohibited from providing non-medical transportation.

An agency provider of non-medical transportation will: (a) Ensure that each driver holds a valid driver's license as specified by Ohio law. (b) Ensure that each driver is covered by valid liability insurance as specified by Ohio law. (c) Obtain, for each driver, a driving record prepared by the bureau of motor vehicles no earlier than fourteen calendar days prior to the date of initial employment as a driver and at least once every three years thereafter. A person having six or more points on the person's driving record is prohibited from providing non-medical transportation. (d) Require each driver to immediately notify the agency provider, in writing, if the driver accumulates six or more points on the driver's driving record or has a driver's license suspended or revoked. (e) Ensure that each driver completes testing for controlled substances by a laboratory certified for such testing within thirty-two hours and completes testing for blood alcohol level by an entity certified for such testing within eight hours of a motor vehicle accident involving the driver while the driver was providing non-medical transportation when: (i) The accident involves the loss of human life; or (ii) The driver receives a citation under state or local law for a moving traffic violation arising from the accident, if the accident involved: (a) Bodily injury to any person who, as a result of the injury, immediately receives medical treatment away from the scene of the accident; or (b) One or more motor vehicles incurred disabling damage as a result of the accident, requiring the motor vehicle to be 5123-9-18 8 transported away from the scene by a tow truck or other motor vehicle. (f) Develop and implement written policies and procedures regarding vehicle accessibility, vehicle maintenance, and requirements for vehicle drivers.

Other Standard (specify):

Providers of transportation that is not available to the general public are eligible to bill on a per mile or per trip basis when the vehicles/providers/drivers meet the certification standards of the Department. The service type is determined by the team and individual choice and authorized in the individual's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Developmental Disabilities (DODD).

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

County board of DD providers of non-medical transportation per trip

Provider Qualifications**License (specify):**

Certificate (specify):

Non-medical transportation will be provided by an independent provider, an agency provider, or an operator of commercial transportation that meets the requirements noted below, and, with the exception of a bus or rail system owned or operated by a government authority, that has a medicaid provider agreement with the Ohio department of medicaid. An applicant seeking approval to provide non-medical transportation will complete and submit an application to DODD. An applicant seeking approval to provide non-medical transportation as an independent provider will present the applicant's driving record prepared by the bureau of motor vehicles no earlier than fourteen calendar days prior to the date of application for initial or renewal provider certification. A person having six or more points on the person's driving record is prohibited from providing non-medical transportation.

An agency provider of non-medical transportation will: (a) Ensure that each driver holds a valid driver's license as specified by Ohio law. (b) Ensure that each driver is covered by valid liability insurance as specified by Ohio law. (c) Obtain, for each driver, a driving record prepared by the bureau of motor vehicles no earlier than fourteen calendar days prior to the date of initial employment as a driver and at least once every three years thereafter. A person having six or more points on the person's driving record is prohibited from providing non-medical transportation. (d) Require each driver to immediately notify the agency provider, in writing, if the driver accumulates six or more points on the driver's driving record or has a driver's license suspended or revoked. (e) Ensure that each driver completes testing for controlled substances by a laboratory certified for such testing within thirty-two hours and completes testing for blood alcohol level by an entity certified for such testing within eight hours of a motor vehicle accident involving the driver while the driver was providing non-medical transportation when: (i) The accident involves the loss of human life; or (ii) The driver receives a citation under state or local law for a moving traffic violation arising from the accident, if the accident involved: (a) Bodily injury to any person who, as a result of the injury, immediately receives medical treatment away from the scene of the accident; or (b) One or more motor vehicles incurred disabling damage as a result of the accident, requiring the motor vehicle to be 5123-9-18 8 transported away from the scene by a tow truck or other motor vehicle. (f) Develop and implement written policies and procedures regarding vehicle accessibility, vehicle maintenance, and requirements for vehicle drivers.

Other Standard (specify):

Providers of transportation that is not available to the general public are eligible to bill on a per mile or per trip basis when the vehicles/providers/drivers meet the certification standards of the Department. The service type is determined by the team and individual choice and authorized in the individual's service plan.

Verification of Provider Qualifications**Entity Responsible for Verification:**

The Department of Developmental Disabilities (DODD).

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

For profit and non-profit private providers of non-medical transportation per trip

Provider Qualifications

License (specify):

Certificate (specify):

Non-medical transportation will be provided by an independent provider, an agency provider, or an operator of commercial transportation that meets the requirements noted below, and, with the exception of a bus or rail system owned or operated by a government authority, that has a medicaid provider agreement with the Ohio department of medicaid. An applicant seeking approval to provide non-medical transportation will complete and submit an application to DODD. An applicant seeking approval to provide non-medical transportation as an independent provider will present the applicant's driving record prepared by the bureau of motor vehicles no earlier than fourteen calendar days prior to the date of application for initial or renewal provider certification. A person having six or more points on the person's driving record is prohibited from providing non-medical transportation.

An agency provider of non-medical transportation will: (a) Ensure that each driver holds a valid driver's license as specified by Ohio law. (b) Ensure that each driver is covered by valid liability insurance as specified by Ohio law. (c) Obtain, for each driver, a driving record prepared by the bureau of motor vehicles no earlier than fourteen calendar days prior to the date of initial employment as a driver and at least once every three years thereafter. A person having six or more points on the person's driving record is prohibited from providing non-medical transportation. (d) Require each driver to immediately notify the agency provider, in writing, if the driver accumulates six or more points on the driver's driving record or has a driver's license suspended or revoked. (e) Ensure that each driver completes testing for controlled substances by a laboratory certified for such testing within thirty-two hours and completes testing for blood alcohol level by an entity certified for such testing within eight hours of a motor vehicle accident involving the driver while the driver was providing non-medical transportation when: (i) The accident involves the loss of human life; or (ii) The driver receives a citation under state or local law for a moving traffic violation arising from the accident, if the accident involved: (a) Bodily injury to any person who, as a result of the injury, immediately receives medical treatment away from the scene of the accident; or (b) One or more motor vehicles incurred disabling damage as a result of the accident, requiring the motor vehicle to be 5123-9-18 transported away from the scene by a tow truck or other motor vehicle. (f) Develop and implement written policies and procedures regarding vehicle accessibility, vehicle maintenance, and requirements for vehicle drivers.

Other Standard (specify):

Providers of transportation that is not available to the general public are eligible to bill on a per mile or per trip basis when the vehicles/providers/drivers meet the certification standards of the Department. The service type is determined by the team and individual choice and authorized in the individual's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Developmental Disabilities (DODD).

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service**Service Name: Non-Medical Transportation**

Provider Category:

Agency

Provider Type:

For profit and non-profit private providers of non-medical transportation per mile

Provider Qualifications**License (specify):****Certificate (specify):**

Non-medical transportation will be provided by an independent provider, an agency provider, or an operator of commercial transportation that meets the requirements noted below, and, with the exception of a bus or rail system owned or operated by a government authority, that has a medicaid provider agreement with the Ohio department of medicaid. An applicant seeking approval to provide non-medical transportation will complete and submit an application to DODD. An applicant seeking approval to provide non-medical transportation as an independent provider will present the applicant's driving record prepared by the bureau of motor vehicles no earlier than fourteen calendar days prior to the date of application for initial or renewal provider certification. A person having six or more points on the person's driving record is prohibited from providing non-medical transportation.

An agency provider of non-medical transportation will: (a) Ensure that each driver holds a valid driver's license as specified by Ohio law. (b) Ensure that each driver is covered by valid liability insurance as specified by Ohio law. (c) Obtain, for each driver, a driving record prepared by the bureau of motor vehicles no earlier than fourteen calendar days prior to the date of initial employment as a driver and at least once every three years thereafter. A person having six or more points on the person's driving record is prohibited from providing non-medical transportation. (d) Require each driver to immediately notify the agency provider, in writing, if the driver accumulates six or more points on the driver's driving record or has a driver's license suspended or revoked. (e) Ensure that each driver completes testing for controlled substances by a laboratory certified for such testing within thirty-two hours and completes testing for blood alcohol level by an entity certified for such testing within eight hours of a motor vehicle accident involving the driver while the driver was providing non-medical transportation when: (i) The accident involves the loss of human life; or (ii) The driver receives a citation under state or local law for a moving traffic violation arising from the accident, if the accident involved: (a) Bodily injury to any person who, as a result of the injury, immediately receives medical treatment away from the scene of the accident; or (b) One or more motor vehicles incurred disabling damage as a result of the accident, requiring the motor vehicle to be 5123-9-18 8 transported away from the scene by a tow truck or other motor vehicle. (f) Develop and implement written policies and procedures regarding vehicle accessibility, vehicle maintenance, and requirements for vehicle drivers.

Other Standard (specify):

Providers of transportation that is not available to the general public are eligible to bill on a per mile or per trip basis when the vehicles/providers/drivers meet the certification standards of the Department. The service type is determined by the team and individual choice and authorized in the individual's service plan.

Verification of Provider Qualifications**Entity Responsible for Verification:**

The Department of Developmental Disabilities (DODD).

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service**Service Name: Non-Medical Transportation**

Provider Category:

Agency

Provider Type:

County board of DD providers of non-medical transportation per mile

Provider Qualifications**License (specify):****Certificate (specify):**

Non-medical transportation will be provided by an independent provider, an agency provider, or an operator of commercial transportation that meets the requirements noted below, and, with the exception of a bus or rail system owned or operated by a government authority, that has a medicaid provider agreement with the Ohio department of medicaid. An applicant seeking approval to provide non-medical transportation will complete and submit an application to DODD. An applicant seeking approval to provide non-medical transportation as an independent provider will present the applicant's driving record prepared by the bureau of motor vehicles no earlier than fourteen calendar days prior to the date of application for initial or renewal provider certification. A person having six or more points on the person's driving record is prohibited from providing non-medical transportation.

An agency provider of non-medical transportation will: (a) Ensure that each driver holds a valid driver's license as specified by Ohio law. (b) Ensure that each driver is covered by valid liability insurance as specified by Ohio law. (c) Obtain, for each driver, a driving record prepared by the bureau of motor vehicles no earlier than fourteen calendar days prior to the date of initial employment as a driver and at least once every three years thereafter. A person having six or more points on the person's driving record is prohibited from providing non-medical transportation. (d) Require each driver to immediately notify the agency provider, in writing, if the driver accumulates six or more points on the driver's driving record or has a driver's license suspended or revoked. (e) Ensure that each driver completes testing for controlled substances by a laboratory certified for such testing within thirty-two hours and completes testing for blood alcohol level by an entity certified for such testing within eight hours of a motor vehicle accident involving the driver while the driver was providing non-medical transportation when: (i) The accident involves the loss of human life; or (ii) The driver receives a citation under state or local law for a moving traffic violation arising from the accident, if the accident involved: (a) Bodily injury to any person who, as a result of the injury, immediately receives medical treatment away from the scene of the accident; or (b) One or more motor vehicles incurred disabling damage as a result of the accident, requiring the motor vehicle to be 5123-9-18 8 transported away from the scene by a tow truck or other motor vehicle. (f) Develop and implement written policies and procedures regarding vehicle accessibility, vehicle maintenance, and requirements for vehicle drivers.

Other Standard (specify):

Providers of transportation that is not available to the general public are eligible to bill on a per mile or per trip basis when the vehicles/providers/drivers meet the certification standards of the Department. The service type is determined by the team and individual choice and authorized in the individual's service plan.

Verification of Provider Qualifications**Entity Responsible for Verification:**

The Department of Developmental Disabilities (DODD).

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Non-Medical Transportation****Provider Category:**

Agency

Provider Type:

Public bus transit system, public light rail transit system and taxicabs per mile

Provider Qualifications**License (specify):**

Certificate (specify):

An agency provider or an independent provider submitting claims for payment as an operator of commercial transportation will demonstrate ownership and operation of an enterprise that meets the definition of "commercial transportation" in paragraph (B)(4) of this rule

Non-medical transportation will be provided by an independent provider, an agency provider, or an operator of commercial transportation that meets the requirements noted below, and, with the exception of a bus or rail system owned or operated by a government authority, that has a medicaid provider agreement with the Ohio department of medicaid. An applicant seeking approval to provide non-medical transportation will complete and submit an application to DODD. An applicant seeking approval to provide non-medical transportation as an independent provider will present the applicant's driving record prepared by the bureau of motor vehicles no earlier than fourteen calendar days prior to the date of application for initial or renewal provider certification. A person having six or more points on the person's driving record is prohibited from providing non-medical transportation.

An agency provider of non-medical transportation will: (a) Ensure that each driver holds a valid driver's license as specified by Ohio law. (b) Ensure that each driver is covered by valid liability insurance as specified by Ohio law. (c) Obtain, for each driver, a driving record prepared by the bureau of motor vehicles no earlier than fourteen calendar days prior to the date of initial employment as a driver and at least once every three years thereafter. A person having six or more points on the person's driving record is prohibited from providing non-medical transportation. (d) Require each driver to immediately notify the agency provider, in writing, if the driver accumulates six or more points on the driver's driving record or has a driver's license suspended or revoked. (e) Ensure that each driver completes testing for controlled substances by a laboratory certified for such testing within thirty-two hours and completes testing for blood alcohol level by an entity certified for such testing within eight hours of a motor vehicle accident involving the driver while the driver was providing non-medical transportation when: (i) The accident involves the loss of human life; or (ii) The driver receives a citation under state or local law for a moving traffic violation arising from the accident, if the accident involved: (a) Bodily injury to any person who, as a result of the injury, immediately receives medical treatment away from the scene of the accident; or (b) One or more motor vehicles incurred disabling damage as a result of the accident, requiring the motor vehicle to be transported away from the scene by a tow truck or other motor vehicle. (f) Develop and implement written policies and procedures regarding vehicle accessibility, vehicle maintenance, and requirements for vehicle drivers.

Other Standard (specify):

Non-Medical transportation providers whose services are available to the general public will not be subject to certification when the transportation service is subcontracted by or purchased on behalf of a waiver recipient by a waiver provider certified to provide Adult Day Support, Vocational Habilitation, and/or Supported Employment-Enclave.

Verification of Provider Qualifications**Entity Responsible for Verification:**

The Department of Developmental Disabilities (DODD).

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Remote Supports

HCBS Taxonomy:**Category 1:**

17 Other Services

Sub-Category 1:

17990 other

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Remote support means the continuous oversight of technology by remote support staff and immediate availability of remote support staff working at a monitoring base to respond to the assessed needs of an individual while the individual is at the individual's residence. Remote support does not necessarily require constant surveillance or remote viewing of an individual. The remote support will be provided in real time, not via a recording, by awake staff at a monitoring base. While remote support is being provided, the remote support staff will not have duties other than to provide remote support. The remote support provider will have sufficient staff on hand at the monitoring base to ensure the health and welfare of individuals receiving remote support. The remote support staff interact with the individual in accordance with the individual service plan using equipment or technology with the capability for live two-way communication. Equipment or technology used to meet this requirement must include one or more of the following systems: motion sensing system, radio frequency identification, live video feed, live audio feed, web-based monitoring system, or a device that otherwise meets the requirement for two-way communication. Remote Support will not be provided in a shared living setting.

The monitoring base means the physical building from which the remote support staff monitor an individual. The monitoring base will be located in a private area that ensures the privacy of the individual being served and will not be located at the residence of any person who receives home and community-based services or in a car or any other vehicle, whether moving or parked. The remote support provider will ensure the monitoring base is operated in accordance with this rule. When the monitoring base is located in the residence of remote support staff, the remote support provider will ensure remote support staff understand that the residence may be visited during compliance reviews. The remote support provider will have a backup power system in place at every monitoring base in the event of electrical outages as well as other back up systems and additional safeguards in place as necessary to ensure compliance with the service. The remote support provider will develop and implement written protocols for verification and testing to ensure the equipment and technology used to provide remote support are working.

The individual service plan will include: typical days of the week and times of the day remote support will be provided, the assessed need and the equipment or technology used to address the need, the arrangement for backup support including whether backup support is paid or unpaid, the name and contact information for the person or agency provider that provides backup support and the amount of time deemed reasonable for backup support to arrive at the individual's residence based on the individual's assessed needs and the protocol to be followed should the individual request that the equipment or technology used to provision of remote support be deactivated.

Remote support equipment that involves the use of audio and/or video technology that permits remote support staff to view activities and/or listen to conversations in the residence and/or record activities in the residence, will not be activated by the provider when the provider is not being paid to provide services. The individual who receives the service and each person who lives with the individual shall consent in writing after being fully informed of what remote support entails including, but not limited to, that the remote support staff will observe their activities and/or listen to their conversations in the residence, where in the residence the remote support will take place, and whether or not recordings will be made. If the

individual or a person who lives with the individual has a guardian, the guardian shall consent in writing. The individual's service and support administrator shall keep a copy of each signed consent form with the individual service plan.

Backup support means the person or entity that is responsible for responding to an individual's residence in the event of an emergency or when the individual receiving remote support otherwise needs in-person assistance or the equipment or technology used for delivery of remote support stops working for any reason. Backup support may be provided by an unpaid family member, friend, or other person selected by the individual or a paid agency provider of homemaker/personal care, as applicable. When backup support is provided on a paid basis, the provider of remote support and the provider of homemaker/personal care or participant-directed homemaker/personal care will enter into a written agreement to ensure backup support is available if necessary. The written agreement will specify the terms of the arrangement including, the names of the individuals for whom paid backup is being provided, how the provider of remote support is to contact the provider of homemaker/personal care or participant-directed homemaker/personal care when backup support is needed.

Individuals and/or guardians who consent to the use of remote supports use this service in lieu of in-person caregiving, most typically provisioned through Ohio's Homemaker/Personal Care (HPC) service. As an example, a remote support device can be used to set reminders for medication administration for an individual who can self-administer. Remote supports allow for an individual to choose the method of supportive caregiving which best suits their needs. In this way, remote supports help ensure an individual's rights of privacy, dignity, and respect, as well as freedom from coercion in that individuals now have a different method of receiving care.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Remote supports shall not be provided in a shared living or non-residential setting.

Remote support shall be provided pursuant to an individual service plan. When remote support involves the use of audio and/or video equipment, the individual who receives the service and each person who lives with the individual shall consent in writing after being fully informed of what remote support entails, including, but not limited to, that the remote support staff will observe their activities and/or listen to their conversations in the residence, where in the residence the remote support will take place, and whether or not recording will be made. If the individual or a person who lives with the individual has a guardian, the guardian shall consent in writing. The individual's service and support administrator shall keep a copy of each signed consent form with the individual service plan.

In general, the use of cameras in bathrooms or bedrooms is not permitted. If ever a unique health and safety situation necessitated the need for cameras in a bathroom or bedroom, beyond a fall sensor, the overseeing Human Rights Committee would be required to authorize the plan and would ensure rights and privacy were specified in the plan.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Providers of Remote Supports

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Remote Supports

Provider Category:

Agency

Provider Type:

Agency Providers of Remote Supports

Provider Qualifications**License (specify):****Certificate (specify):**

Remote support will be provided by an agency provider that meets the requirements noted below and that has a medicaid provider agreement with the Ohio department of medicaid. An applicant seeking approval to provide remote support will complete and submit an application through DODD. Staff of agency providers and entities under contract with agency providers who monitor individuals from the monitoring base will complete the following before starting in their role:

Training provided or arranged by the agency provider in: (a) Mission, vision, values, and organizational structure of the agency provider (b) Policies, procedures, and work rules of the agency provider (c) Overview of specific services provided by the agency provider (d) Service documentation that supports billing for services provided. Training provided by the department or by an entity using department provided curriculum in: (a) Empathy-based care (b) Role of a direct support professional including "National Alliance for Direct Support Professionals" code of ethics (c) Rights of individuals set forth in section 5123.62 of the Revised Code (d) Implementation of individual service plans and service outcomes (e) Recognizing and reporting major unusual incidents and unusual incidents (f) Universal precautions for infection control.

Training provided or arranged by the agency provider specific to the individual service plan of each individual the direct support professional will support regarding what is important to the individual and what is important for the individual (examples include but are not limited to: health and safety; community integration; employment goals; behavioral support strategy; management of the individual's funds; or medication administration/delegated nursing needs)

Within thirty calendar days of hire, each direct support professional will successfully complete training provided or arranged by the agency provider in: (1) Person-centered planning and provision of services (2) Facilitating community participation and integration for individuals served (3) addressing major unusual incidents and unusual incidents to ensure health, welfare and continuous quality improvement including a review of health and welfare alerts issued by the department (4) Empathy-based care (C) On an annual basis, each direct support professional will successfully complete: (1) Two hours of training provided by the department or by an entity using department-provided curriculum in topics relevant to the direct support professional's duties including: (a) "National Alliance for Direct Support Professionals" code of ethics (b) Rights of individuals set forth in section 5123.62 of the Revised Code (c) Empathy-based care (2) Six hours of training provided or arranged by the agency provider in: (a) Recognizing and reporting major unusual incidents and unusual incidents, agency-specific data regarding major unusual incidents, and strategies for preventing major unusual incidents (b) Review of health and welfare alerts issued by the department since previous year's training (c) Topics selected from the following list that are relevant to services provided and people served by the agency provider: (i) Components of quality care (examples include but are not limited to: interpersonal relationships and trust; cultural competency; effective communication; person-centered philosophy, planning, and practice; implementing individual service plans; trauma-informed care; or empathy-based care) (ii) Health and safety (examples include but are not limited to: signs and symptoms of illness or injury and procedure for response; or transportation safety) (iii) Positive behavioral support (examples include but are not limited to: creating positive culture; general requirements for intervention and behavioral support strategies and role of the direct support professional including documentation; or crisis intervention techniques)

Other Standard (specify):**Verification of Provider Qualifications****Entity Responsible for Verification:**

Ohio Department of Developmental Disabilities

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

HCBS Taxonomy:
Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

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 individual's service plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. A self-directed model of transportation, as described in Ohio waiver rule 5123-9-26, has been established to assist individuals served to navigate their community as defined in the individual's service plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized. Transportation services may be provided in addition to the Non-Medical Transportation services that may only be used to enable individuals to access Adult Day Support, Vocational Habilitation, Individual Employment Support, Group Employment Support and Career Planning. To avoid service duplication with Non-Medical Transportation Service, documentation is required to show what service has been billed at what time. DODD conducts audits on services provided by aligning what is in the plan (ISP) with what has been approved in the Payment Authorization for Waiver Services (PAWS) and what has been billed in the Medicaid Billing System to ensure that no duplication has occurred. The SSA maintains the responsibility for monitoring the services as authorized in the ISP.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Transportation Providers
Individual	Independent Transportation Providers
Individual	Financial Management Services Entity

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Transportation

Provider Category:

Agency

Provider Type:

Agency Transportation Providers

Provider Qualifications

License (specify):

Certificate (specify):

Transportation will be provided by an independent provider, or an agency provider, or an operator of commercial vehicles that meets the requirements below and that has a medicaid provider agreement with the Ohio department of medicaid. An applicant seeking approval to provide transportation will complete and submit an application to DODD. An agency provider of transportation will: (a) Ensure that each driver holds a valid driver's license as specified by Ohio law. (b) Ensure that each driver is covered by valid liability insurance as specified by Ohio law. (c) Obtain, for each driver, a driving record prepared by the bureau of motor vehicles no earlier than fourteen calendar days prior to the date of initial employment as a driver and at least once every three years thereafter. A person having six or more points on the person's driving record is prohibited from providing transportation. (d) Require each driver to immediately notify the agency provider, in writing, if the driver accumulates six or more points on the driver's driving record or has a driver's license suspended or revoked. (e) Ensure that each driver completes testing for controlled substances by a laboratory certified for such testing within thirty-two hours and completes testing for blood alcohol level by an entity certified for such testing within eight hours of a motor vehicle accident involving the driver while the driver was providing transportation when: (i) The accident involves the loss of human life; or (ii) The driver receives a citation under state or local law for a moving traffic violation arising from the accident, if the accident involved: (a) Bodily injury to any person who, as a result of the injury, immediately receives medical treatment away from the scene of the accident; or (b) One or more motor vehicles incurred disabling damage as a result of the accident, requiring the motor vehicle to be transported away from the scene by a tow truck or other motor vehicle. (e)(f) Develop and implement written policies and procedures regarding vehicle accessibility, vehicle maintenance, and requirements for vehicle drivers.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Developmental Disabilities (DODD).

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three

years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Transportation

Provider Category:

Individual

Provider Type:

Independent Transportation Providers

Provider Qualifications

License (specify):

Certificate (specify):

Transportation will be provided by an independent provider, or an agency provider, or an operator of commercial vehicles that meets the requirements below and that has a medicaid provider agreement with the Ohio department of medicaid. An applicant seeking approval to provide transportation will complete and submit an application to DODD. An applicant seeking approval to provide transportation as an independent provider will present the applicant's driving record prepared by the bureau of motor vehicles no earlier than fourteen calendar days prior to the date of application for initial or renewal provider certification. A person having six or more points on the person's driving record is prohibited from providing transportation. An independent provider of transportation will: (a) Hold a valid driver's license as specified by Ohio law. (b) Have valid liability insurance as specified by Ohio law. (c) Immediately notify the department, in writing, if the independent provider accumulates six or more points on the independent provider's driving record or has a driver's license suspended or revoked. (d) Complete testing for controlled substances by a laboratory certified for such testing within thirty-two hours and complete testing for blood alcohol level by an entity certified for such testing within eight hours of a motor vehicle accident involving the driver while the driver was providing transportation when: (i) The accident involves the loss of human life; or (ii) The driver receives a citation under state or local law for a moving traffic violation arising from the accident, if the accident involved: (a) Bodily injury to any person who, as a result of the injury, immediately receives medical treatment away from the scene of the accident; or (b) One or more motor vehicles incurred disabling damage as a result of the accident, requiring the motor vehicle to be transported away from the scene by a tow truck or other motor vehicle.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Developmental Disabilities (DODD).

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Transportation

Provider Category:

Individual

Provider Type:

Financial Management Services Entity

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

See additional information provided in Appendix E-1-i

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Developmental Disabilities (DODD)

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Vehicle Modification

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Vehicle modification means adaptation or alteration of an automobile or van that is an individual's primary means of transportation, necessary to enable the individual to integrate more fully into the community and ensure the individual's health, welfare, and safety.

Vehicle modification includes:

1. Adaptation or alteration to an automobile or van that meets an individual's assessed needs, installation of:
 - a. External handling devices or carriers;
 - b. Lifts;
 - c. Vehicle operating aids, such as assistive equipment and technologies;
 - d. Raised or lowered floors or roofs;
 - e. Raised doors.
 - f. Remote devices;
 - g. Scooter or wheelchair hoists, hitches, or tie-downs;
 - h. Transferring seats or equipment; and
 - i. Factory-installed adaptations or alterations when documented on a separate, itemized invoice associated with the purchase of a new vehicle that is not pre-owned or pre-leased. Such modifications are payable upon proof of transfer of vehicle ownership from the dealer into the name of the allowable owner of the vehicle.
 - j. Maintenance, repair, or replacement of a previously approved vehicle modification funded by the individual's waiver.
 - k. Transfer of adaptable equipment from one vehicle to another for use by the same individual.
2. Vehicle modification does not include:
 - a. Adaptations or alterations costing more than the lowest-cost alternative that meets the individual's assessed needs.
 - b. Adaptation or alteration to a vehicle available through another funding source.
 - c. Improvements of general utility and not of direct medical or remedial benefit to the individual.
 - d. Repair or replacement of a previously approved vehicle modification that was damaged as a result of apparent misuse, abuse, or negligence.
 - e. Adaptations or alterations to a leased vehicle.
 - f. Removal of adaptations or alterations and return of a vehicle to its prior condition when an individual no longer has a need for the vehicle.
 - g. Installation of used parts.
 - h. Purchase or lease of a vehicle.
 - i. Purchase of extended warranties.
 - j. Maintenance, repair, or replacement of a previously installed adaptation or alteration funded by a source other than the individual's waiver.
 - k. Rental of an alternative vehicle for use while a vehicle is being modified or repaired in accordance with this rule.
 - l. Maintenance, repair, or replacement of a previously installed adaptation or alteration funded by a source other than the individual's waiver.

The vehicle that is being modified must be owned by a) the individual; (b) the individual's family member with whom the individual lives or has consistent and ongoing contact who may or may not be a paid provider of home and community-based services to the individual; or (c) a person who is neither the individual's family member nor a paid provider of home and community-based services to the individual but is a primary ongoing caregiver to the individual.

Prior to authorizing a vehicle modification, the service and support administrator, based on the person centered planning process and outcomes in the individual service plan, will request an assessment conducted by an occupational therapist or a physical therapist licensed pursuant to Chapter 4755 or the Revised Code, or a driver rehabilitation specialist certified by the association for driver rehabilitation specialists, to determine the appropriateness of the vehicle modification for the specific participant. The service and support administrator will establish ownership of the vehicle to be modified and obtain the vehicle owner's written consent to modify the vehicle; secure a written attestation from the individual or the individual's parent or guardian, as applicable, that the vehicle to be modified is the individual's primary means of transportation; obtain a written statement from an automotive service excellence-certified professional that the vehicle is in good operating condition, if not new; secure documentation necessary to establish the vehicle owner has liability insurance and collision insurance for the vehicle to be modified.

A provider of vehicle modification will comply with all federal, state and local regulations that apply to the vehicle modification or operation of the provider's business or trade; Provide a written warranty against defective workmanship lasting at least one year from the date of final acceptance of work; Provide a written statement that all materials furnished and installed perform their advertised function. A provider of vehicle modification may not be the owner of the vehicle being modified.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Payment for vehicle modification will not exceed ten thousand dollars per waiver eligibility span which is the twelve-month period following either an individual's initial waiver enrollment date or a subsequent eligibility redetermination date. When the cost of a needed modification exceeds \$10,000 as described in C-4 of the application, the department and the county board will collaborate with the individual and the individual's team to ensure the individual's health and welfare needs are met either through waiver funding or non-medicaid funds.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency provider of vehicle modification

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Vehicle Modification

Provider Category:

Agency

Provider Type:

Agency provider of vehicle modification

Provider Qualifications

License (specify):

Certificate (specify):

Vehicle modification will be provided by an agency provider that meets the requirements noted below and has a medicaid provider agreement with the Ohio department of medicaid. An agency provider of vehicle modification or its subcontractor will: (a) Be registered as a motor vehicle repair business with the national highway traffic safety administration in accordance with 49 C.F.R. 595.6. (b) Ensure the person who installs a vehicle modification meets requirements and has successfully completed all required training as specified by the manufacturer of the adaptation or alternation being installed. An agency provider of vehicle modification that subcontracts any part of the process: (a) Will maintain documentation demonstrating that its subcontractor meets the requirements noted and (b) Is responsible for ensuring each vehicle modification is completed in accordance with applicable federal, state, and local regulations. An applicant seeking approval to provide vehicle modification will complete and submit an application. Persons engaged by the applicant to install a vehicle modification are not required to: (i) Hold first aid certification or cardiopulmonary resuscitation certification.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Developmental Disabilities (DODD).

Frequency of Verification:

Initial certification for providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Waiver Nursing Delegation

HCBS Taxonomy:

Category 1:

05 Nursing

Sub-Category 1:

05020 skilled nursing

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Waiver nursing delegation services means the initial and ongoing supports provided by a licensed nurse who is delegating a nursing task or assuming responsibility for individuals who are receiving delegated nursing care. Waiver nursing delegation services include two distinct components: assessment of the individual receiving delegated nursing care that includes a face-to-face interview and observation of the individual receiving care and supervision of the performance of the nursing task performed by the unlicensed person.

All nurses providing waiver nursing services to individuals enrolled on the SELF waiver shall provide services within the nurse's scope of practice as set forth in Chapter 4723. of the Revised Code (Ohio's Nurse Practice Act) and Administrative Code rules adopted there under, and hold a current, valid, and unrestricted license issued by the Ohio board of nursing.

Ohio's Medicaid state plan does not currently fund nursing delegation.

Related legal guardians of individuals over the age of 18 are permitted to be providers. Family members who live with the individual are not eligible to be paid for waiver nursing delegation provided to that individual.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Waiver nursing delegation shall be provided pursuant to an individual service plan that conforms to the requirements of rule 5123-4-02 of the Administrative Code.

An individual may receive up to one assessment every 60 days in a residential setting and one assessment every 60 days in a non-residential setting.

Waiver nursing delegation may be reimbursed for no more than 10 hours per month for each individual in all settings.

LPNs may not perform waiver nursing delegation assessment.

The scope and intensity of supervision of unlicensed personnel shall be determined by the RN or LPN.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	LPN
Individual	RN
Agency	Medicare-certified HHA, an agency accredited by ACHC, CHAP or the Joint Commission or another national accrediting organization approved by CMS, and DODD certified agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Waiver Nursing Delegation

Provider Category:

Individual

Provider Type:

LPN

Provider Qualifications

License (*specify*):

LPN

Certificate (*specify*):

Waiver nursing delegation will be provided by an agency provider or an independent provider that meets the requirements of this rule. A provider of waiver nursing will obtain and maintain a medicaid provider agreement with the Ohio department of medicaid. Waiver nursing will be provided by a registered nurse or by a licensed practical nurse working at the direction of a registered nurse who: (a) Possesses current valid licensure in good standing to practice nursing in Ohio pursuant to Chapter 4723. of the Revised Code; and (b) Is working within the scope of practice as set forth in Chapter 4723. of the Revised Code and rules adopted thereunder.

Other Standard (*specify*):

Verification of Provider Qualifications**Entity Responsible for Verification:**

The Department of Developmental Disabilities (DODD).

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Waiver Nursing Delegation

Provider Category:

Individual

Provider Type:

RN

Provider Qualifications**License (specify):**

RN

Certificate (specify):

Waiver nursing delegation will be provided by an agency provider or an independent provider that meets the requirements of this rule. A provider of waiver nursing will obtain and maintain a medicaid provider agreement with the Ohio department of medicaid. Waiver nursing will be provided by a registered nurse or by a licensed practical nurse working at the direction of a registered nurse who: (a) Possesses current valid licensure in good standing to practice nursing in Ohio pursuant to Chapter 4723. of the Revised Code; and (b) Is working within the scope of practice as set forth in Chapter 4723. of the Revised Code and rules adopted thereunder.

Other Standard (specify):**Verification of Provider Qualifications****Entity Responsible for Verification:**

The Department of Developmental Disabilities (DODD).

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Waiver Nursing Delegation

Provider Category:

Agency

Provider Type:

Medicare-certified HHA, an agency accredited by ACHC, CHAP or the Joint Commission or another national accrediting organization approved by CMS, and DODD certified agencies

Provider Qualifications**License (specify):**

RN, LPN

Certificate (specify):

Medicare-certified HHA, an agency accredited by ACHC, CHAP or the Joint Commission or another national accrediting organization approved by CMS, and DODD certified agencies

RN, LPN License. Waiver nursing delegation will be provided by an agency provider or an independent provider that meets the requirements of this rule. A provider of waiver nursing will obtain and maintain a medicaid provider agreement with the Ohio department of medicaid. Waiver nursing will be provided by a registered nurse or by a licensed practical nurse working at the direction of a registered nurse who: (a) Possesses current valid licensure in good standing to practice nursing in Ohio pursuant to Chapter 4723. of the Revised Code; and (b) Is working within the scope of practice as set forth in Chapter 4723. of the Revised Code and rules adopted thereunder.

Other Standard (specify):**Verification of Provider Qualifications****Entity Responsible for Verification:**

The Department of Developmental Disabilities (DODD).

Frequency of Verification:

Initial certification for both agency and independent providers will be issued for a term of three years. Renewal certification will be issued for a term of three years. DODD Compliance reviews of certified providers occur at least once every three years during their certification periods.

Appendix C: Participant Services**C-1: Summary of Services Covered (2 of 2)**

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

Not applicable - Case management is not furnished as a distinct activity to waiver participants.

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

As a waiver service defined in Appendix C-3. *Do not complete item C-1-c.*

As a Medicaid state plan service under section 1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*

As an administrative activity. *Complete item C-1-c.*

As a primary care case management system service under a concurrent managed care authority. *Complete item C-1-c.*

As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management). *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

County boards of developmental disabilities conduct case management services (Targeted Case Management, or TCM) through Service and Support Administrators (SSAs) who are certified/registered through the Ohio Department of Developmental Disabilities.

- d. Remote/Telehealth Delivery of Waiver Services.** Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

Service
Support Brokerage
Assistive Technology
Habilitation - Adult Day Support
Habilitation - Vocational Habilitation
Health Care Assessment
Individual Employment Support
Remote Supports

1. Will any in-person visits be required?

Yes.

No.

2. By checking each box below, the state assures that it will address the following when delivering the service remotely/via telehealth.

The remote service will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. Explain:

The use of remote service delivery promotes individual outcomes in the service plan and includes the following assurance: Privacy is given to the individual with respect to personal space as needed and during care of health related needs, break times, etc.; Providers are responsible for applicable laws governing an individual's right to privacy and protection of health information. Applicable to support brokerage, adult day support, assistive technology, vocational habilitation, health care assessment, individual employment support and remote supports. Remote service delivery does not occur during times of personal care provision.

How the telehealth service delivery will facilitate community integration. Explain:

For services to be delivered remotely, it is required the individual agrees to the conditions of remote support with language specified in the person centered individual service plan. The use of remote service delivery promotes individual outcomes in the service plan. Virtual support may not have the effect of isolating an individual from the individual's community nor will it prevent the individual from interacting with people with or without disabilities. Accessing applicable services remotely promotes an individual's access to interact with the greater community through permitting an alternative when in person participation may not be feasible.

Applicable to support brokerage, adult day support, assistive technology, vocational habilitation, health care assessment, individual employment support and remote supports.

How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service can be rendered without someone who is physically present or is separated from the individual. Explain:

Telehealth services are not authorized for hands-on assistance needs.

How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service. *Explain:*

Prior to the use of technology or platform applications related to remote services, necessary supports will be identified in the person centered plan and provided should the individual require assistance. Providers will assure the person has access to support or instruction for successful service delivery. Applicable to support brokerage, adult day support, assistive technology, vocational habilitation, health care assessment, individual employment support and remote supports.

How the telehealth will ensure the health and safety of an individual. *Explain:*

Remote Support allows an off-site direct service provider to monitor and respond to a person's health, safety, and other needs using live communication, while offering the person more independence in their home or in the case of vocational habilitation or adult day support, allows the person the ability to participate when they may otherwise be unable to attend in person.

Any potential risks assessed will be mitigated during the person centered planning process. Applicable to support brokerage, adult day support, assistive technology, vocational habilitation, health care assessment, individual employment support and remote supports.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

- a. Criminal History and/or Background Investigations.** Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

No. Criminal history and/or background investigations are not required.

Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

At the time of initial enrollment and renewal, the Department of Developmental Disabilities (DODD) requests that every independent provider and every agency have a report sent to the Department as part of their application requirements. Certification will not be granted without this document, which must be sent directly from the Bureau of Criminal Identification and Investigation (BCII) to DODD.

DODD does not enroll an applicant who provides direct services to individuals with developmental disabilities as a SELF waiver provider until a background check has been satisfactorily completed.

Criminal history/background checks are conducted for all providers having direct contact with waiver participants. Background investigations follow the requirements listed in Section 5123.081 of the Ohio Revised Code.

A report is submitted by the Ohio's Bureau of Criminal Identification and Investigation (BCII) directly to DODD regarding an applicant's criminal record. If the applicant who is the subject of a background investigation does not present proof that he/she has been a resident of Ohio for the five-year period immediately prior to the date of the background investigation, a request that BCII obtain information regarding the applicant's criminal record from the federal bureau of investigation (FBI) shall be made. If the applicant presents proof that he/she has been a resident of Ohio for that five-year period, a request may be made that BCII include information from the FBI in its report.

An individual provider is required to report to DODD if he or she is ever formally charged with, convicted of, or pleads guilty to any of the disqualifying offenses listed or described in divisions (A)(3)(a) to (e) of section 109.572 of the Revised Code. The individual provider shall make such report, in writing, no later than fourteen calendar days after the date of such charge, conviction or guilty plea.

An agency provider shall require any employee in a direct services position to report, in writing, to the agency provider if the employee is ever formally charged with, convicted of, or plead guilty to any of the disqualifying offenses listed or described in divisions (A)(3)(a) to (e) of section 109.572 of the Revised Code no later than fourteen calendar days after the date of such charge, conviction, or guilty plea.

- b. Abuse Registry Screening.** Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

No. The state does not conduct abuse registry screening.

Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The requirements for the abuser registry are contained in Sections 5123.50 through 5123.54 of the Ohio Revised Code. The Department of Developmental Disabilities (DODD) maintains an abuser registry and screens provider applicants for waiver services that have direct contact with waiver participants against the abuser registry. Certification as an independent waiver provider who is engaged in a direct services position shall not be approved until the screening has been satisfactorily completed. Agency providers must assure that all employees or contractors who are engaged in a direct services position have been screened against the abuser registry. Agency providers will not hire or employ anyone engaged in a direct services position who is on the abuser registry.

Certification shall be denied to any applicant whose name appears on the abuser registry. For waiver providers who previously have been certified, DODD regulations require the revocation of all providers' certifications whose names have been placed on the registry. If a provider is employing someone in a direct services position that is on the registry, DODD would immediately require the person on the registry to be removed from contact with any person with a developmental disability. The provider would be sanctioned for violating the abuse registry guidelines, which may involve revocation of the provider's certification.

Additionally, contact is made with the Ohio Department of Health to inquire whether the nurse aide registry established under section 3721.32 of the Revised Code reveals that its director has made a determination of abuse, neglect, or misappropriation of property of a resident of a long-term care facility or residential care facility by the applicant. The Ohio Department of Developmental Disabilities will deny certification to an applicant whose name appears on the nurse aide registry with regard to abuse, neglect or misappropriation.

For employees, subcontractors of the applicant, and employees of subcontractors who provide specialized services to an individual with a developmental disability as defined in division (G) of section 5123.50 of the Revised Code, the applicant shall provide to DODD written assurance that, as of the date of the application, no such persons are listed on the abuser registry established pursuant to sections 5123.50 to 5123.54 of the Revised Code.

DODD compliance reviews verify whether the provider has checked the registry to ensure none of the employees have been placed on the registry.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *Select one:*

No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.

Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is "*extraordinary care*", exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which

payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

Requirements are outlined below and are also codified in Ohio Administrative Code 5160-44-32.

Type of legally responsible individuals: adoptive and biological parents of a minor child or spouse of an may serve as a direct care worker for homemaker/personal care services as described below.

Through assessment and care planning activities, the support coordination entity determines each of the following are met:

*Services are needed from the parent of a minor child or spouse while a willing and able direct care worker/provider is sought;

*The health and safety needs of the individual may be assured through the parent of a minor child or spouse serving as a direct care worker;

*Services authorized to be provided by the parent of a minor child or spouse are determined to meet extraordinary care requirements, as determined through Ohio's Extraordinary Care Instrument (ODM Form 10372).

Limitations:

*The parent of a minor child or spouse must be employed through an agency or as a participant directed service.

*Service is not authorized for respite purposes.

*The maximum number of hours a parent of a minor child or spouse may be authorized is forty hours, unless DODD, ODM or their designee determines additional hours are necessary to meet the health and safety needs of the individual.

Routine strategies outlined throughout the waiver application are employed to ensure permitting a legally responsible individuals to serve as a direct care worker is in the best interest of the participant. This includes increased care coordination/SSA oversight activities when this allowance is implemented.

Service payments: Routine agency billing procedures apply.

The state ensures payments are made only for services rendered through care coordination oversight and authorization, person-centered planning and routine provider oversight activities described throughout this waiver application.

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

The state does not make payment to relatives/legal guardians for furnishing waiver services.

The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Requirements are outlined below and are also codified in Ohio Administrative Code 5160-44-32.

Individuals with legal decision-making authority (authority granted to an individual or entity to act on behalf of an individual through the designation of authorized representative, declaration for mental health treatment, general power of attorney, representative payee, or appointment of legal custody or guardianship pursuant to a court order are prohibited from serving as a direct care worker for an individual, except as follows:

Parent of an adult individual with the following designations may serve as a direct care worker of homemaker personal care services as an independent provider or through agency employment.

*representative payee

*designations listed below.

An adult child, grandparent, grandchild, great-grandparent, great-grand-children, brother, sister, aunt, uncle, nephew, niece, and step relations of an individual above the age of eighteen with the following designations may serve as a direct care worker of homemaker personal care services as an independent provider or through agency employment:

*authorized representative

*declaration for mental health treatment

*general power of attorney

*healthcare (medical) power of attorney

*appointment of legal custody of a minor

*guardianship pursuant to a court order in accordance with the Rules of Superintendence for the Courts of Ohio

Standard procedures for service authorization, oversight and verification are applied through the care coordination entity and provider oversight contractor to ensure payment is made only for services furnished in the best interest of the individual.

Relatives with designated legal decision-making authority may be authorized the number of hours necessary to meet the needs determined by their person centered plan and authorized by ODM, DODD or the designee.

Relatives without legal decision-making authority as described in 5160-44-32 may receive payment for providing waiver services, in accordance with chapter 5123-9 of the Ohio administrative code.

Services in which a relative or legal guardian may provide include:

Assistive Technology

Career Planning

Group Employment Support

Habilitation, Adult day support or vocational habilitation

Home delivered meals

Individual employment support

Non medical transportation

Participant Directed Homemaker/personal care

Remote supports

Support brokerage (relative only)

Transportation

Waiver nursing delegation

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

Other policy.

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR § 431.51:

The Department of Developmental Disabilities (DODD) continuously certifies applicants to be providers of waiver services. Prospective providers must access the Provider Certification Wizard (PCW) to make application for certification. All documents required to be certified as a waiver provider, along with information regarding the certification process, are posted on DODD's website. Prospective providers may call or email DODD for information about the requirements or assistance with the application process. Once certified by the DODD, the Medicaid Provider application is forwarded to ODM for review and assignment of a Medicaid provider number.

County Boards also assist in the open enrollment of providers by passing along information regarding waiver services and the provider application process to potential providers.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one:*

No, the state does not choose the option to provide HCBS in acute care hospitals.

Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions. *By checking the boxes below, the state assures:*

The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;

The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;

The HCBS must be identified in the individual's person-centered service plan; and

The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.

And specify: (a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting; (b) How the 1915(c) HCBS will assist the individual in returning to the community; and (c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.

The following service includes options for service in acute care hospitals: participant directed homemaker/personal care (PDHPC).

PDHPC may be provided to an individual in an acute care hospital to address the individual's intensive personal care, behavioral support/ stabilization, or communication needs when the following conditions are met:

- (a) participant directed homemaker/ personal care is necessary to ensure smooth transition between the acute care hospital and the individual's home and to preserve the individual's functional abilities; Staff will assist with discharge planning to assure that the person's needs can be met back in their community location following a hospitalization. Staff ensure all discharge needs are identified during the person's transition back to the community.
- (b) participant directed homemaker/personal care is not a substitute for services the acute care hospital provides or is obligated to provide (e.g., attendant care) through its conditions of participation, federal law, state law, or other applicable requirement;
- (c) The person providing participant directed homemaker/personal care while the individual is in the hospital setting must remain awake during the approved service hours;
- (d) A maximum of sixteen hours of participant directed homemaker/personal care per day may be provided to an individual in an acute care hospital;
- (e) An individual may receive participant directed homemaker/personal care in an acute care hospital on no more than thirty calendar days per waiver eligibility span which is the twelve-month period following either an individual's initial waiver enrollment date or a subsequent eligibility redetermination date; and
- (f) The cost of participant directed homemaker/personal care provided to an individual in an acute care hospital can be accommodated by the individual's budget authorized in the medicaid services system. The care is billed and paid at the typically billed rate.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

- a. Sub-Assurance: The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

C-2: Number and percent of new agency providers that meet initial certification requirements prior to providing waiver services. Numerator: Number of new agency

providers that meet initial certification requirements prior to providing waiver services. Denominator: Total number of new agency providers enrolled.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DODD's Provider Certification Wizard

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

C-4: Number and percent of agency providers that continue to meet certification requirements at recertification or review. Numerator: Number of agency providers that continue to meet certification requirements at recertification or review.

Denominator: Total number of agency providers due for a re-certification or review.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DODD's Provider Certification Wizard

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify:	Annually	Stratified Describe Group:

	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

C-5: Number and percent of enrolled providers for which an appropriate background and registry check were conducted timely. Numerator: Number of enrolled providers for which an appropriate background and registry check were conducted timely. Denominator: Total number of enrolled provider due for a background and registry check.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DODD's Provider Certification Wizard

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Continuously and Ongoing
	Other Specify:

Performance Measure:

C-3: Number and percent of independent providers that continue to meet certification requirements at recertification or review. Numerator: Number of independent providers that continue to meet certification requirements at recertification or review. Denominator: Total number of independent providers due for a re-certification or review.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DODD's Provider Certification Wizard

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and	Other

	Ongoing	Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

C-1: Number and percent of new independent providers that meet initial certification requirements prior to providing waiver services. Numerator: Total number of new independent providers enrolled that meet initial certification requirements prior to providing waiver services. Denominator: Total number of new independent providers enrolled.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

DODD's Provider Certification Wizard

Responsible Party for data	Frequency of data collection/generation	Sampling Approach <i>(check each that applies):</i>
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collection/generation (check each that applies):	(check each that applies):	
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Continuously and Ongoing
	Other Specify:

Performance Measure:

C-6: Number and percent of HCBS non-residential settings reviewed as part of ongoing review that meet OAC 5123-9-02 requirements. Numerator: Number of HCBS non-residential settings reviewed that meet all requirements of OAC 5123-9-02. Denominator: Total HCBS non-residential settings reviewed.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:

		Records Review - Sample selected based on regulatory review schedule and number of settings subject to OAC 5123-9-02.
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

b. Sub-Assurance: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to

analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

N/A CMS acknowledged in the SELF Evidence Report submitted in 2023 that the SELF waiver does not permit non-licensed/non-certified providers to deliver waiver services. This sub-assurance does not apply. At renewal, CMS requested the state to indicate in the application that this sub-assurance does not apply and a PM is not required.

Data Source (Select one):

Other

If 'Other' is selected, specify:

N/A

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: N/A	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify: N/A
	Other Specify: N/A	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: N/A	Annually
	Continuously and Ongoing
	Other Specify: N/A

- c. **Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

C-7: Number and percent of independent providers who were certified because they met training requirements. Numerator: Number of independent providers who were certified because they met training requirements. Denominator: Total number of independent providers due for a review.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DODD's Provider Certification Wizard

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid	Weekly	100% Review

Agency		
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify:

Performance Measure:

C-8: Number and percent of agency providers who were certified because they met training requirements. Numerator: Number of agency providers who were certified because they met training requirements. Denominator: Total number of agency providers due for a review.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DODD's Provider Certification Wizard

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Activities by ODM for assuring compliance:

ODM conducts quality briefings with the operating agency at least four times per year to review data generated through the departments' quality processes, including results of any completed targeted reviews, waiver performance measure data, and data presented by the operating agency on the oversight activities conducted by that department. This data includes but is not limited to problems detected, corrective measures taken, and how the operating agency verified, or intends to verify, that the actions were effective.

Performance Measures data reports are submitted to ODM by DODD on a quarterly basis.

The information is gathered from county board and DODD compliance activities. DODD is able to identify and address individual problems as they are discovered and provide technical assistance that may include plans of corrective action. When problems are discovered, the individual county board is notified and technical assistance is provided using e-mail, phone contact and/or letters to county board staff. When issues are noted that are systemic, DODD will provide statewide training and incorporate that corrective action into its monitoring during the next monitoring cycle.

Case Specific Resolution: During the course of any review conducted by ODM or DODD, when staff encounter a situation in which a waiver recipients health or welfare is at risk, or when case management deficiencies are identified, the staff follow a protocol to report these observations. Depending on the severity of the situation, the staff will take immediate action, coordinate intervention with providers or case managers, and report the finding to ODM managers. ODM communicates findings to DODD for further review and appropriate intervention, and with explicit variable timeframes within which a report back to ODM is expected. ODM logs and tracks all such findings and referrals to assure appropriate case-specific resolution.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information

regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Provider applicants cannot provide waiver services prior to meeting initial certification requirements. Providers are not given their DODD contract number or Medicaid Provider number until the standards of certification have been met as established in Ohio Administrative Code (OAC) 5123-2-08 and 5123-2-09.

Requirements are specific to independent providers verse agency providers; all approved providers are identified in the provider database as either being an agency or independent provider. Effective dates of certification are not granted until DODD has received all documentation supporting the initial certification requirements. Requirements, including documents, for certification are currently listed by provider type on the DODD website. Provider applicants must use the online certification tool, the Provider Services Management (PSM) system to apply for certification. The application process consists of the applicant being asked a series of questions that will determine a list of required documentation based on their answers. Once the application is submitted by the applicant, it is forwarded to an electronic workflow program that is used to ensure requirements of initial and renewal certification are met.

All providers are notified within 90 days of their expiration date that they must renew their certification. They are sent a list of requirements via letter sent through the US Postal Service; this letter includes information pertaining to their expiration date and instructions as to how to proceed with certification renewal. If the provider does not meet the standards of certification to renew, the provider can no longer provide services and will not be able to bill for services provided after their expiration date. If the provider submits their application after their expiration date, a new effective date will be assigned that will align with the date that all completed documentation was received. This can result in a lapse in the certification record for the provider. If the application is submitted prior to expiration, but is incomplete, per OAC 5123-2-08 and 5123-2-09, the provider has 90 days to submit a completed application.

Providers are able to apply for certification for services under all of the DODD waivers using PSM. The services are listed within the application and the request for documentation is dependent upon the services selected. Goods and service providers are not included as DODD certified providers. Providers are only certified once the requirements of certification have been verified. Providers who do not submit documentation within the required timeframe are not denied; they are simply not certified. This includes providers who have not met the requirement for training documentation for initial and renewal certification. The DODD Office of Compliance will conduct compliance reviews to ensure anyone working for an agency in a direct service position has met any certification requirements. If they have not, citations will be issued by the Department. Reports can be accessed by Department staff outlining the number of providers who have been certified for initial or renewal certification, the type of provider, and the services for which they have been certified.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

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Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

- a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

Not applicable- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Applicable - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

Furnish the information specified above.

The following waiver services have applicable cost limits for each waiver eligibility span which is the twelve-month period following either an individual's initial waiver enrollment date or a subsequent eligibility redetermination date:

For assistive technology service, the cost of all components of assistive technology equipment shall not exceed \$5,000. The cost for initial training of a service animal will not exceed \$10,000. The cost for additional training, following the initial training will not exceed \$2,000. The cost for a service animal annual exam and routine vaccinations will not exceed \$500.

For environmental accessibility adaptations, the cost limit is \$15,000.

For functional behavioral assessment, the waiver year limit is \$1,500.

For vehicle modification, the cost limit is \$10,000.

For support brokerage, the cost limit is \$8,000.

For all services, when the cost of a needed service exceeds the identified service limit, the department of developmental disabilities and the county board will collaborate with the individual and the individual's team to ensure the individual's health and welfare needs are met either through waiver funding or non-medicaid funds. When waiver funding is necessary, the county board will submit documentation to the department establishing how the additional service cost will ensure the individual's health and welfare.

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

Furnish the information specified above.

The overall cost limitations for this waiver are \$41,424/year for children (defined as under age 22 and eligible for educational services) and \$62,136/year for adults.

Funding ranges or limitations apply to an individual's waiver eligibility span which is the twelve-month period following either an individual's initial waiver enrollment date or a subsequent eligibility redetermination date.

The Department of Developmental Disabilities (DODD) analyzed data on the average costs for both children and adults on the DODD-operated waivers Individual Options and Level One. This cost limitation for both children and adults includes accounting of the January and July 2024 rate increases appropriated by Ohio legislatures for direct service providers (DSPs) providing Homemaker/Personal care services and for the increase in rates for the Non-Medical Transportation service.

The budget amounts described herein apply to all currently approved waiver services offered under the SELF benefit package.

Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.

Furnish the information specified above.

Other Type of Limit. The state employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 §§ CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings in which 1915(c) HCBS are recieved. (*Specify and describe the types of settings in which waiver services are received.*)

Settings for the waiver program are fully described in Ohio Administrative Code 5123-9-2 home and community based services waivers- ensuring the suitability of services and service settings.

The following is identified in the rule:

"Provider-controlled residential setting" means a residence where the landlord is:

- (a) An entity that is owned in whole or in part by the individual's independent provider;
- (b) An immediate family member of the individual's independent provider;
- (c) An immediate family member of an owner or a management employee of the individual's agency provider;
- (d) Affiliated with the individual's agency provider, meaning the landlord;
- (i) Employs a person who is also an owner or a management employee of the agency provider; or
- (ii) Has, serving as a member of its board, a person who is also serving as a member of the board of the agency provider;
- (e) An entity that is owned in whole or in part by an owner, a management employee, or an immediate family member of the individual's agency provider; or
- (f) An owner or a management employee of the individual's agency provider.

"Provider-owned residential setting" means a residence where the provider is both the landlord and the residential home and community-based services provider. There are only three acceptable types of provider-owned residential settings under Ohio law:

- (a) A setting where shared living is provided;
- (b) A setting owned by an independent provider who is living in the setting and providing services to an individual who is living in the setting; or
- (c) A residential facility licensed pursuant to section 5123.19 of the Revised Code.

Home and community-based services

(1) An individual's private residence is presumed to be a suitable setting for home and community-based services when it meets the requirements set forth in paragraphs (C)(1)(a) to (C)(1)(e) of the rule. For the purposes of the rule, provider-controlled residential settings and provider-owned residential settings are not private residences.

- (a) The private residence is integrated in and supports the individual's full access to the greater community.
- (b) The private residence is selected by the individual from among setting options.
- (c) The private residence ensures an individual's right to privacy, dignity, and respect as well as freedom from coercion and restraint.
- (d) The private residence optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices.
- (e) The private residence facilitates individual choice regarding services and supports, and who provides them.

Settings presumed unsuitable for home and community-based services

(1) Home and community-based services will not be provided in provider-owned residential settings that do not meet an exception set forth in paragraph (B)(15) of the rule.

(2) Except for the provision of short-term respite services as approved by the centers for medicare and medicaid services, home and community-based services will not be provided in:

- (a) Hospitals except when:
 - (i) Homemaker/personal care is provided to an individual in an acute care hospital in accordance with rule 5123-9-30 of the Administrative Code;
 - (ii) Participant-directed homemaker/personal care is provided to an individual in an acute care hospital in accordance with rule 5123-9-32 of the Administrative Code; or
 - (iii) Shared living is provided to an individual in an acute care hospital in accordance with rule 5123-9-33 of the Administrative Code;
- (b) Institutions for mental diseases;
- (c) Intermediate care facilities for individuals with intellectual disabilities;
- (d) Nursing facilities; or
- (e) Other locations that have been determined by the secretary of the United States department of health and human services or the department as having the qualities of an institution and the effect of isolating individuals from the broader community.

(3) Absent a determination by the centers for medicare and medicaid services that the settings are suitable, home and community-based services will not be provided in:

- (a) Settings located in a building that is a publicly-operated or privately-operated facility that also provides inpatient institutional treatment; or

(b) Settings located in a building on the grounds of or immediately adjacent to a publicly-operated facility that provides inpatient institutional treatment.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

Person Centered Planning and Monitoring

To ensure proper training for PCSP development, the State has published three training modules, geared toward care coordination responsibilities within the nursing facility-based waiver programs. These include HCBS Settings Overview, HCBS Settings Criteria and Modifications and Care Coordination Role in HCBS Settings. The training modules are located here: at <https://medicaid.ohio.gov/families-and-individuals/citizen-programs-and-initiatives/hcbs/hcbs-transition>. The state reviews a sampling of person-centered service plans to ensure ongoing compliance.

Description of how the state assesses providers for initial compliance and conducts ongoing monitoring for continued compliance.

Initial Compliance

Provider owned and controlled settings for residential, non-residential adult day support and employment services, were reviewed and determined either have met compliance with HCBS settings or submitted to CMS for heightened scrutiny approval. Ohio continues to complete re-reviews and remediation of provider owned and controlled settings, as described and approved by CMS in the corrective action plan.

Ongoing HCBS Setting Compliance Monitoring

Residential and non-residential settings serving individuals in Ohio's HCBS delivery systems to be monitored beyond the transition period through scheduled provider compliance reviews and ongoing reviews completed by entities responsible for program care coordination and service authorization activities. Event-based reviews continue to be conducted upon receipt of complaints from individuals/guardians, community members, or others.

New Residential and non-residential HCBS service setting applicants:

An initial on-site assessment is conducted for all new settings that provide residential and non-residential HCBS.

For all settings applying to serve individuals in an Ohio HCBS program, the assessment is conducted prior to the entity being issued a Medicaid provider agreement to furnish HCBS waiver services.

For individuals enrolled on an Ohio HCBS program, the entity responsible for care coordination and/or service authorization will ensure that new settings comply with the HCBS settings standards prior to adding the service to the individual's service plan. If a setting's non-compliance prevents a service from being added to an individual's plan, the individual will be afforded due process in accordance with Ohio Revised Code 5101:6-1 through 5101:6-9.

All HCBS service providers newly applying to become a service provider are assessed and verified to meet HCBS settings requirements prior to approval to become a Medicaid waiver

service provider. Sites unable to meet HCBS settings requirements are prohibited from becoming new service providers. Providers meeting criteria for Heightened Scrutiny may not receive approval until the outcome of the CMS HS review has been determined and approval is received.

Description of a beneficiary's recourse to notify the state of provider non-compliance (grievance process, notification of case manager, etc.) and how the state will address beneficiary feedback.

The State recognizes protection and advocacy entities are key partners in ongoing compliance by informing individuals of their right to file a complaint regarding a specific setting and/or to report directly to the State any concerns with a setting's ability to comply. Upon receiving a report by an individual or another entity, the State will initiate a formal review, as appropriate.

Using the existing complaint processes, individuals have the right to file a complaint regarding a specific setting

Individuals may report complaints through their care coordination entity, long term state ombudsman and/or to report directly to the State any concerns with a setting's ability to comply. Upon receiving a report by an individual or another entity, the State will initiate a formal review, as appropriate.

Case Manager /Service and Support Administrator

The case manager/service and support administrator or waiver service coordinator also is an independent resource that the consumer can notify of any ongoing issue whether it is related to the HCBS settings rule or not. The waiver service coordinator serves as an invaluable resource for the HCBS participant to help with authorizing paid supports, locating and informing the HCBS participant about community related resources, acting as support when there are provider related concerns including the HCBS settings rule, and just and a trusted confidant to the HCBS participant. The waiver service coordinator is expected to make referrals to the appropriate entity depending on the instance, whether that is the licensing agency, provider compliance, or protective services. The waiver service coordinator frequently reaches out the participant for regular assessments and check-ins and is also available by phone, in-person, or electronically as the HCBS participant needs or concerns arise. HCBS participant for regular assessments and check-ins and is also available by phone, in-person, or electronically as the HCBS participant needs or concerns arise.

3. By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:

The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. (see Appendix D-1-d-ii)

Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

Facilitates individual choice regarding services and supports, and who provides them.

Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.

Provider-owned or controlled residential settings. (Specify whether the waiver includes provider-owned or controlled settings.)

No, the waiver does not include provider-owned or controlled settings.

Yes, the waiver includes provider-owned or controlled settings. (By checking each box below, the state assures that each setting, in addition to meeting the above requirements, will meet the following additional conditions):

The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

Each individual has privacy in their sleeping or living unit:

Units have entrance doors lockable by the individual.

Only appropriate staff have keys to unit entrance doors.

Individuals sharing units have a choice of roommates in that setting.

Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

Individuals have the freedom and support to control their own schedules and activities.

Individuals have access to food at any time.

Individuals are able to have visitors of their choosing at any time.

The setting is physically accessible to the individual.

Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan(see Appendix D-1-d-ii of this waiver application).

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Individual Service Plan

a. Responsibility for Service Plan Development. Per 42 CFR § 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(Select each that applies):*

Registered nurse, licensed to practice in the state

Licensed practical or vocational nurse, acting within the scope of practice under state law

Licensed physician (M.D. or D.O)

Case Manager (qualifications specified in Appendix C-1/C-3)

Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Service and support administrators (SSA) are responsible for service plan development and revision (ORC 5126.15 and rule 5123-4-02 of the Administrative Code). An SSA must be, regardless of title, employed by or under subcontract with a county board of developmental disabilities (county board) to perform the functions of service and support administration, and must hold the appropriate certification in accordance with rule 5123-5-02 of the Administrative Code. The minimum qualifications for certification are an associate degree from a college or university and the successful completion of required training.

A county board superintendent will ensure that service and support administrators successfully complete, no later than thirty calendar days after hire, department-provided web-based training in:

- Empowering individuals served through development of person-centered individual service plans;
- Coordinating services;
- Enhancing team effectiveness;
- Understanding medicaid;
- Overview of intermediate care facilities for individuals with intellectual disabilities;
- Overview of department-administered home and community-based services waivers including self-directed services, budget authority, and employer authority; Targeted case management; and
- Employment navigation.

An orientation program of at least eight hours that addresses: Organizational background of the county board or contracting entity. Components of quality care for individuals served including Person-centered philosophy. Health and safety. Positive behavior support. Services that comprise service and support administration.

Specific qualifications are:

(1) Service and support administrator

(a) A superintendent may issue service and support administrator certification for an initial period of five years to an applicant who holds an associate's degree, bachelor's degree, or graduate-level degree from an accredited college or university. Pursuant to sections 5126.15 and 5126.201 of the Revised Code, a person holding an associate's degree will be a conditional status service and support administrator and perform the duties of service and support administration only under the supervision of a management employee who is a service and support administration supervisor.

(b) A county board superintendent will ensure that service and support administrators successfully complete, no later than ninety calendar days after hire, an orientation program of at least eight hours that addresses, but is not limited to:

(i) Organizational background of the county board or contracting entity, including:

- (a) Mission, vision, values, and organizational structure;
- (b) Policies, procedures, and work rules;
- (c) Ethical and professional conduct and practice; and
- (d) Avoiding conflicts of interest.

(ii) Components of quality care for individuals served, including:

- (a) Interpersonal relationships and trust;
- (b) Trauma-responsive care;
- (c) Cultural and personal sensitivity;
- (d) Effective communication;
- (e) Roles and responsibilities of team members; and
- (f) Record-keeping, including progress notes and incident/accident reports.

(iii) Health and safety, including:

- (a) Signs and symptoms of illness or injury and procedure for response;
- (b) Building/site-specific emergency response plans; and
- (c) Program-specific transportation safety.

(iv) Requirements for development and implementation of behavioral support strategies in accordance with rule 5123-2-06 of the Administrative Code.

(v) Crisis intervention techniques.

(vi) Services that comprise service and support administration.

(d) A superintendent will ensure that service and support administrators (other than those who have at least one year of experience as a service and support administrator at the point of hire) successfully complete, no later than one year after hire, training specific to the provision of service and support administration that includes, but is not limited to:

- (i) Eligibility determination;
- (ii) Establishing individual budgets;
- (iii) Using Ohio individual service plan to conduct assessments and develop individual service plans;
- (iv) Effective service coordination;
- (v) Management of individuals' funds and related documentation requirements; and
- (vi) Self-determination which includes assisting an individual to develop self-advocacy skills, to exercise civil rights, to exercise choice and control over the services received, and to acquire skills that support becoming more independent, productive, and integrated within the community.

(e) A superintendent may renew the service and support administrator certification for a second period of five years provided the applicant has successfully completed the following in accordance with rule 5123-5-02:

- (i) The orientation program
- (ii) The department-provided web-based training
- (iii) Training specific to the provision of service and support administration and
- (iv) At least sixty hours of continuing professional education during the period of the initial service and support administrator certification.

The training described in rule may be counted toward the sixty hours.

(f) A superintendent may renew the service and support administrator certification for subsequent periods of five years provided the applicant has successfully completed:

- (i) The department-provided web-based training prior to application to renew the service and support administrator certification; and
- (ii) At least sixty hours of continuing professional education during the period of the preceding service and support administrator certification. The training may be counted toward the sixty hours.

Social Worker

Specify qualifications:

Other

Specify the individuals and their qualifications:

The Support Broker, considered to be an agent of the individual, is responsible for assisting the individual and the Service and Support Administrator (SSA) with the development of the Individual Service Plan (ISP). The Support Broker if chosen by an individual will have successfully completed the Support Broker training established by the Department of Developmental Disabilities (DODD) and meets the qualifications as listed in Ohio Administrative Code (OAC) 5123-9-47. Support Brokerage may be provided as a waiver service or on an unpaid basis. Whether a Support Broker would be paid or unpaid will be individual-specific and will be a decision made by the individual and their ISP team based on the resources available to, and requested by, the individual.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

- b. Service Plan Development Safeguards.** Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest

protections. *Select one:*

Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant. *Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:*

County boards of developmental disabilities (county boards) currently serve as the single provider of case management through Ohio's Targeted Case Management (TCM) services.

County boards of developmental disabilities (county boards) receive payments for waiver services provided only when no other qualified or available provider is found for the purposes of service provisioning: Non-Medical transportation (token/voucher).

So long as a county board of developmental disabilities is a provider of home and community-based services, the county board shall ensure administrative separation between county board staff doing assessments and service planning and county board staff delivering direct services.

Case management shall not be assigned responsibilities for implementing other services for individuals and shall not be employed by or serve in other administrative functions for any other entity that provides programs or services to individuals with developmental disabilities in accordance with section 5126.15 of the Ohio Revised Code.

Personnel providing TCM shall inform individuals, at least annually, of the right to choose from among all qualified providers and shall provide assistance, as needed, with the provider selection process in accordance with section Ohio Administrative Code rule 5123-9-11 section (C)(1): The county board will 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 will 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) When a provider offers more than one service, the individual may choose to receive only one of the offered services from that provider.
- (d) The individual may choose to receive services from a different provider at any time;
- (e) 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
- (f) The service and support administrator will assist the individual with the provider selection process if the individual requests assistance.

Additionally, As part of service plan development, the person centered planning process requires the CBDD to provide the Choice of Provider fact sheet to the individual, as well as due process rights, complaint filing information and other important safeguards. The individual or their authorized rep review the safeguards and acknowledge by checking the box and check attesting they received the information (or it was explained to them).

Individuals who wish to appeal a decision related to their HCBS services may request a state hearing in accordance with section 5101.35 of the Revised Code and Chapters 5101:6-1 to 5101:6-9 of the Administrative Code. In addition to this oversight, the DODD compliance team reviews individual support plans to ensure individuals rights are explained and they are acknowledging through the person centered planning process.

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;

An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;

Direct oversight of the process or periodic evaluation by a state agency;

Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and

Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) Each participant receives information and support from the Service and Support Administrator (SSA) and the Support Broker to direct and be actively engaged in the service plan development process. The Department of Developmental Disabilities (DODD) website publishes a variety of handbooks and brochures to assist participants and family members to understand home and community-based services (HCBS) waivers and the service planning process. A handbook will be created to be used as an informational resource concerning the participant-direction specifications of this waiver.

(b) The participant selects who is included in the planning process. If the individual employs a Support Broker, they will assist with ensuring those persons selected by the individual are involved in the planning process. In addition, SSAs will undergo training on what Support Brokerage and Participant Direction are as a means of gaining a more comprehensive understanding for the process and requirements for this waiver. The Support Broker and SSA assist the individual in developing the individual service plan (ISP) and selecting providers. The SSA has ultimate responsibility for ensuring the completion of the ISP (as well as for the annual re-determination and ISP review) and for implementation and monitoring of the ISP.

The SSA is ultimately responsible for the actual creation of plan and recommendation of approval, etc. and for resolving any issues that may arise in relation to the creation and implementation of the ISP.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

- d. i. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

- a.) The primary point of coordinating, and the entity responsible for the development of the Individual Service Plan (ISP), is the county board Service and Support Administrator (SSA). The SSA will assist the participant, at the time of initial enrollment, in selecting a Support Broker if chosen by the individual. In conjunction with the SSA, the Support Broker will help the participant with the development of their Individual Service Plan (ISP). At the time of initial enrollment, in order to assure health and welfare of participants disenrolling from other Department of Developmental Disabilities (DODD)-administered waivers and to allow the participant to have access to a Support Broker if wanted, the SSA and the participant create an interim plan which only identifies the provider of Support Brokerage and the budget associated with the service of Support Brokerage, where applicable. This interim plan authorizes the Support Broker to begin working with the participant and the SSA in the creation of the ISP and individual budget for the other services the individual will receive. The interim plan will indicate that the SSA, Support Broker, and individual will have no more than 30 days from date of enrollment to develop a full Individual Service Plan. The details contained in the interim plan will be transferred to the ISP prior to the expiration of the interim plan. If an individual has chosen to employ (either paid or unpaid) a Support Broker, this person is responsible for working with the SSA to identify all potentially viable resources, as well as assisting the participant to implement what is in his/her plan. The participant, with assistance of the Support Broker, determines who participates in the person-centered ISP development process. The SSA is responsible to actively participate on the planning team as well as for reviewing the ISP and budget to recommend for approval.
- b.) The SSA is responsible for ensuring the development of the ISP and for ensuring that this process occurs with the active participation of the individual to be served, the Support Broker if applicable, the guardian/representative of the individual, as applicable, other persons selected by the individual (including, but not limited to, family members), and the provider(s) selected by the individual. The ISP shall focus on the individual's strengths, interests, and talents, and will integrate all services and supports, regardless of funding, available to meet the needs and desired outcomes of the individual. The SSA is also responsible for ensuring the ISP addresses the results of the assessment process and results from service monitoring. Input from the individual, the individual's guardian/representative, the SSA, the Support Broker, and other team members determine the types of assessments that are included in the planning process. Assessments and evaluations by certified and/or licensed professionals shall be completed as dictated by the needs of the individual. Assessments shall also include evaluation of the individual's likes, dislikes, priorities, and desired outcomes, as well as what is important to and for the individual, including skill development, health, safety, and welfare needs, as applicable. The initial assessment as well as the annual reassessment will be done in-person.
- c.) It is the county board SSA's responsibility to inform the participant of the services that are available under this waiver and the responsibilities associated with participant-direction.
- d.) The participant, the Support Broker, if applicable, and the SSA, will determine what services would best meet the needs of the participant. The ISP shall include services and supports that assist the individual to engage in meaningful, productive activities and develop community connections. All services and activities indicated shall include the provider type, the frequency, and the funding source; and specify how services will be coordinated among providers and across all settings for the individual. The SSA will also review the ISP to ensure the amount, scope, frequency, and duration of the services selected will meet the participant's needs. The ISP shall identify at least one outcome important to the individual to be advanced or achieved within 12 months.
- e.) The participant, the Support Broker, if applicable, and the SSA will coordinate the services that are listed in the individual's service plan.
- f.) The Support Broker and/or the SSA will assist the participant to find potential providers for their ISP services. The participant, SSA and the Support Broker will implement and provide day-to-day oversight of the plan. The SSA has responsibility for ensuring that the services stated in the ISP are implemented in the timeframes specified, for monitoring that the services have been delivered and continue based on the requirements of the ISP, and that the services in the ISP continue to meet the health and welfare needs of the individual.
- g.) Once developed, the plan will be reviewed by the Support Broker, if applicable and participant, with the SSA, at least annually, unless there is a change in participant need/circumstance or the participant requests a change to their ISP. After the participant and Support Broker submit the requested changes and review with the SSA, revisions to the ISP will be recommended by the SSA for approval to ensure the ISP will continue to address the participant's needs and desired outcomes. DODD requires an ISP review within 10 days of request. In addition, requests may be addressed sooner in cases of emergency. ISP revisions will be completed within 30 calendar days of the request.

When an individual requests to move funds from one service to another, the individual and the Support Broker, if applicable, will request a meeting with the individual's SSA and, upon determining that no health and welfare issues would be caused by change in funds for the identified services, the SSA is to modify the ISP and budget accordingly, then notify the Financial Management Service (FMS) about the changes. The SSA would have the responsibility of verifying utilization with the FMS prior to movement of funds so that rejections do not occur. The FMS will provide monthly utilization reports to assist with tracking the individual's budget.

All ISPs are subject to the approval and review of the single state Medicaid agency (ODM).

In those instances when an independent provider is selected for a service that is subject to rate negotiation, the rate used in the individual's budget is developed from a collaborative process. As stated in the language in the waiver application, the first step in the process is the development of the individual's ISP, which details the actual services that the individual will receive and the level of service that they will need for the services listed in the plan. The ISP team (which includes the individual and the Support Broker, if applicable) will devise the options that will work for the individual in terms of determining, based on the level of need and the waiver services selected, what range of rates can be offered to the prospective provider while still keeping to the overall cost limitations of the waiver. Based on this, the individual and the Support Broker will present an offer to the prospective provider and the rate negotiation process will begin. Once a rate has been settled upon, that rate will be used in the final formulation of the individual's budget.

As a part of the service plan development, the Ohio ISP service planning template requires the individual and/or their guardian to review and sign off on the ISP. Per 5123-4-02 section (b)(f), "verify by signature and date that prior to implementation each individual service plan:

- (i) indicates the provider, frequency, and funding source for each service and support; and
- (ii) Specifies which provider will deliver each service or support across all settings".

- ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:

A specific and individualized assessed need for the modification.

Positive interventions and supports used prior to any modifications to the person-centered service plan.

Less intrusive methods of meeting the need that have been tried but did not work.

A clear description of the condition that is directly proportionate to the specific assessed need.

Regular collection and review of data to measure the ongoing effectiveness of the modification.

Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

Informed consent of the individual.

An assurance that interventions and supports will cause no harm to the individual.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The service and support administrator (SSA) is required to perform/coordinate assessments after the initial request for services and at least annually thereafter to determine the health, safety and welfare needs of the participant as part of the service planning process. Assessments by licensed and/or certified professionals shall be completed as dictated by the needs of the individual or the requirements of the service. The SSA is also required to monitor incident trends and the development and implementation of prevention and/or risk management plans as needed for the participant.

Back-up plans are part of the discussion during the person-centered planning process about what is needed for the participant. The back-up plan will be specifically tailored to each participant and will incorporate a variety of approaches, including back up-workers and/or family/natural support who can be called when a scheduled worker does not arrive at their designated time. The participant can also contact their county board of developmental disabilities' emergency service (available 24 hours/day, 7 days/week).

Backup plans are required in each ISP. SSAs, individuals and their ISP team engage in risk evaluation and assessment on an ongoing basis. SSAs facilitate discussion of services requested and/or denied by the individual that may create a concern for the health and welfare of the individual. The team works collaboratively with the individual in the process of balancing rights, risks and responsibility.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The Department of Developmental Disabilities (DODD) ensures individuals have Free Choice of Provider through interviews and documentation reviews conducted during the accreditation review process. In accordance with OAC 5123-9-11 DODD assures the free choice of provider processes are adhered to and is intended to emphasize the right of individuals to choose any qualified provider of home and community-based services.

DODD maintains a current list of all qualified providers on its website. Annually county boards of developmental disabilities (county boards) are required to provide to all individuals enrolled on the waiver a description of the individual's right to choose any qualified provider from all those available statewide; the procedures that Service and Support Administrators (SSAs) will follow to assist individuals in the selection of providers of home and community-based services; and a description of the information available on the website and instructions for accessing this information.

When an individual chooses a qualified provider who is willing to provide services to him/her, the SSA assists the individual in making arrangements to initiate services with the chosen provider.

If an individual requires assistance to choose qualified providers, the county board informs the individual of the list of qualified providers available on the DODD website; assists the individual to access the website information, if needed; assists the individual to obtain outcomes of past monitoring reviews of services provided by the qualified provider(s) whom the individuals wishes to consider, if requested, and contacts the preliminary provider(s) selected by the individual to determine the provider's interest in providing services to the individual, unless the individuals wishes to contact the provider(s) directly.

To the extent that the individual requests assistance in the provider choice selection process, the SSA follows the Provider Choice Process approved by DODD and Ohio Department of Medicaid (ODM) to facilitate communication, meetings, and information sharing between the individuals and qualified providers until the individual has selected a qualified provider. (OAC 5123-9-11)

The Free Choice of Provider rule requires that county boards annually provide consumers with information regarding the availability of alternate providers and how to access the list of all providers on the DODD website. This may be done at the service plan review for each person and/or can be a mass mailing to all individuals on an annual basis. Throughout the year communication between the SSA and individual would address this information as appropriate following the process specified in the Free Choice of Provider rule (OAC 5123-9-11). ODM ensures this during reviews and hearing requests and DODD ensures this as part of the accreditation review process. In addition, if either department receives a complaint that this is not occurring, it can be reviewed on a case-by-case basis.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR § 441.301(b)(1)(i):

The single State Medicaid Agency, the Ohio Department of Medicaid, (ODM) assures the compliant performance of this waiver by: delegating specific responsibilities to the Operating Agency, the Department of Developmental Disabilities, (DODD) through an interagency agreement; establishing general Medicaid rules processing claims for federal reimbursement, conducting audits; conducting post-payment review of Medicaid claims; monitoring the compliance and effectiveness of the Operating Agency's operations; leading the development of quality improvement plans; and facilitating interagency data-sharing and collaboration.

Responsibilities delegated to the Operating Agency (DODD) include: assuring compliant and effective case management for applicants and waiver participants by county boards of developmental disabilities (county boards); managing a system for participant protection from harm; certifying particular types of waiver service providers; assuring that paid claims are for services authorized in individual service plans; setting program standards/expectations; monitoring and evaluating local administration of the waiver; providing technical assistance; facilitating continuous quality improvement in the waiver's local administration; and more generally, ensuring that all waiver assurances are addressed and met for all waiver participants. These requirements are articulated in an interagency agreement which is reviewed and re-negotiated at least every two years.

Requirements to comply with federal assurances are also codified in state statute and administrative rules and clarified in procedure manuals. While some rules and guidelines apply narrowly to specific programs administered by the operating agency, other rules promulgated by ODM authorize those rules or guidelines, establish overarching standards for Medicaid programs, and further establish the authority and responsibility of ODM to assure the federal compliance of all Medicaid programs.

In addition, ODM monitors service planning activity through the quality performance measures. ODM also retains the right to review and modify service plans at any time.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR § 92.42. Service plans are maintained by the following (*check each that applies*):

Medicaid agency

Operating agency

Case manager

Other

Specify:

The participant and their local county board of developmental disabilities.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Service and Support Administrator (SSA) is responsible for monitoring the implementation of the service plan in accordance with OAC 5123-4-02 in order to verify the health, safety and welfare of the individual; consistent implementation of services; achievement of the desired outcomes for the individual as stated in the service plan; and individual's service plan is reviewed at least annually and more often should the needs of the individual change. This ongoing monitoring is tailored to the individual and occurs through regular interaction with the individual and his or her provider(s). The scope, type, and frequency of reviews are specified in the individual service plan (ISP). The on-going oversight provided by the Support Broker, if applicable occurs through regular interaction with the participant and their provider(s), as defined within the ISP.

Monitoring will include at least one in-person visit to the setting where the individual resides every six months and at least one in-person visit to the setting where the individual receives adult day or employment services every twelve months. The SSA may determine that the frequency of monitoring needs to be increased based on whether the individual has intensive behavior or medical needs, an interruption of service of more than thirty calendar days, a crisis or other destabilizing events within a three-month period, a transition from an ICF within the past twelve months, an individual receives services from a provider that has been notified of the department's intent to suspend or revoke their certification, when requested by the individual, the individual's guardian or the adult whom the individual has identified, as applicable and the individual receives services in a manner or setting that has been determined to be out of compliance with requirements regarding home and community based services.

The service and support administrator may monitor services through unscheduled visits to setting where an individual receives services. Unscheduled visits to a family home where an individual receives services may occur only when multiple documented attempts to contact a family have failed and the service and support administrator has documented substantiated concerns related to the health and welfare of the individual receiving services or at the request of an individual or the individual's guardian. Upon an unscheduled visit to a family home where an individual receives services, a service and support administrator may request entry to the home but may not enter without the consent of the family, individual, or guardian, as applicable. If consent is denied, the service and support administrator will document denial and, if health or welfare concerns persist, refer the matter to the appropriate protective authorities.

The Department of Developmental Disabilities (DODD) monitors service plan implementation through the provider compliance and accreditation review processes. Reviewing service plan documentation and the corresponding service plans is one component of the accreditation and provider compliance review processes conducted by DODD field review staff.

Reviewing service plans and the monitoring activities of SSAs is one component of the accreditation review process. Accreditation reviews are scheduled at least once every three years based on the term of the county board's accreditation award. A county board may be accredited for one to three years based on the outcome of their review.

Provider compliance reviews are scheduled at least once every three years for each provider who has actively billed during the last calendar year and is providing services in an unlicensed setting. Special reviews for each review process are conducted based on requests and/or complaints received from individuals and family members, advocates, other stakeholders, and concerned citizens. County boards of developmental disabilities (county boards) cannot complete compliance reviews of day services while providing day services. This function can only be performed by DODD.

- b. Monitoring Safeguard.** Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation. (Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. By checking each box, the state attests to having a process in place to ensure:

Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;

An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;

Direct oversight of the process or periodic evaluation by a state agency;

Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and

Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. *Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.*

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

D-1: Number and percent of participants whose service plans address their assessed needs, including health and safety risk factors, and personal goals. Numerator: Number of participants whose service plans address their assessed needs, including health and safety risk factors, and personal goals. **Denominator:** Total number of participants reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:

		Records review - Sample selected based in regulatory review schedule & number of members receiving services through that provider - minimum of 10% of members per year
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

- b. Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.**

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

D-2: Number and percent of service plans that were developed according to policies and procedures as described in the approved waiver. Numerator: Number of service plans that were developed according to policies and procedures as described in the approved waiver. Denominator: Total number of participants reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:

		Records review - Sample selected based in regulatory review schedule & number of members receiving services through that provider - minimum of 10% of members per year
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

c. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

D-3: Number and percent of service plans reviewed that were updated at least annually. Numerator: Number of service plans reviewed that were updated at least annually. Denominator: Denominator: Total number of service plans reviewed that an annual update were due.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:

		Records review - Sample selected based in regulatory review schedule & number of members receiving services through that provider - minimum of 10% of members per year
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

D-4: Number and percent of service plans reviewed that were updated when the participant's needs changed. Numerator: Number of service plans reviewed that were

updated when the participant's needs changed. Denominator: Total number of service plan reviewed for whom participants experienced a change in need.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify: Records review - Sample selected based in regulatory review schedule & number of members receiving services through that provider - minimum of 10% of members per year
	Other Specify:	

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

d. Sub-assurance: Participants are afforded choice between/among waiver services and providers.**Performance Measures**

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

D-5: Number and percent of participants reviewed who received services in the type, scope, amount, duration and frequency specified in the service plan. Numerator: Number of participants reviewed who received services in the type, scope, amount, duration and frequency specified in the service plan. **Denominator:** Total number of participants reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify: Records review - Sample selected based in regulatory review schedule & number of members receiving services through that provider - minimum of 10% of members per year
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

- e. **Sub-assurance:** *The state monitors service plan development in accordance with its policies and procedures.*

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

D-6: Number and percent of participants notified of their rights to choose among waiver services and/or providers. Numerator: Number of participants notified of their rights to choose among waiver services and/or providers. Denominator: Total number of participants reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
--	---	---

State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify: Records review - Sample selected based in regulatory review schedule & number of members receiving services through that provider - minimum of 10% of members per year
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Activities by ODM for assuring compliance:

ODM conducts quality briefings with the operating agency at least four times per year to review data generated through the departments' quality processes, including results of any completed targeted reviews, waiver performance measure data, and data presented by the operating agency on the oversight activities conducted by that department. This data includes but is not limited to problems detected, corrective measures taken, and how the operating agency verified, or intends to verify, that the actions were effective.

Case Specific Resolution: During the course of any review conducted by ODM or DODD, when staff encounter a situation in which a waiver recipients health or welfare is at risk, or when case management deficiencies are identified, the staff follow a protocol to report these observations. Depending on the severity of the situation, the staff will take immediate action, coordinate intervention with providers or case managers, and report the finding to ODM managers. ODM communicates findings to DODD for further review and appropriate intervention, and with explicit variable timeframes within which a report back to ODM is expected. ODM logs and tracks all such findings and referrals to assure appropriate case-specific resolution.

Performance Measures data reports are submitted to ODM by DODD on a quarterly basis.

The information is gathered from county board and DODD compliance activities. DODD is able to identify and address individual problems as they are discovered and provide technical assistance that may include plans of corrective action. When problems are discovered, the individual county board is notified and technical assistance is provided using e-mail, phone contact and/or letters to county board staff. When issues are noted that are systemic, DODD will provide statewide training and incorporate that corrective action into its monitoring during the next monitoring cycle.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The Department of Developmental Disabilities (DODD) becomes aware of problems through a variety of mechanisms including, but not limited to, formal and informal complaints, technical assistance requests, and routine & special regulatory review processes (accreditation, licensure, provider compliance, etc.. During the DODD regulatory review process in the

areas of Service Plan Development and Service Plan Implementation are reviewed to ensure that the service plan meets the assessed needs and the wants of the waiver recipient. When non-compliance in this area is identified, a citation is issued to the provider. The provider will be required to submit a plan of correction by the specified due date. Verification of the plan of correction will be done to ensure that the plan of correction has been implemented to correct the area of non-compliance. When issues are noted that are systemic, DODD will provide statewide training and additional technical assistance and monitor for improvement during subsequent monitoring cycles.

It is the responsibility of the County Board of Developmental Disability's service and support administrator (SSA) to ensure that the individual service plan (ISP) is compiled correctly and timely. During the DODD regulatory review process in the areas of Service Plan Development and Service Plan Implementation the following are reviewed 1) the service plan meets the assessed needs and the wants of the waiver recipient, 2) it is developed according to the required processes, 3) it is developed utilizing the correct forms, 4) it is updated at least annually, 5) it updated when the needs of the waiver recipient change, and 6) the recipient receives services in the type, scope, amount, duration, and frequency identified in the service plan. When non-compliance in an area is identified, a citation is issued to the County Board and the County Board will be required to submit a plan of correction by the specified due date. Verification of the plan of correction will be done to ensure that the plan of correction has been implemented to correct the area of non-compliance. When issues are noted that are systemic, DODD will provide statewide training and additional technical assistance and monitor for improvement during subsequent monitoring cycles.

During the DODD regulatory review process the waiver recipient's SSA is asked to complete a questionnaire which asks for copies of the Freedom of Choice and the Freedom Choice of Provider forms. When non-compliance in this area is identified, a citation is issued to the County Board. The County Board will be required to submit a plan of correction by the specified due date. Verification of the plan of correction will be done to ensure that the plan of correction has been implemented to correct the area of non-compliance. When issues are noted that are systemic, DODD will provide statewide training and additional technical assistance and monitor for improvement during subsequent monitoring cycles.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify: Semi-annually

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

a.) This waiver includes many opportunities for participants to control and manage his or her supports and services by allowing the participant to:

- Develop a person-centered plan that ensures health and welfare (with assistance from the Service and Supports Administrator (SSA) and Support Broker, if applicable)
- Develop an individual budget
- Negotiate rates within a range for applicable services
- Serve as the employer of record, if applicable
- Recruit, hire, and manage providers
- Establish work schedules
- Train and supervise providers
- Discharge providers when necessary (or request that the co-employer do it on their behalf, if applicable)
- Participate in the development and implementation of a backup/emergency plan

b.) Prior to entrance on this waiver, all participants will be informed that they will need to self-direct at least one service under this waiver, which at minimum means deciding what portion of their individual budget they wish to allocate to at least one of their service provider(s) in accordance with the cost limitations established for the services.

c.) The SSA will assist the participant in directing their services by helping them to select a Support Broker, if applicable. Once the Support Broker is chosen, that person, in conjunction with the SSA, will assist the individual in selecting the services for their ISP and determining the budget amounts for those services.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver.
Select one:

Participant: Employer Authority. As specified in **Appendix E-2, Item a**, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

Participant: Budget Authority. As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

Both Authorities. The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.

Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.

The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

Waiver is designed to support only individuals who want to direct their services.

The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.

The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Service and Support Administrators provide information to participants by sharing the DODD website resources and training materials. Materials and information given to the participant by the service and support administrator (SSA) prior to enrollment on this waiver to ensures the participant understands the responsibilities associated both with this waiver and with participant-direction.

This information will also be revisited with the participant by the Support Broker, if applicable, and the SSA at least annually when the individual service plan is reviewed and revised. Resources provided can be found at the SELF Waiver | Department of Developmental Disabilities (<https://dodd.ohio.gov/waivers-and-services/waivers/1-self-waiver>). Media provided includes details on all services provided, eligibility, participant direction explanation, and funding limits. Detailed information is linked (<https://dodd.ohio.gov/waivers-and-services/waivers/participant-directed-waiver-services>) with information about Support Brokerage, Financial Management Services including Employer and Budget Authority details, and details on leaving participant direction. Additional resources and downloadable files are available on the site as well.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative (*select one*):

The state does not provide for the direction of waiver services by a representative.

The state provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

Waiver services may be directed by a legal representative of the participant.

Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The participant who wishes to designate a non-legal representative/designee would do so by signing a form. A power of attorney may be used for this. Unless otherwise limited by the participant, the non-legal representative/designee would have direction over the individual service plan (ISP), the budget, selection of residence and providers, and negotiation of rates. If the participant objects to a decision made by the non-legal representative/designee, the participant's decision prevails. The participant may revoke the designation at any time, and the revocation should be in writing.

The non-legal representative/designee cannot be a provider, nor can they be employed by a county board of developmental disability (county board), or a provider, or a contractor of either. The ISP process, along with the involvement of the service and support administrator (SSA) and Support Broker, if applicable, will provide the mechanism for ensuring decisions are made in the best interests of the participant. Safeguards include the participation and watchfulness of the Support Broker and the SSA as would be expected in their roles.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Transportation		
Participant-Directed Goods and Services		

Waiver Service	Employer Authority	Budget Authority
Support Brokerage		
Clinical/Therapeutic Intervention		
Participant-Directed Homemaker/Personal Care		

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

Yes. Financial Management Services are furnished through a third party entity. (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

Governmental entities

Private entities

No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. Do not complete Item E-1-i.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

FMS are covered as the waiver service specified in Appendix C-1/C-3

The waiver service entitled:

FMS are provided as an administrative activity.

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The entity who provides the Financial Management Service (FMS) is a statewide FMS vendor for the Department of Developmental Disabilities (DODD)-administered waiver programs that was selected via a competitive bidding request for proposals (RFPs) process.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The FMS will be paid as a monthly fee per participant as part of their contract with the state.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

Assist participant in verifying support worker citizenship status

Collect and process timesheets of support workers

Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

Other

Specify:

Supports furnished when the participant exercises budget authority:

Maintain a separate account for each participant's participant-directed budget

Track and report participant funds, disbursements and the balance of participant funds

Process and pay invoices for goods and services approved in the service plan

Provide participant with periodic reports of expenditures and the status of the participant-directed budget

Other services and supports

Specify:

Additional functions/activities:

Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency

Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency

Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget

Other

Specify:

- iv. Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The Ohio Department of Medicaid (ODM), in collaboration with the Department of Developmental Disabilities, hold responsibility for the oversight of the FMS entity's execution of Medicaid provider agreements. Through the competitive bid process, the FMS entity entered into an agreement with ODM and DODD by committing to adhere to the standards established in the request for proposals and the signed contract with DODD. ODM and DODD oversee this process through the quarterly performance measure review as noted in Appendix A-Administration and Oversight.

The Department of Developmental Disabilities (DODD) monitors and assesses the performance of the Financial Management Service (FMS) vendor in the following ways:

- Annual reviews conducted by DODD Audit staff or by a contract with an audit agency that review a representative sample of participant files including all fiscal and financial records. Expenditures are reviewed for being allowed under the waiver and Ohio Administrative Code, and whether expenditures are accurately and appropriately assigned and reported.
- All expenditures are reported monthly to DODD from the FMS. DODD staff identifies inconsistencies based on information including utilization, individual budgets, expenditures, dates of service, waiver enrollment date and then follow up with FMS staff to see correction of errors.
- The FMS will be required by contract to comply with applicable audit requirements and responsibilities of the Office of Management and Budget (OMB) Circular A-133.

On a quarterly basis, DODD will review the timeliness of processing payroll and payment of other invoices by the FMS.

Periodically, DODD will randomly select a number of provider files maintained by the FMS to verify qualifications of these providers. At the end of the first year, DODD will review all systems and practices to confirm compliance with the contract and Medicaid regulations. An independent outside audit group will conduct internal audits in accordance with a Compliance Plan which must be approved by DODD.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

--

Waiver Service Coverage.

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (*check each that applies*):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Transportation	
Home Delivered Meals	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Vehicle Modification	
Health Care Assessment	
Participant/Family Stability Assistance	
Habilitation - Adult Day Support	
Residential Respite	
Functional Behavioral Assessment	
Remote Supports	
Habilitation - Vocational Habilitation	
Group Employment Support	
Individual Employment Support	
Assistive Technology	
Participant-Directed Goods and Services	
Waiver Nursing Delegation	
Support Brokerage	
Non-Medical Transportation	
Clinical/Therapeutic Intervention	
Community Respite	
Participant-Directed Homemaker/Personal Care	
Career Planning	
Environmental Accessibility Adaptations	

Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (*select one*).

No. Arrangements have not been made for independent advocacy.

Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

Independent advocacy can be accessed as a waiver service under Participant-directed Homemaker/personal care.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

If a participant chooses to voluntarily terminate from the waiver, a waiver opportunity from the Department of Developmental Disabilities (DODD)-administered waivers known as Individual Options (IO) or Level One may be made available to the participant. If there are no waivers available, a secondary option would be to access other available state/local resources. If no other alternatives are appropriate to meet the individual's needs, he/she will be referred for intermediate care facility for individuals with intellectual or developmental disabilities (ICF/IID) services. The service and support administrator (SSA) and Support Broker, if applicable will assist the participant in order to responsibly transfer the participant to waiver or community-based services, or to assist the participant in ICF/IID placement.

The individual, and their Support Broker, if applicable, and their SSA will devise and implement a transition plan that will assure the individual's health and welfare is not put in jeopardy if an individual decides they no longer want to direct their services.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

If the participant's health and welfare can no longer be assured, the participant may be involuntarily terminated from the waiver. A waiver opportunity from the DODD-administered waivers known as Individual Options (IO) or Level One may be made available to the participant. If there are no waivers available, a secondary option would be to access other available state/local resources. If no other alternatives are appropriate to meet the participant's needs, he/she will be referred for intermediate care facility for individuals with intellectual disabilities (ICF/IID) services.

The service and support administrator (SSA) and Support Broker will assist the participant in order to responsibly transfer the participant to waiver or other community-based services, or to assist the participant in ICF/IID placement.

When a participant is involuntarily terminated from the use of participant-direction, they will be offered fair hearing rights and provided with an explanation of how to access these rights.

The SSA is required to implement a transition plan in the case of an individual's involuntary termination of participant direction.

Appendix E: Participant Direction of Services

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		4000
Year 2		4000
Year 3		4000
Year 4		4000
Year 5		4000

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

The contracted FMS entity may serve as the Employer of Record in a Co-Employer status if the individual chooses them. The FMS entity's qualifications will be detailed in the requirements of the contract that the FMS holds with the State.

Agencies with Choice may also serve as the Employer of Record in a Co-Employer arrangement. In those instances, the agencies must meet the qualifications for the waiver service they are certified to provide.

The SSA and the Support Broker will have responsibility for ensuring that the individual is the managing employer and that the Employer of Record operates in accordance with the individual's preferences as permitted by law.

In alignment with all participant directed services, monitoring and oversight provided by the local county board and DODD Provider Compliance ensures compliance with rules and regulations of self-direction. SSA's, Support Brokers, authorized representatives are responsible for supporting the participant is the managing employer and the Employer of Record operates in accordance with the participant's preferences.

Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

Recruit staff

Refer staff to agency for hiring (co-employer)

Select staff from worker registry

Hire staff common law employer

Verify staff qualifications

Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

Provider applicants incur the expense of the background (BCII) check.

Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Determine staff duties consistent with the service specifications in Appendix C-1/C-3.

Determine staff wages and benefits subject to state limits

Schedule staff

Orient and instruct staff in duties

Supervise staff

Evaluate staff performance

Verify time worked by staff and approve time sheets

Discharge staff (common law employer)

Discharge staff from providing services (co-employer)

Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

Reallocate funds among services included in the budget

Determine the amount paid for services within the state's established limits

Substitute service providers

Schedule the provision of services

Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3

Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3

Identify service providers and refer for provider enrollment

Authorize payment for waiver goods and services

Review and approve provider invoices for services rendered

Other

Specify:

--

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

- ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The person-centered planning process will result in an individual service plan (ISP) that details the services that the participant needs, regardless of funding source. Once the plan is developed, the frequency, duration and provider rates for each of the waiver services are used to calculate the cost for each waiver service. Once the annual cost for each waiver service is calculated, they are totaled to establish the projected, annualized cost within the waiver's cost limitations (also known as the Individual Budget) of all waiver services for the participant. Additional information regarding cost limitations for this waiver can be found in Appendix C-4.

Information regarding the Individual Budgeting process will be provided to the individual by the county board of developmental disabilities (county board) service and support administrator (SSA) and will be available upon request.

All participants on the SELF Waiver will have control over the allocated amount for some services on this waiver within the cost limitations of the services (where applicable), with the exception of the Adult Day array of Services (Adult Day Support, Vocational Habilitation/Basic Employment Skills Training, Individual Employment Support, Group Employment Support, Career Planning, Home Delivered Meals, and Non-Medical Transportation). The individual budgeting process will involve the SSA, the participant and their Support Broker, if applicable.

- Individual budgets are determined through the planning process.
- The budget will include the dollar amount over which the individual exercises decision-making authority and control over the types and amounts of services and supports.
- The budget is reviewed and approved at least annually by the county board SSA.
- The county board will review and recommend approval of the ISP and authorize the Individual Budget. The authorized ISP and budget amount shall be provided to the Financial Management Service (FMS).
- Direct oversight of the Individual Budget is the responsibility of the individual, the FMS entity, the individual's Support Broker, if applicable and the SSA. The individual, their Support Broker, the county board, and the Department of Developmental Disabilities (DODD) shall receive a fiscal report monthly from the FMS.

When an individual requests to move funds from one service to another, the individual and the Support Broker will request a meeting with the individual's SSA and, upon determining that no health and welfare issues would be caused by change in funds for the identified services, the SSA is to modify the ISP and budget accordingly, then notify the FMS about the changes.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

- iii. **Informing Participant of Budget Amount.** Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The participant and their Support Broker, if applicable will devise the participant's Individual Budget based on the services listed in the individual support plan (ISP). Participants will be notified of the cost limitations associated with the waiver by the service and support administrator (SSA) prior to enrolling on the waiver.

If an individual wants to adjust their plan or budget, the individual and Support Broker will contact and set up a meeting with the SSA to discuss this request for an adjustment. If the request for an adjustment is reasonable, is within the established cost limitations for the waiver, and does not jeopardize the individual's health and welfare, the SSA should approve the request, then notify the Financial Management Service (FMS) about the changes.

Determining the reasonableness of a participant's request for a budget adjustment will take into consideration the extent to which the request addresses the participant's needs, goals and preferences as described in the service plan and strategies identified there to mitigate risks to the participant.

DODD's Service and Support Administration rule (OAC 5123-4-02) requires that an individual must be provided with written notification and an explanation of the individual's right to a Medicaid fair hearing if the ISP process results in a recommendation for the approval, reduction, denial, or termination of a home and community-based (HCBS) waiver service or Medicaid case management service. The participant's request for a budget adjustment would be predicated on an underlying service request, the denial of which would trigger the hearing rights referenced in the rule.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one:*

Modifications to the participant directed budget must be preceded by a change in the service plan.

The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

- v. Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The service and support administrator (SSA) and Support Broker work with the participant to ensure that the budget is utilized according to the Individual Service Plan (ISP). When problems are identified such as underutilization, the Support Broker and the SSA work together with the participant to find solutions and make changes as necessary.

In addition, the Financial Management Service (FMS) entity, based on the participant's individual budget, pays expenditures that are in accordance with the authorized budget, and provides the participant, the Support Broker, the county board of developmental disabilities, and the Department of Developmental Disabilities (DODD) with a monthly report of expenditures and budget status to ensure that the budget is not being depleted prematurely. The FMS entity will also not submit claims for reimbursement if they are not included in the ISP.

It is the FMS' responsibility to monitor and track the budget; provide reports to the individual, Support Broker, SSA, and DODD; and to identify and provide notification of any problems that occur. It is the SSA's responsibility to convene a meeting with the individual and their Support Broker to address any problems identified by the FMS.

It is the FMS' responsibility to make adjustments in a timely manner, and it is the responsibility of DODD to ensure that this occurs as part of its contract with the FMS.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

At the time of application for benefits, the individual or authorized representative is informed, in writing of the right to a state hearing, of the method by which a state hearing may be requested and that the case may be presented by an authorized representative, such as legal counsel, relative, friend, or other spokesperson. Individuals receive an "Explanation of State Hearing Procedures," JFS 04059(rev 1/2015), or its computer-generated equivalent, to provide this notice in accordance with rule 5101:6-2-01 of the Ohio Administrative Code (OAC).

Applicants for SELF waiver enrollment, and waiver enrollees, who are affected by any agency decision made to approve, reduce, suspend deny or terminate enrollment or to deny the choice of a qualified and willing provider or any agency decision to change the level and/or type of waiver service delivered, including any changes made to the individual service plan (ISP), shall be afforded Medicaid due process. As part of the waiver enrollment process, all applicants for the SELF waiver receive written information about the procedures for requesting a Medicaid Fair Hearing. If enrollment on the waiver is denied, the applicant will be given written notice of the denial and information about how to request a Fair Hearing to appeal the denial of enrollment. All waiver enrollees receive prior notice for any adverse action proposed by the agency. This notice includes the right to a state hearing and an explanation of the hearing procedures and is either generated manually by County Boards or electronically by county Department of Job and Family Services. Each agency retains copies of any notices it issues.

The individual must call or write their local county agency or write the Ohio Department of Job and Family Services (ODJFS), Office of Legal Services, Bureau of State Hearings (BSH). A hearing request must be received within 90 days of the mailing date of the notice of action.

DODD assures participation through an agency representative (DODD and/or County Board) pursuant to OAC 5101:6-6-01 and OAC 5101:6-6-02 at hearings requested by applicants, enrollees and disenrolled individuals of the SELF waiver.

Individuals who request hearings are notified about the action to be taken regarding the hearing request and are informed of the date, time, and location of the hearing at least ten days in advance. Services proposed to be reduced or terminated must be continued at the same level when the hearing is requested within fifteen days of the mailing date on the notice. Hearing decisions are rendered no later than 90 days after the hearing request. When agency compliance with a hearing decision is required, it must be acted upon within 15 calendar days of the decision or within 90 days of request for hearing, whichever is first.

Individuals are informed in writing of the hearing decision and are notified of the right to request an administrative appeal if they disagree with the hearing decision. If an administrative appeal is requested, a decision must be issued within 15 days of the appeal request. The individual is informed in writing of the decision and compliance, if ordered, must be acted upon within 15 calendar days of the decision.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

- **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Do not complete this item.

Appendix F: Participant-Rights

a. Operation of Grievance/Complaint System. *Select one:*

No. This Appendix does not apply

Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

- **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

The Ohio Department of Developmental Disabilities (DODD)

- **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department of Developmental Disabilities (DODD) receives and acts upon complaints in a variety of ways. DODD's Major Unusual Incident (MUI)/Registry Unit receives complaints through a toll-free number for reporting abuse/neglect and other MUIs. Complaints are also received via email and U.S. mail. Each complaint received is logged and acted upon the same or next day and followed up until the issue is resolved. Some calls result in MUIs while other calls are assorted complaints which are referred to other department staff, county boards of developmental disabilities (county boards), or outside entities such as the Department of Health. These include medical, behavior, environmental and other miscellaneous subjects. Managers in the MUI/Registry Unit recommend closure when the issue has been resolved. The case is then closed by DODD unit supervisors.

DODD employs a Family Outreach & Education Coordinator who works with families to provide technical assistance, including addressing complaints.

DODD Office of Compliance will follow up on any complaints regarding county boards or certified waiver providers. This could result in citations being issued. Citations require a plan of correction that must be approved by DODD. Individuals may also contact their service and support administrator (SSA) to voice any concerns or complaints. Each county board is required to have a complaint resolution process.

None of the above complaint resolution processes may be used in place of or to delay a Medicaid state hearing. As an alternative dispute resolution process that does not involve a decision by the SSA or county board, Individuals who wish to appeal a decision related to their Home and Community-based services may request a state hearing in accordance with section 5101.35 of the Revised Code and Chapters 5101:6-1 to 5101:6-9 of the Administrative Code.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

Yes. The state operates a Critical Event or Incident Reporting and Management Process (*complete Items b through e*)

No. This Appendix does not apply (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

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b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The State has an established system for reporting, and responding to, investigation and remediation of all critical incidents. The State has identified and established reporting standards for reportable incidents which do not meet the criteria for a critical incident. The State has defined the responsibilities of all incident reporters, case management entities and investigative entities.

"Major Unusual Incident" (MUI) means the alleged, suspected, or actual occurrence of an incident when there is reason to believe the incident has occurred. MUIs include the following and are defined in Ohio Administrative Code 5123-17-02:

Category A:

1. Emotional abuse: the use of actions, words, gestures, or other communicative means to purposefully threaten, coerce, intimidate, harass, or humiliate an individual or a pattern of behavior that creates a hostile environment.
2. Exploitation: the unlawful or improper act of using an individual or an individual's resources for monetary or personal benefit, profit or gain.
3. Failure to report
4. Misappropriation: depriving, defrauding or otherwise obtaining the real or personal property of an individual by any means prohibited by the Revised Code or the Administrative Code.
5. Neglect when there is a duty to do so, failing to provide an individual with medical care, personal care or other support that consequently results in death or serious injury or places an individual or another person at risk of serious injury.
6. Physical abuse: the use of physical force that can reasonably be expected to result in physical harm to an individual
7. Prohibited sexual relations
8. Rights code violation
9. Sexual abuse: unlawful sexual conduct or sexual contact as defined in section 2907.01 of the Revised Code and the commission of any act prohibited by Chapter 2907 of the Revised Code (e.g., public indecency, importuning and voyeurism) when the sexual conduct, sexual contact, or act involves an individual.
10. Unexplained or unanticipated death.

Category B:

1. Attempted Suicide
2. Death other than unexplained or unanticipated death
3. Medical emergency
4. Missing individual
5. Peer-to-peer acts
6. Significant injury: an injury to an individual of known cause or unknown cause that results in a dental injury that requires treatment by a dentist, concussion, broken bone, dislocation or second or third degree burns or that requires immobilization, casting, or five or more sutures.

Category C:

1. Law enforcement
2. Unanticipated hospitalization
3. Unapproved behavior support: the use by a developmental disabilities employee of a prohibited measure as defined in rule 5123-2-06 of the Administrative Code or the use of a restrictive measure implemented without approval of the human rights committee or without informed consent of the individual or the individual's guardian in accordance with rule 5123-2-06 of the Administrative Code, when use of the prohibited measure or restrictive measure results in risk to the individual's health or welfare.

The following is a list of required reporters for all incidents:

- County Boards of Developmental Disabilities (County Boards)
- Ohio Department of Developmental Disabilities (DODD)
- DODD operated Developmental Centers
- All Developmental Disabilities DD licensed or certified providers
- Developmental Disabilities employees providing specialized services
- The Ohio Department of Medicaid

The timeframe for reporting abuse, neglect, misappropriation, exploitation, prohibited sexual relations, and unexplained or unanticipated death to the county board is immediate to four hours. The remaining MUIs must be reported no later than three p.m. the next working day. DODD is notified by the county board through the Ohio Incident Tracking & Monitoring System (OITMS) by five p.m. on the working day following notification by the provider or

becoming aware of the MUI.

Immediate action to protect the individual(s) is taken by the provider and ensured by the county board. Notifications are made immediately to law enforcement for alleged criminal acts and to Children's Services if the individual is under twenty-two.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Anyone, an individual, family member, legal representative, service provider, or county board employee may make a report of abuse or any other MUI via the methods described below.

DODD and county boards of developmental disabilities (county boards) conduct annual trainings on reporting and investigation of MUIs for county boards, developmental center staff, providers, and families.

DODD sends out Health and Welfare Alerts on health and safety issues through an online newsletter that goes to families, providers, and county boards. The Alerts also go to all county boards and certified and licensed providers through a list serve.

Reports are made by phone or online. A MUI contact person has been identified at each county board to receive reports of possible MUIs. Incidents may be reported to that person or to any county board or DODD employee or to the MUI Reporting Hotline established at each board. DODD also has a hotline 1-866-617-6733, which may be used if there are concerns or difficulties in reporting to the county board.

DODD's Online Reporting System is located at DODD-Online Complaint Form <https://dodd.ohio.gov/your-family/report-a-concern/report-abuse>.

County boards have Hotlines or Help Lines for receiving reports that have been communicated to providers and families. DODD letterhead includes the Hotline telephone number for reporting Abuse, Neglect, and MUIs. DODD, in addition to the hotline for reporting abuse and neglect, lists each county board's after-hours number for reporting MUIs on its website.

DODD distributed a MUI Family Fact Sheet on MUIs which was distributed through the county boards and placed on the Department's website.

All providers shall be trained on the requirements of Ohio Administrative Code (OAC) rule 5123-17-02 prior to application for initial certification in accordance with rule 5123-2-08 and 5123-2-09 of the OAC. Providers shall receive annual training on the requirements of this rule including a review of Health and Welfare alerts issued by DODD since the previous year's training. DODD's Office of Compliance conducts provider compliance reviews to assure that the training is completed as required by OAC 5123-17-02.

As technology has improved over time, the opportunity to provide Ohioans education and training regarding abuse and neglect for individuals, families, providers and constituents has been greatly enhanced. Currently, Ohio provides in person, online training modules, webinar-based training, social media and written correspondence options for obtaining the annual training. DODD offers free interactive health and welfare modules through the My Learning system to satisfy annual training requirements. The module reviews reporting requirements, immediate actions, health welfare alerts from the previous year and falls and choking prevention. The modules are available to anyone, and those who successfully complete all five modules, receive a certificate of completion.

In person trainings are scheduled in advance with registration required to assure attendee tracking and the opportunity for Continuing Professional Development (CPDs). DODD successfully scheduled larger venues and was able to increase the number of people able to attend in person trainings.

The web-based trainings are taped and cataloged so attendees can listen at the time of the webinar or go back and access the training information via our web-based resource library at a more convenient time. The trainings are cataloged by topic and housed on the DODD website. Ohio made these changes several years ago at the request of families and providers who appreciated the trainings but could not always attend at the time the training was scheduled. This has been successful and allows our State to share information with individuals, families and providers in a timely and comprehensive manner.

In addition, Ohio has provided training via "Facebook Live." Social media enhancements allow Ohio to expand training opportunities to reach individuals, families and providers in ways that were not possible in the past.

Written information is shared through the DODD list serve, on the website and through subscription. The MUI Family Fact Sheet has been a tremendous resource to individuals, families and providers regarding abuse and neglect reporting. In addition, the health and welfare alerts are widely distributed and hold valuable information on protecting the health and welfare of individuals supported in Ohio.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and

the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The county board of developmental disabilities' (county board) Major Unusual Incident (MUI) Unit receives reports of critical incidents. This Unit is responsible for determining if it meets the criteria of a MUI, ensuring immediate actions have been taken to protect the individual(s), making notifications, and initiating the investigation for all MUIs. Investigations into allegations of abuse, neglect, misappropriation, exploitation, and suspicious or accidental deaths are initiated within twenty-four hours of the report. For all other MUIs the investigation is initiated within a reasonable amount of time based on the initial information received and consistent with the health and safety of the individual(s), but no later than three working days. All investigations are to be completed within forty-five working days unless extensions are granted by the Department of Developmental Disabilities (DODD) based upon established criteria.

The Ohio Department of Medicaid's (ODM) Clinical Operations Bureau also provides monitoring and oversight to assure the health and welfare of individuals enrolled on DODD home and community-based waivers (HCBS). ODM conducts critical incident report reviews annually selecting cases for review via random sampling. Those incidents include but are not limited to incidents of alleged neglect or abuse resulting in ER treatment or removal by law enforcement; suspicious, unusual, accidental deaths, and misappropriations valued at over \$500.

ODM is made aware of these incidents through various means including notification by DODD, discovered during other ODM oversight activities, contacted by other agencies, media sources, stakeholders and citizens.

The monitoring is completed by viewing the report and all investigation updates recorded in Ohio's Incident Tracking & Monitoring System (OITMS) and other DODD and ODM electronic sources. Inquiries and concerns by ODM regarding any aspect of the investigation process/progress are added to the report by DODD with timelines for responses included. Prior to ODM considering a case closed, ODM's Clinical Operations Bureau ensures if the steps taken to assure the immediate health and safety of the individual(s) involved in the incident are and continue to be adequate; that appropriate notification was made to law enforcement, children's services, guardians, other appropriate agencies and parties; that all of the causes and contributing factors are identified, and are adequately remedied and/or addressed in the prevention plans; and that all questions by all parties have been answered, that the recommendations and prevention plans have been implemented/completed.

Participants and other relevant parties are notified in writing of the outcome as outlined in OAC 5123-17-02 no later than five working days following the county board's or DODD's recommendation via OITMS that the report be closed.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

In accordance with Ohio Administrative Code rule 5123-17-02, the Department of Developmental Disabilities (DODD) reviews all initial Major Unusual Incident (MUI)/Registry Unit incident reports to ensure the health and safety of individuals. All substantiated reports of abuse, neglect, and misappropriation involving staff are reviewed. Other incidents are reviewed as deemed necessary to ensure the health and safety of individuals.

The DODD MUI/Registry Unit conducts assessments of county boards of developmental disabilities (county boards) to ensure the following:

1. Incidents are reported appropriately;
2. Immediate actions are taken;
3. Necessary notifications are made;
4. Thorough investigations are conducted;
5. Preventative measures have been identified to address the cause and contributing factors;
6. Trend and pattern analysis is completed and appropriate remediation is identified;
7. Unusual incidents are appropriately reported locally; and
8. Required training is completed.

MUI Assessments are conducted based on the performance of the county board but at least on a three-year cycle. Triggers are identified which could result in the assessment being done sooner.

There is a MUI assessment that is part of the Accreditation review; however, the MUI division also conducts their own three-year performance-based cycle of reviews (which are separate from the Accreditation reviews) based on the MUI division's assessment of a county board's performance.

MUI Trend and Pattern analyses and remediation is done once a year by providers and county boards. DODD reviews all analyses completed by county boards and samples those completed by providers. County boards are responsible for reviewing the analyses for providers in their county.

The DODD MUI/Registry Unit flags serious or egregious incidents as Director's Alerts. These cases are closely monitored for a thorough investigation and good prevention planning.

DODD holds a quarterly Mortality Review Committee compiled of stakeholders, including the Ohio Department of Medicaid (ODM), to review deaths for the purpose of/or licensing boards. In addition, the committee looks at causes of deaths and what steps might be taken to educate the field on the causes.

A statewide Trend and Pattern Committee, made up of stakeholders, including ODM, meets twice a year to review statewide trends and patterns along with activities and initiatives being taken by DODD in regard to health and safety.

DODD's MUI/Registry Unit conducts annual, in-depth analysis on Abuse, Neglect, and Misappropriation to determine who, what types, root causes, and provides interventions to reduce reoccurrences. This is communicated through Alerts and during annual trainings.

DODD's MUI/Registry Unit notifies the county board of individual trends and requires the county board to identify what action will be implemented to address the trends.

DODD works in conjunction with Office of System Supports and Standards when trends and patterns are noted with a particular provider.

The ODM Clinical Operations Bureau participates in DODD's semi-annual Trends and Patterns Committee and DODD's quarterly Mortality Review Committee as part of their additional oversight responsibilities.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. (Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will

display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)

The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

--

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The State of Ohio has in place Ohio Administrative Code (OAC) 5123-2-06 development and implementation of behavioral support strategies rule (Behavior Support Rule) that regulates the use of all restraints (including manual, mechanical, and chemical). Safeguards and protocols in the rule include:

- Behavior support strategies that include restrictive measures (including restraint) may only be used as a last resort when necessary to keep people safe and with informed consent of the person and prior approval by a human rights committee;
- A list of prohibited measures, including: prone restraint; use of manual or mechanical restraint that causes pain or harm; using any restrictive measure for punishment, retaliation, instruction or teaching, convenience of providers, or substitute for services;
- A comprehensive assessment process that takes into consideration a person's: interpersonal, environmental, medical, mental health, and emotional needs and other motivational factors;
- Requirements for people who are conducting and developing behavior support strategies that include restrictive measures;
- Behavior support strategies that include restrictive measures shall be designed in a manner that promotes healing, recovery, and emotional well-being; be data-driven; recognize the role of environment; capitalize on strengths; delineate measures to be implemented and those responsible for implementation; specify steps to be taken to ensure the safety of the individual and others;
- Behavior support strategies that include restrictive measures shall be implemented with sufficient safeguards and supervision to ensure the health, welfare and rights of individuals receiving specialized services and anyone serving the individual must be trained on the strategy prior to serving;
- Shall be reviewed at least every 90 days;
- All county boards of developmental disabilities (county boards) must have a human rights committee to safeguard individual's rights and protect individuals from physical, emotional, and psychological harm – their role and responsibility is clearly defined in the Behavior Support Rule;
- Use of restrictive measures without prior approval by the human rights committee must be reported as an "unapproved behavior support";
- The Department of Developmental Disabilities (DODD) must be notified after approval of the human rights committee and prior to implementation of all behavior support strategies that include restrictive measures;
- All county boards must collect and analyze data regarding behavior support strategies that include restrictive measures and furnish data to their human rights committee.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The Department of Developmental Disabilities (DODD) is responsible for overseeing the use of restrictive measures. The following specifies how the oversight is conducted:

After approval by the human rights committee and prior to implementation, a county board of developmental disabilities (county board) must complete and submit the “Restrictive Measure Notification” form electronically to DODD (Note: DODD does not use the notification system as a means to approve plans, the approval of plans that include restrictive measures occurs at the local level. The notification system is used to collect and monitor data for trends and patterns, provide oversight, and to identify cases where technical assistance may be needed.) The notification must be submitted initially, when revised, renewed or discontinued.

DODD may select a sample of behavior support strategies for additional review to ensure that the strategies are developed and implemented and monitored in accordance with this rule.

DODD shall take immediate action, as necessary, to protect the health and safety of individuals served.

DODD shall compile and analyze data regarding the use of behavior support strategies throughout the state for the purposes of determining methods for enhancing risk reduction efforts and outcomes, reducing the frequency of restrictive measures, and identifying technical assistance and training needs.

DODD conducts both Major Unusual Incidents (MUI), and regular regulatory reviews (Accreditation, Licensure, & Provider Compliance Reviews) to ensure consistent and routine reviews of behavior support policies and procedures that are in place and followed.

The rule addressing MUIs and Unusual Incidents (UIs) to Ensure Health, Welfare and Continuous Quality Improvement, and the Behavior Support Rule requires a MUI to be filed when there is an unapproved behavior support and there is a risk to the individual’s health and welfare. The system has required fields that must be completed. Additionally, the intake staff at DODD follow-up on any reports that are incomplete. If an unreported incident is identified during the course of the review or as a part of a complaint received, a MUI is filed, a citation is issued, and a plan of correction is required.

When the Ohio Department of Medicaid (ODM) discovers a case of the improper or unauthorized use of restraint(s) and restrictive intervention(s) that have not yet been reported through the DODD Ohio Incident Tracking and Monitoring System the case is reported to the proper DODD parties. If the unauthorized use of restraints is identified during the course of a review by ODM clinical staff, that case will be managed through the Unmet Needs process described in Appendix A in order to ensure that the waiver individual’s health or welfare is being assured.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one):*

The state does not permit or prohibits the use of restrictive interventions

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification

are available to CMS upon request through the Medicaid agency or the operating agency.

The State of Ohio has in place Ohio Administrative Code (OAC) 5123-2-06 development and implementation of behavioral support strategies rule that regulates the use of all restrictive measures. Safeguards and protocols in the rule include:

- Behavior support strategies that include restrictive measures may only be used as a last resort when necessary to keep people safe, and in the case of rights restrictions, when an individual's actions may result in legal sanction. The strategies require informed consent of the person and prior approval by a human rights committee;
- A list of prohibited measures, including: prone restraint; use of manual or mechanical restraint that has the potential to inhibit or restrict an individual's ability to breathe or that is medically contraindicated and that causes pain or harm; using any restrictive measure for punishment, retaliation, convenience of providers, a substitute for specialized services, disabling an individual's communication device, denial of meals and snacks excluding denial of snacks or beverages for an individual with primary polydipsia or a compulsive eating disorder, placing an individual in a room with no light, subjecting an individual to damaging or painful sound, application of electric shock, excluding electroconvulsive therapy prescribed by a physician or a credentialed advanced practice registered nurse, subjecting an individual to any humiliating or derogatory treatment, squirting an individual with any substance as an inducement or consequence for behavior.
- A comprehensive assessment process that takes into consideration a person's: interpersonal, environmental, medical, mental health, and emotional needs and other motivational factors;
- Requirements for people who are conducting and developing behavior support strategies that include restrictive measures;
- Behavior support strategies that include restrictive measures shall be designed in a manner that promotes healing, recovery, and emotional well-being; be data-driven; recognize the role of environment; capitalize on strengths; delineate measures to be implemented and those responsible for implementation; specify steps to be taken to ensure the safety of the individual and others;
- Behavior support strategies that include restrictive measures shall be implemented with sufficient safeguards and supervision to ensure the health, welfare and rights of individuals receiving specialized services and anyone serving the individual must be trained on the strategy prior to serving;
- Shall be reviewed at least every 90 days;
- All county boards of developmental disabilities (county boards) must have a human rights committee to safeguard individual's rights and protect individuals from physical, emotional, and psychological harm – their role and responsibility is clearly defined in the Behavior Support Rule;
- Use of restrictive measures without prior approval by the human rights committee must be reported as an MUI for "unapproved behavior support" when use of the restrictive measure results in a risk to the individual's health or welfare;
- All county boards must collect and analyze data annually regarding behavior support strategies that include restrictive measures and furnish data to their human rights committee.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The Department of Developmental Disabilities (DODD) is responsible for overseeing the use of restraints. The following specifies how the oversight is conducted:

- After approval by the human rights committee and prior to implementation, a county board of developmental disabilities (county board) must complete and submit the “Restrictive Measure Notification” form electronically to DODD (Note: DODD does not use the notification system as a means to approve plans, the approval of plans that include restrictive measures occurs at the local level. The notification system is used to collect and monitor data for trends and patterns, provide oversight, and to identify cases where technical assistance may be needed.) The notification must be submitted initially, when revised or renewed, and (optionally) when discontinued.
- DODD may select a sample of behavior support strategies for additional review to ensure that the strategies are developed and implemented and monitored in accordance with this rule.
- DODD shall take immediate action, as necessary, to protect the health and safety of individuals served.
- DODD shall compile and analyze data regarding the use of behavior support strategies throughout the state for the purposes of determining methods for enhancing risk reduction efforts and outcomes, reducing the frequency of restrictive measures, and identifying technical assistance and training needs.
- DODD conducts both Major Unusual Incidents (MUI), and regular regulatory reviews (Accreditation, Licensure, & Provider Compliance Reviews) to ensure consistent and routine reviews of behavior support policies and procedures that are in place for individuals.

The rule addressing MUIs and Unusual Incidents (UIs) to Ensure Health, Welfare and Continuous Quality Improvement and the Behavior Support Rule requires an MUI to be filed when use of a prohibited measure or restrictive measure results in a risk to the individual’s health and safety. The system has required fields that must be completed plus the intake staff at DODD follow-up on any reports that are incomplete. If an unreported incident is identified during the course of the review or as a part of a complaint received, a MUI is filed, a citation is issued, and a plan of correction is required.

When the Ohio Department of Medicaid (ODM) discovers a case of the improper or unauthorized use of restrictive intervention(s) that have not yet been reported through the Ohio Incident Tracking & Monitoring System (OITMS) the case is reported to the proper DODD parties. If the unauthorized use of restrictive interventions is identified during the course of a review by ODM clinical staff, that case will be managed through the Unmet Needs process described in Appendix A in order to ensure that the waiver individual’s health or welfare is being assured.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The State of Ohio has in place Ohio Administrative Code (OAC) 5123-2-06 development and implementation of behavioral support strategies rule that regulates the use of all restrictive measures, including “Time Out.” Safeguards and protocols in the rule include:

- Behavior support strategies that include restrictive measures (including Time Out) may only be used as a last resort when necessary to keep people safe and with informed consent of the person and prior approval by a human rights committee;
- A list of prohibited measures, including: prone restraint; use of manual or mechanical restraint that has the potential to inhibit or restrict an individual’s ability to breathe or that is medically contraindicated and that causes pain or harm; using any restrictive measure for punishment, retaliation, convenience of providers, a substitute for specialized services, disabling an individual’s communication device, denial of meals and snacks excluding denial of snacks or beverages for an individual with primary polydipsia or a compulsive eating disorder, placing an individual in a room with no light, subjecting an individual to damaging or painful sound, application of electric shock, excluding electroconvulsive therapy prescribed by a physician or a credentialed advanced practice registered nurse, subjecting an individual to any humiliating or derogatory treatment, squirting an individual with any substance as an inducement or consequence for behavior.
- Time Out may not exceed 30 minutes for any incident or 1 hour in a 24 hour period; may not be key-locked; shall be adequately lighted and ventilated and provide a safe environment for the person;
- An individual in a time-out room or area must be protected from hazardous conditions, shall be under constant visual supervision, and time out shall cease immediately once risk of harm has passed or the individual engages in self-abuse, becomes incontinent, or shows other signs of illness;
- A comprehensive assessment process that takes into consideration a person’s: interpersonal, environmental, medical, mental health, and emotional needs and other motivational factors;
- Requirements for people who are conducting and developing behavior support strategies that include restrictive measures;
- Behavior support strategies that include restrictive measures shall be designed in a manner that promotes healing, recovery, and emotional well-being; be data-driven; recognize the role of environment; capitalize on strengths; delineate measures to be implemented and those responsible for implementation; specify steps to be taken to ensure the safety of the individual and others;
- Behavior support strategies that include restrictive measures shall be implemented with Use of restrictive measures without prior approval by the human rights committee must be reported as an “unapproved behavior support”;
- All county boards of developmental disabilities (county boards) must collect and analyze data regarding behavior support strategies that include restrictive measures and furnish data to their human rights committee.
- Sufficient safeguards and supervision to ensure the health, welfare and rights of individuals receiving specialized services and anyone serving the individual must be trained on the strategy prior to serving;
- Shall be reviewed at least every 90 days;
- All county boards must have a human rights committee to safeguard individual’s rights and protect individuals from physical, emotional, and psychological harm – their role and responsibility is clearly defined in OAC 5123-2-06.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is

conducted and its frequency:

The Department of Developmental Disabilities (DODD) is responsible for overseeing the use of restrictive interventions, including seclusion (“time out”). The following specifies how the oversight is conducted:

- After approval by the human rights committee and prior to implementation, a county board of developmental disabilities (county board) must complete and submit the “Restrictive Measure Notification” form electronically to DODD (Note: DODD does not use the notification system as a means to approve plans, the approval of plans that include restrictive measures occurs at the local level. The notification system is used to collect and monitor data for trends and patterns, provide oversight, and to identify cases where technical assistance may be needed.) The notification must be submitted initially, when revised or renewed, and (optionally) when discontinued.
- DODD may select a sample of behavior support strategies for additional review to ensure that the strategies are developed and implemented and monitored in accordance with this rule.
- DODD shall take immediate action, as necessary, to protect the health and safety of individuals served.
- DODD shall compile and analyze data regarding the use of behavior support strategies throughout the state for the purposes of determining methods for enhancing risk reduction efforts and outcomes, reducing the frequency of restrictive measures, and identifying technical assistance and training needs.
- DODD conducts both Major Unusual Incidents (MUI), and regular regulatory reviews (Accreditation, Licensure, & Provider Compliance Reviews) to ensure consistent and routine reviews of behavior support policies and procedures that are in place for individuals.

The rule on addressing MUIs and Unusual Incidents (UIs) to Ensure Health, Welfare and Continuous Quality Improvement and the Behavior Support Rule requires an MUI to be filed when there is an unapproved behavioral support that results in a risk to the individual’s health and welfare. The system has required fields that must be completed plus the intake staff at DODD follow-up on any reports that are incomplete. If an unreported incident is identified during the course of the review or as a part of a complaint received, a MUI is filed, a citation is issued, and a plan of correction is required.

When the Ohio Department of Medicaid (ODM) discovers a case of the improper or unauthorized use of seclusion that have not yet been reported through DODD Incident Tracking System the case is reported to the proper DODD parties. If the unauthorized use of seclusion is identified during the course of a review by ODM clinical staff, that case will be managed through the Unmet Needs process described in Appendix A in order to ensure that the waiver individual’s health or welfare is being assured.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

No. This Appendix is not applicable (do not complete the remaining items)

Yes. This Appendix applies (complete the remaining items)

• **Medication Management and Follow-Up**

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Individual medication management and follow up is the responsibility of the physician, clinical nurse specialist, psychiatrist or other prescribing authority. These various health care professionals determine the need to monitor and follow up based on the individual's diagnoses, individual's medication regimen and stability of the individual being served. In addition, a quality assessment is completed for each individual receiving administration of prescribed medications, performance of health-related activities, and/or tube feedings at least once every three years or more frequently if needed (see OAC 5123-6-07). The quality assessment includes:

- Observation of administering prescribed medication or performing health-related activities;
- Review of documentation of prescribed medication administration and health-related activities for completeness of documentation and for documentation of appropriate actions taken based on parameters provided in prescribed medication administration and health-related activities training;
- Review of all prescribed medication errors from the past twelve months;
- Review of the system used by the employer or provider to monitor and document completeness and correct techniques used during oral and topical prescribed medication administration and performance of health-related activities.

Plans that incorporate medication for behavior control is prohibited unless it is prescribed by and under the supervision of a licensed physician who is involved in the interdisciplinary planning process. The protocols for this are described under Appendix G-2.

Prior documented informed consent is obtained from the individual receiving services from the county board of developmental disabilities (county board) program, or guardian if the individual is eighteen years old or older, or from the parent or guardian if the individual is under eighteen years of age.

The medication administration Quality Assessment (QA) review is conducted by an RN, thus assuring professional evaluation of the systems in place for providing safe, accurate and effective administration of all medications. Only medications prescribed for an individual (by a professional with prescribing authority under Ohio law) may be administered. Only personnel who are relevantly professionally credentialed or who have completed the training and skills validation for the Department of Developmental Disabilities (DODD) Medication Administration Certification may administer medications. The use of the standards of practices established for Medication Administration Certification is evaluated as part of the RN QA review. Any potentially harmful practices identified would be addressed via the Plan of Correction (POC) element of the RN QA. The reviewing RN confirms the plan of correction and submits to QA outcome to the county board.

During all compliance reviews: if an individual in the sample receives medications for behavior, the plan is reviewed to ensure the appropriate process has been followed. Medications prescribed for behavior modification must be approved by the Human Rights Committee and reviewed by the team monthly.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The Ohio Department of Developmental Disabilities (DODD) monitors medication administration through regularly scheduled reviews. The frequency of these reviews is based upon the terms of a provider's certification, license or accreditation, which range from one to three years. Special reviews (not scheduled) can be conducted by DODD if requested by an individual, parent or guardian or if there is suspicion of abuse, neglect, or non-compliance with laws or rules especially those related to medication administration.

DODD also becomes aware of potentially harmful practices through the review of major unusual incidents. These incidents are initially investigated by local county boards of developmental disabilities (county boards) personnel and the results of the investigation forwarded to the state for review. Medication errors that result in harm or reasonable risk of harm to an individual are classified, reported, and investigated as major unusual incidents.

Personnel who do not safely administer medications are reported to DODD by employers, county boards, Quality Assessment (QA) RNs and delegating nurses by electronic record and uploading of documentation to the unlicensed personnel's Medication Administration Certification record. Unresolved issues identified via the RN QA Reviews are reported to the DODD RN and to the DODD Office of Compliance for follow through on resolutions. MUI reports require plans of correction to prevent future events; MUI cases are followed by DODD until appropriate plan of correction (POC) is confirmed.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

Not applicable. *(do not complete the remaining items)*

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

- **State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

A self-medication assessment is done to determine if an individual is capable of self-medicating and specifies how and when it is to be reviewed, revised, and redone. This must be reviewed annually and completely re-done at least every 3 years if an individual does not meet the criteria for self-medication. This can be done more frequently than every 3 years if there is change in the individual's medication condition or if a problem with self-medication is observed. (Ohio Administrative Code 5123-6-02)

In accordance with Section 5123.47 of the Revised Code, a family member of a person with a developmental disability may authorize an independent provider to administer oral and topical prescribed medications or perform other health care tasks as part of the in-home care the worker provides to the individual, if all of the following apply:

- The family member is the primary supervisor of the care.
- The independent provider has been selected by the family member or the individual receiving care and is under the direct supervision of the family member.
- The independent provider is providing the care through an employment or other arrangement entered into directly with the family member and is not otherwise employed by or under contract with a person or government entity to provide services to individuals with developmental disabilities.
- A family member shall obtain a prescription, if applicable, and written instructions from a health care professional for the care to be provided to the individual. The family member shall authorize the independent provider to provide the care by preparing a written document granting the authority. The family member shall provide the independent provider with appropriate training and written instructions in accordance with the instructions obtained from the health care professional.
- A family member who authorizes an independent provider to administer oral and topical prescribed medications or perform other health care tasks retains full responsibility for the health and safety of the individual receiving the care and for ensuring that the worker provides the care appropriately and safely. No entity that funds or monitors the provision of in-home care may be held liable for the results of the care provided under this section by an independent provider, including such entities as the county board of developmental disabilities and the department of developmental disabilities.
- An independent provider who is authorized under this section by a family member to provide care to an individual may not be held liable for any injury caused in providing the care, unless the worker provides the care in a manner that is not in accordance with the training and instructions received or the worker acts in a manner that constitutes wanton or reckless misconduct.

Per OAC 5123-6-03 (B), staff that will be administering medication to individuals that do not self-administer is required to become certified to administer medications. For general medication administration staff are required to meet specific standard and then must attend a class that is a minimum of 14 hours per OAC 5123-6-06 (C)(1)(a), perform return demonstration of proficiency skills, and take a written test that must be passed with at least a score of 80% as described in OAC 5123-6-06 (E)(1). This certification must be renewed annually. To do this, the staff must complete at least 2 hours of continuing education and complete a successful return demonstration of skills per 5123-6-06 (E)(1)(a). To administer medication per gastrostomy or jejunostomy, the staff must take the general medication administration class and become certified. After completing the initial certification they must take an additional four-hour class per 5123-6-06 (C)(2)(a), complete a return demonstration of skill and take a written test and pass with at least 80% as described in OAC 5123-6-06 (D)(1). This certification is available to them for one year and must be renewed annually. The renewal process is described in OAC 5123-6-06 (E)(1) and includes annual completion of at least one hour of continuing education and a successful return demonstration of skill. In addition initially individual specific training must be completed and a nurse (an RN or an LPN under the direction of an RN) must delegate this to the staff prior to the medication administration beginning as required per OAC 5123-6-06(C)(2).

Unlicensed personnel may administer insulin or other injectable treatments for metabolic glycemic disorders after being certified as in 5123-6-06 (E). The staff must take the general medication administration class and then per 5123-6-06 (B)(3)(a) they must take an additional minimum four-hour class. OAC 5123-6-06 (D)(1) states that

during the class the staff must complete a successful return demonstration, take a written test and pass with at least 80%. In addition, prior to doing medication administration each certified staff must be provided individual specific training related to the individuals they will be serving per OAC 5123-6-06 (C)(3)(b)(xii) and a nurse (an RN or an LPN under the direction of an RN) must delegate that specific medication administration to the staff per OAC 5123-6-06 (C)(3)(b)(xii).

Ohio Revised Code (ORC) 5123.41 through 5123.46 and 5123.65, along with OAC 5123-6-01 govern administration of medication to be completed by waiver providers. These laws and rules require staff who will be administering medications to individuals that cannot self-medicate to meet certain standards and to become and maintain certification as described above. Specific curriculum has been developed and must be used unless an individual has developed his/her own and had it approved by the Department of Developmental Disabilities (DODD). All tests are developed by the DODD must be administered as the “written test” and no exceptions are granted. Medication administration must be documented on a medication administration record although a specific form is not required. Mandated elements to be included on the form are specified in OAC 5123-6-07.

The renewal process for certifications required for medication administration are contingent on continuing education requirements and annual skills verification. Multiple notations on the provider’s Medication Administration Certification record results in DODD review of the specific performance problems and may result in denial of renewed certification.

- **Medication Error Reporting.** *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).

Complete the following three items:

- (a) Specify state agency (or agencies) to which errors are reported:

Errors are reported to the Department of Developmental Disabilities per OAC 5123-6-07 (F)(2)(b), “Immediately notify the department...” by making a notation in the personnel’s certification record (via MAIS notation system).

- (b) Specify the types of medication errors that providers are required to *record*:

Medication errors as listed in OAC 5123-6-01(Z) <https://codes.ohio.gov/ohio-administrative-code/rule-5123-6-01>

(Z) "Medication/treatment error" means:

- (1) Wrong prescribed medication/treatment administered or performed;
- (2) Medication/treatment administered or performed at the wrong time;
- (3) Medication/treatment administered or performed by a route not prescribed or in the case of over-the-counter medication, not as indicated by the manufacturer;
- (4) Incorrect dose or amount of medication/treatment administered or performed;
- (5) Expired medication/treatment administered or performed;
- (6) Contaminated medication/treatment administered or performed;
- (7) Improperly stored medication/treatment administered or performed;
- (8) Medication/treatment, other than over-the-counter medication authorized in accordance with section 5123.42 of the Revised Code, administered or performed without corresponding order from a licensed health professional authorized to prescribe drugs;
- (9) Not performing or administering a prescribed medication/treatment during the prescribed time, including but not limited to, failure to ensure the medication/treatment, equipment, or supplies needed to administer or perform the medication/treatment are available at the prescribed time or declination of a prescribed medication/treatment by an individual;
- (10) Not documenting a medication/treatment that was administered or performed;
- (11) Administration or performance of prescribed medication/treatment by developmental disabilities personnel without certification or whose certification has expired;
- (12) Administration of over-the-counter medication authorized in accordance with section 5123.42 of the Revised Code by developmental disabilities personnel without required training; and
- (13) Administration or performance of medication/treatment without nursing delegation when nursing delegation is required.

(c) Specify the types of medication errors that providers must *report* to the state:

Per Ohio Administrative Code 5123-17-02 (C)(25) "...medication errors without a likely risk to health and welfare;" are unusual incidents unless additional circumstances warrant it to be classified as a Major Unusual Incident in accordance with Ohio Administrative Code 5123-17-02 (C)(16)(a), (b) & (c).

Per 5123-6-07 (F)(1) "...if an employer of developmentally disabilities personnel believes or is notified...that developmental disabilities personnel have not or will not safely perform health related activities or administer prescribed medication the employer will shall prohibit the action from continuing or commencing."

AND per 5123-6-07 (F)(2)(b) "Immediately notify the department..." by making a notation in the personnel's certification record (via MAIS notation system).

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

- **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Department of Developmental Disabilities (DODD) monitors performance of waiver providers through review of various county board of developmental disabilities (county board) reports and county board quality assessment reviews. Incidents or issues that may be questioned can be reported to the county board or the DODD at times other than when a report is filed or a Quality Assessment (QA) review is completed. When reported directly to DODD, DODD will complete an investigation to determine necessary action.

Personnel who do not safely administer medications are reported to DODD by employers, county boards, QA RNs and delegating nurses by electronic record and uploading of documentation to the unlicensed personnel's Medication Administration Certification record. A history of medication in the prior 18 months will electronically trigger a DODD review prior to personnel being eligible for certification renewal. Unresolved issues identified via the RN QA Reviews are reported to the DODD RN and to the Office of Compliance for follow through on resolutions. Major Unusual Incidents (MUI) reports require plans of correction to prevent future events; MUI cases are followed by DODD until appropriate POC is confirmed.

RN Trainers, QA RNs, Employers and DODD use the Medicaid Administration Information System (MAIS) to track certifications issued to unlicensed personnel. "Notations" can be entered on a personnel's certification record related to medication administration problems. The medication administration rule (Ohio Administrative Code (OAC) 5123-6-07) mandates that if a certified personnel is not administering medication safely the employer or county board or delegating nurse must take them off medication administration duty and report that to DODD (via the MAIS notation system); an additional notation must be added if/when the personnel is able to be adequately reeducated to return to safe practice.

Notations are entered with preselected categories and documentation of the details of each event must be uploaded to DODD along with the notation. Notations are also made if personnel are substantiated in a medication related MUI and if problems are noted during QA reviews.

If personnel have four notations recorded in an eighteen-month period, renewal of MA Certification cannot happen without specific DODD review of the personnel's record. QA RNs and DODD reviewers have the ability to see the event notations as part of the QA review processes. Notation documentation details are only visible to DODD.

The MAIS also mandates significantly more data entry to track where personnel work and who is providing the mandated employer oversight of medication administration safety and performance by MA Certified unlicensed personnel. DODD is working to include all the data fields from the MAIS into the Data Warehouse where it can be queried for data mining of patterns and trends.

When the Ohio Department of Medicaid (ODM) discovers non-compliance with laws or rules governing medication administration without an occurrence or potential of harm which had not been discovered or is not adequately being addressed by DODD that case will be processed through the Unmet Needs process described in Appendix A. When ODM discovers an instance of harm occurring or where there is a reasonable risk of harm to an individual due to medication management or administration issues case it is reported to the proper DODD parties and processed through the Unmet Needs process described in Appendix A.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

i. Sub-Assurances:

a. Sub-assurance: *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to*

prevent instances of abuse, neglect, exploitation and unexplained death.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

G-2: Number and percent of unexplained or suspicious deaths with a required need for investigation for which an investigation was completed according to Rule requirements. N= Total number of unexplained or suspicious death investigations completed according to the Rule requirements. D= Total number of unexplained or suspicious death investigations.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DODD's Incident Tracking System (ITS)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:

	Other Specify: 	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

G-1: Number and percent of Abuse (physical, verbal, emotional, sexual), Neglect, Exploitation, and Misappropriation Incidents (over \$500) reported into the ODM approved incident management system(s) within the required timeframe. N=Total number of ANEM incidents/cases reported into the ODM approved incident management system within the required timeframe. D=Total number of ANEM incident/cases.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

DODD's Incident Tracking System (ITS)

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid	Weekly	100% Review

Agency		
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify:

- b. Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

G-4: Number and percent of substantiated Abuse (physical, verbal, emotional, sexual), Neglect, Exploitation, and Misappropriation Incidents (over \$500) with a prevention plan developed as a result of the incident. N= Total number of ANEM prevention plans completed. D= Total number of ANEM incidents needing a prevention plan.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DODD's Incident Tracking System

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

G-3: Number and percent of Abuse (physical, verbal, emotional, sexual), Neglect, Exploitation, and Misappropriation Incidents (over \$500) incident investigations that were completed according to the Rule requirements. N= Total number of ANEM investigations completed according to the Rule requirements. D= Total number of ANEM investigations.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DODD's Incident Tracking System

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

G-5: Number and percent of substantiated unauthorized (or unapproved) restraint, seclusion or other restrictive intervention incidents with a prevention plan developed as a result of the incident. N= Total number of unauthorized (or unapproved) restraint prevention plans completed. D= Total number of unauthorized (or unapproved) restraint incidents needing a prevention plan.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DODD's Incident Tracking System (ITS)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review

Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

- d. **Sub-assurance:** *The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

G-6: Number and percent of incidents investigated for Abuse (physical, verbal, emotional, sexual), Neglect, Exploitation, and all Misappropriation (over \$500) incidents investigated that involved paid caregivers. N= Total number of ANEM incidents investigated that involved a paid caregiver. D= Total number of ANEM incidents that involved a paid caregiver.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DODD's Incident Tracking System (ITS)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:

	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Activities by ODM for assuring compliance:

ODM conducts quality briefings with the operating agency at least four times per year to review data generated through the departments' quality processes, including results of any completed targeted reviews, waiver performance measure data, and data presented by the operating agency on the oversight activities conducted by that department. This data includes but is not limited to problems detected, corrective measures taken, and how the operating agency verified, or intends to verify, that the actions were effective.

Performance Measures data reports are submitted to ODM by DODD on a quarterly basis.

The information is gathered from county board and DODD compliance activities. DODD is able to identify and address individual problems as they are discovered and provide technical assistance that may include plans of corrective action.

When problems are discovered, the individual county board is notified and technical assistance is provided using e-mail, phone contact and/or letters to county board staff. When issues are noted that are systemic, DODD will provide statewide training and incorporate that corrective action into its monitoring during the next monitoring cycle.

Case Specific Resolution: During the course of any review conducted by ODM or DODD, when staff encounter a situation in which a waiver recipients health or welfare is at risk, or when case management deficiencies are identified, the staff follow a protocol to report these observations. Depending on the severity of the situation, the staff will take immediate

action, coordinate intervention with providers or case managers, and report the finding to ODM managers. ODM communicates findings to DODD for further review and appropriate intervention, and with explicit variable timeframes within which a report back to ODM is expected. ODM logs and tracks all such findings and referrals to assure appropriate case-specific resolution.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

For critical incidents, the Ohio Department of Medicaid (ODM) monitors both prevention and outcome activities performed by the Department of Developmental Disabilities (DODD) and the county boards of developmental disabilities (county boards) to assure that all prevention, investigation and resolution protocols are followed through and to completion. ODM meets regularly with DODD and works collaboratively to identify and observe trends, propose changes to rules and protocols, and support ongoing improvement to systems intended to assure prevention and adequate response to incidents of abuse.

DODD becomes aware of problems through a variety of mechanisms including, but not limited to, formal & informal complaints, technical assistance requests, and routine and special regulatory review processes (accreditation, licensure, provider compliance, etc.). As problems are discovered, the individual county board is notified and technical assistance is provided using email, phone contact and/or letters to the county board Superintendent. During the DODD regulatory review process citations may be issued and plans of correction required as needed and appropriate. When issues are noted that are systemic, DODD will provide statewide training and additional technical assistance and monitor for improvement during subsequent monitoring cycles.

This aggregate data tracks each major unusual incident (MUI) category for increases or decreases over time through the Ohio Incident Tracking & Management System (OITMS). The data is tracked by the DODD MUI / Registry Unit. The outcomes of the data are reviewed by the MUI Registry Unit and referred to the Statewide Pattern / Trend Committee. Prevention planning occurs based on the issue/s identified. Prevention may involve the county board or the MUI Registry Unit based on the data review.

This aggregate data tracks mortality rates by cause of death over time through the incident tracking System. The data is tracked by the DODD MUI Registry Unit and referred to the Mortality Review Committee (MRC) quarterly, semi-annually and annually. Prevention planning occurs via Regional Manager incident review / follow up and Mortality Review Committee recommendations.

This percentage rate is reviewed semiannually and annually and compared over time. The data is tracked by the MUI Registry Unit and referred to the Statewide Pattern / Trend Committee. The information is reviewed to assure that reporting and investigation timelines are continually met. Regional Managers follow up with counties that are not meeting statewide averages as required.

This aggregate data tracks Unapproved Behavior Support (UBS) MUI's to note increases and decreases over time. The information is reviewed by the MUI / Registry Unit and the outcomes referred to the Statewide Pattern / Trend Committee semi-annually and annually. Issues that are identified through MUI Registry Unit review are often referred to the Office of Compliance for additional follow up.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other	Annually

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
Specify: 	
	Continuously and Ongoing
	Other Specify: Semi-annually

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of health and welfare that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 1915(c) of the Social Security Act and 42 CFR § 441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver quality improvement strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a quality improvement strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the quality improvement strategy.

Quality Improvement Strategy: Minimum Components

The quality improvement strategy (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and

- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the QIS spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The quality oversight strategy for this waiver relies on the collaborative efforts of staff at the Ohio Department of Medicaid (ODM) and the Department of Developmental Disabilities (DODD) to generate and analyze both data and other performance related information to measure compliance with federal waiver assurances and to assure participant health and welfare.

Role of the State Medicaid Agency

ODM oversees the operation and performance of DODD to ensure operation is in accordance with the approved waiver and assess the effectiveness of DODD's oversight of the County Boards operating the waiver locally. Operation of the waiver is delegated by ODM to DODD through an interagency agreement. This agreement includes authorizing ODM to perform oversight activities to establish the program's compliance with federal and state laws and regulations as well as auditing and fiscal compliance. ODM will employ a multifaceted monitoring and oversight process that includes the following activities:

Quality Steering Committee (QSC)-Convening 4 times per year, the QSC provides administrative oversight for ODM's HCBS Waiver Quality Strategy. Collaboratively, the QSC reviews and analyzes data across waivers to identify promising practices and opportunities for quality improvement. It uses these discussions to assess and compare performance and innovative data analytics across Ohio's HCBS waivers to support collaborative efforts, improve waiver systems, and help move Ohio toward more unified quality management. The committee includes sub activities including the Health Safety and Welfare Committee, Quality Briefings, Targeted Reviews and Quality Improvement Plans.

Convening the Health, Safety and Welfare Oversight Committee 2 times per year. The Health, Safety and Welfare committee meets to review and aggregate data compiled from a variety of sources to identify trends and systemic issues in waiver program operations and participant outcomes. The output from this group includes technical assistance to the case management agencies and continuous evaluation and updates to the policy. ODM assures case-specific resolution through the oversight of the Health, Safety, and Welfare Committee.

Quality Briefings-ODM conducts quality briefings with the operating agency at least four times per year to review data generated through the departments' quality processes. Quality Briefings may be initiated by the Quality Steering Committee, ODM policy staff or stem from identified issues or trends. Quality Briefings may also be used as a venue to discuss the results and performance from current projects undertaken by either or both departments, such as the findings from targeted reviews administered by ODM. In these meetings, the departments include discussion about opportunities for program improvement that were detected, what corrective measures are/ or were taken, and how the operating agency verified, or intends to verify, that the actions were effective. The quality briefings will also serve as the forum for ODM and DODD to share and review the validity and/or usefulness of performance metrics identified in this application. Throughout the process, if areas of non-compliance or opportunities to improve performance are identified, ODM may require DODD to develop and implement quality improvement plans and monitor their effectiveness at achieving desired outcomes. Briefings may include other subject matter experts, outside of waiver managing staff for targeted discussions.

Targeted Reviews: At least once per program year, ODM will identify a target group of waiver participants using data from reporting systems. ODM's staff will perform reviews of the target group to identify best practices as well as areas for improvement in waiver operations, including both service delivery and case management. These reviews will help the State identify and implement system changes that address vulnerabilities and improve individuals' experiences and health outcomes. Targeted reviews may also be included as part of a quality briefing.

On-going assurance of the resolution of case specific issues completed by ODM staff and Clinical Operations staff to address unmet needs and health and welfare of the waiver participant. Resolution is tracked including any needed remediation. An unmet need includes any health and safety risk for the individual, grievance, and/or concerns with case management performance identified. Unmet needs may be identified through the course of any review conducted by ODM or DODD, when staff encounter a situation in which a waiver recipients health or welfare is at risk, or when case management deficiencies are identified, the staff follow a protocol to report these observations. Additionally, constituent inquiries may spark resolution of an unmet need. The unmet needs are tracked for response and resolution. Depending on the severity of the situation, staff will take immediate action, coordinate intervention with providers or SSAs, or identify other interventions to assure health and welfare. ODM communicates findings for further review and appropriate intervention, and with explicit variable timeframes within which a report back to ODM is expected. ODM logs and tracks all findings and referrals to assure appropriate case-specific resolution.

Also, the ODM Clinical operations section monitors both prevention and outcome activities performed by DODD to protect Medicaid individuals on HCBS waivers from significant incidents impacting their health and safety. ODM staff review incident alerts, track and monitor them until resolution has been reached, the individual is healthy and safe, the cause has been identified and remedied, and preventive measures have been taken.

The discovery of potential Incident Alerts may occur through the following means: ODM may be notified by DODD via Director's Alert email or other means; by the ODM health and welfare review committee; through ODM monitoring of DODD Ohio Incident Tracking and Management System; through other service delivery systems; media; or complaints received directly by ODM.

Open, on-going communication and collaboration with DODD through bi-weekly meetings with DODD Medicaid administration staff, ODM clinical staff and ODM policy. These meetings address outstanding individual issues, current projects, updates and any additional items for discussion to assure the waiver program is meeting the needs of persons served. Additional ODM or DODD staff may be included depending on concerns and issues. ODM staff participates in DODD workgroups, taskforces and other programmatic committees. On an ongoing basis, ODM staff participate in quarterly DODD Major Unusual Incident Trends and Patterns reviews and DODD Mortality Reviews. Standing committees with ODM staff engagement include waiver redesign workgroups, Assistive Technology Taskforce, Employment First initiative and others as requested.

Continuous Review of DODD performance measure data. Under continuous review and oversight, including quarterly performance review reports and through annual 372 reporting, ODM examines performance data and other information gathered both by ODM and DODD to measure compliance and performance with respect to the federal waiver assurances including service planning, care management, free choice of provider, level of care, health and welfare, hearing rights, participant satisfaction, and validation of service delivery. This data and any remediation (if necessary) will be submitted in accordance with the approved performance measures in the waiver. This information will also be used by ODM to complete the quality sections of the CMS 372 report required to demonstrate cost neutrality in the waiver.

ODM ensures systemic remediation through a Quality Improvement Plan. Whenever a performance measure is not fully met, falling below a threshold of 86% and cannot be remediated, a systemic remediation Quality Improvement Plan (QIP) would be conducted to determine the cause. A QIP must be implemented once the cause is found unless the state provides justification accepted by CMS that a QIP is not necessary. A QIP may take any of several forms. It may be training, revised policies/procedures, additional waiver services, etc. Each QIP must measure the impact to determine whether it was effective.

Fiscal Reviews – ODM staff perform regular desk reviews of administrative costs, with A-133 Audits being performed every one to three years based on risk. On a biennial basis, ODM staff conduct audits of CBDD prepared cost reports. Additional detail about Ohio's practice for maintaining fiscal oversight of the waiver can be found in Appendix I.

Role of the Operating Agency (DODD)

Through an interagency agreement, ODM delegates to DODD responsibility for the administration of the waiver program. These responsibilities include managing and monitoring the waiver program to assure compliance and quality improvement.

Monitoring by DODD focuses on: 1) assuring compliant and effective case management for applicants and waiver participants by County Boards; 2) managing a system to assure prevention and effective response to incidents of participant abuse and neglect; 3) assuring the qualifications and compliance of particular waiver service providers; 4) assuring that paid claims are for services authorized in individual service plans; 5) setting program standards/expectations; 6) compliance and performance of County Boards which administer the program locally; 7) providing technical assistance; 8) facilitating continuous quality improvement in the waiver's local administration; and more generally, 9) ensuring that all waiver assurances are addressed and met for all waiver participants.

DODD's Office of Compliance conducts compliance reviews in licensed waiver funded settings, unlicensed waiver funded settings, and County Board settings. To ensure consistency, the review process and tools are the same in all settings to determine compliance with administrative rules and waiver assurances. A standardized review tool is used to determine if health, safety and individual satisfaction criteria are met. DODD uses an individual interview process when interviewing individuals/families as part of the department's regulatory review processes.

Compliance Review – regularly scheduled reviews of a provider are conducted prior to the end of the provider's term license, accreditation term or at least once every 3 years for non-licensed waiver settings. The review is conducted utilizing a single review tool. A report is issued to the county board and/or provider identifying areas of deficiencies and requiring a plan of improvement. The plan of improvement is reviewed and approved by the Office of Compliance and follow-up visits are conducted to verify that the appropriate corrections have been made. In cases where an immediate risk to health or safety is identified, the reviewer remains onsite until corrective action is taken. Special Compliance Review – an unscheduled review, which occurs due to identified concerns such as complaints, Major Unusual Incidents, reports of fraud, or adverse outcomes identified by other

entities such as the Ohio Department of Health or the ODM. A report is issued to the county board and/or provider identifying areas of deficiencies and requiring a plan of compliance (POC) improvement. The findings are reported to appropriate State agency.

ii. System Improvement Activities

Responsible Party (check each that applies):	Frequency of Monitoring and Analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify: County Boards of Developmental Disabilities & SELF Waiver Providers	Other Specify: Semi-annually

b. System Design Changes

- i.** Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Ohio Department of Medicaid (ODM) monitoring and oversight responsibilities include ensuring that the Department of Developmental Disabilities (DODD) is exercising its authority for the day-to-day operation of the waiver in accordance with federal Medicaid requirements. ODM supports and facilitates qualitative improvements in the systems, procedures, and protocols DODD employs to ensure conformity of providers, recipients, and other entities with federal Medicaid requirements. ODM will work with DODD to assess the root cause and develop and implement an appropriate course of action to remedy the program.

DODD monitoring and oversight responsibilities include ensuring that the local county boards of developmental disabilities (county boards) are establishing and implementing systems, procedures and protocols to ensure conformity of providers, recipients, staff, or other entities with federal Medicaid requirements. The DODD supports and facilitates qualitative improvements in the systems, procedures, and protocols at the county board level. When a program component is determined to be out of compliance with federal Medicaid requirements, ODM will work with DODD to assess the root cause and develop and implement an appropriate course of action to remedy the program.

ODM is responsible for ensuring DODD and county boards are in compliance with federal regulations, including the amount, duration and scope of services, free choice of providers, timeliness of delivery of services to waiver eligible participant and the availability of services statewide and conducts A-133 audits at least once every three years based on risk.

- ii.** Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

The Ohio Department of Medicaid (ODM) in conjunction with the Department of Developmental Disabilities (DODD) will review the effectiveness of the State's Quality Oversight Strategy including DODD performance data, fiscal reviews results, case-specific resolutions data, quality improvement plans, and technical assistance provided. These discussions will occur through quality briefings outlined in this appendix.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Ohio Department of Developmental Disabilities (DODD), Division of Fiscal Administration -Audit Office performs waiver reviews of SELF waiver claims paid utilizing a risk-based approach. The risk-based approach covers a wide range of providers, individuals, and claims paid. A risk analysis is performed for each waiver cycle to identify riskier providers. Risk factors used in the analysis include, but are not limited to: dollar amount of claims paid; number of individuals served; complexity of services provided; prior noncompliance issues; prior findings; referrals from Office of System Supports and Standards; and changes in compliance requirements to services provided. Once the selection of higher risk providers is determined, selected claims paid are reviewed for each provider for the respective individuals selected for review, depending on the number of individuals served, types of services provided, and/or the number of and dollar amount of claims paid.

The claims paid to Medicaid providers are not considered federal awards, therefore they are not considered sub-recipients and do not meet the criteria for a Single Audit. Additionally, since the providers are not sub-recipients, they are not required to submit or have a financial statement audit.

The Financial Management Services (FMS) entity will also be reviewed by the DODD Audit Office or by a contract with an audit agency. These reviews occur at a scheduled frequency of every three years. We will obtain an understanding procedures and processes utilized by the FMS for processing SELF waiver claims. A selection of claims paid will be reviewed for allowability under the waiver and the Ohio Administrative Code, and whether claims paid are accurately and appropriately reported. The FMS bills in MBS like the other SELF providers. The same process as documented in I-1 is followed for the selection of claims and individuals served under the FMS entity.

The Auditor of the State of Ohio conducts an annual Single State Audit of the Ohio Department of Medicaid (ODM) in accordance with the requirements of the Single Audit Act (31 U.S.C. 7501-7507) as amended by the Single Audit Act Amendments of 1996 (P.L. 104- 146).

In accordance with Ohio Administrative Code rule 5160-1-29, ODM is required to have in effect a program to prevent and detect fraud, waste, and abuse in the Medicaid program. The definition of fraud, waste, and abuse incorporates the concept of payment integrity. ODM, the Ohio State Auditor, and/or the Ohio Office of Attorney General may recoup any amount in excess of that legitimately due to the provider based on review or audit.

The Department of Medicaid's Surveillance Utilization Review Section (SURS) primary function is to conduct audit and review activities to assure the allowability of claims paid to Medicaid providers. The scope of providers subjected to audit and review activities includes claims paid through sister state agencies which administer Medicaid programs on behalf of ODM. ODM conducts post payments reviews based on data mining initiatives or referrals from appropriate parties. The reviews can be conducting by analyzing paid claims data and / or medical records review. These reviews are conducted on an as needed basis. The scope of the reviews is defined in ORC 5164.57 and OAC 5160-1-27.

DODD recovers any overpayments pursuant to Section 5164.58 of the Ohio Revised Code. DODD notifies the provider of the overpayment and requests voluntary repayment. If DODD is unable to obtain voluntary repayment, it shall give the provider notice of an opportunity for a hearing in accordance with Chapter 119 of the Ohio Revised Code. DODD shall conduct the hearing to determine the legal and factual validity of the overpayment. DODD shall submit the hearing officer's report and recommendation and a complete record of the proceedings, including all transcripts to the Director of Ohio Department of Medicaid. The Director of ODM may issue a final adjudication order in accordance with Chapter 119 of the Ohio Revised Code.

Ohio's EVV system captures and logs visit data electronically and includes visit elements required under Section 1903 of the Social Security Act (42 U.S.C. 1396b). Providers of participant directed homemaker/personal care, residential respite (when billed in fifteen-minute units) and waiver nursing delegation services verify service delivery using the EVV system. EVV does not apply to residential respite when billed as a daily rate. ODM, ODA, DODD or their designee edits against visit information before provider payment processing. As of the date of submission of this waiver application, claims payment is not impacted by EVV status.

The state is in the process of implementing EVV compliance as a condition of payment, with an anticipated effective in late 2025.

Ohio's EVV requirements are also outlined in chapter 5160-32 of the Ohio administrative code.

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

i. Sub-Assurances:

a. Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

I-1: Number and percent of paid waiver claims submitted that were authorized.

Numerator: Total number of paid waiver claims submitted that were authorized.

Denominator: Total number of submitted waiver claims.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DODD's Division of Medicaid Development and Administration (MDA)/Claims Services/ Medicaid provider network management system

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify:	Annually	Stratified Describe Group:

	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

I-2: Number and percent of waiver claims paid for individuals who were enrolled on the waiver on the date of services. Numerator: Total number of waiver claims paid for individuals who were enrolled on the waiver on the date of services. Denominator: Total number of submitted waiver claims.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

DODD's Division of Medicaid Development and Administration (MDA)/Claims Services/ Medicaid provider network management system

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Continuously and Ongoing
	Other Specify:

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

I-3: Number and percent of waiver claims that were paid using the correct rate as specified in Chapters 5123:2-9 of the Ohio Administrative Code. Numerator: Total number of paid claims that were paid using the correct rate. Denominator: Total number of approved waiver claims.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DODD's Division of Medicaid Development and Administration (MDA)/Claims Services/ Medicaid Information Technology System (MITS)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing

information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Findings included in the State of Ohio Single State Audit are reviewed by the Ohio Department of Medicaid (ODM). Findings related to the Department of Developmental Disabilities (DODD) and Medicaid are communicated to DODD through the single audit. ODM reviews DODD related findings and determines whether a Plan of Correction (POC) proposed by DODD will correct the finding(s). ODM may issue a Management Decision Letter (MDL) to DODD as a means to approve the POC. Compliance with the MDL is reviewed as part of monitoring conducted by ODM.

DODD monitors claim rejections and denials on a weekly basis by rejection/denial reason code. If there is a large negative change for a county board of developmental disability (county board) or provider or if a county board or provider continuously has a large number of claims rejected or denied, DODD staff will contact the county board or provider and offer technical assistance. Similarly, claims staff research concerning trends in rejection or denial reason codes, and make recommendations or improvements to resolve widespread issues. Claims staff may receive questions on rejected or denied claims from county boards or providers, and research those inquiries within two business days. The length of time required to resolve a claim depends on the nature of the claim and the complexities around the issue.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify: As required in relation to any audit finding.

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for

public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Legislative actions resulting from biennial budget plans drive service rates. The Department of Developmental Disabilities frequently engages individuals, providers, advocates, and other stakeholders regarding rate setting through routine forums, most notably the Waiver Workgroup.

Entities that are Responsible for Rate Determinations: DODD is responsible for the development of statewide rates for waiver services, which they oversee, through an Interagency Agreement with the Ohio Department of Medicaid (ODM). The rate development process includes input from stakeholders. Once developed by DODD, ODM is responsible for the final review and approval of all rates. Analysis of appropriate rates for services occurs throughout the life of the waiver in these forums and are frequently updated prior to a renewal application. DODD maintains fee schedules, codified for each service in Ohio Administrative Code (OAC) Chapter 5123-9. Review and updates of rates and methodology occur from state budget appropriations, completed at least every other year. Codified rates in rule are required to be reviewed every five years. When rate increases occur, the state ensures increases are aligned in self-directed services in the waiver. Rate rebasing occurs when additional legislative appropriations are received and most recently occurred on 1/1/24 and 7/1/2024. Fee schedules include geographic and acuity factors, depending on the service. When necessary to comply with the Fair Labor Standards Act, the reimbursement to independent providers is adjusted for overtime compensation. Overtime payments are calculated based on the wage component of the service rate.

Options for Public Comments: Once approved by ODM, rates are added to OAC, mandating a period for public comment and a public hearing process allowing for public testimony before Ohio's Joint Commission on Agency Rule Review, a body of representatives from the Ohio Senate and the Ohio House of Representatives. Public comments are solicited at the public hearing phase for any new/amended rules to be rescinded or added. Information about payment rates is posted on DODD's website. Also, proposals on payment rate restructuring are made public via the Federal Rate change process whereby the State posts a notice of a payment rate restructuring to the Ohio Registrar's website. Payment rates are available to the individual during the Individual Service Planning and waiver service planning processes.

Groupings of Services Using the Same Rate Setting Methodology- The State broadly categorizes services into three different groups of independent rate model, equipment rate model and service specific models.

Independent Rate Model Services that use an independent model - The independent rate model was originally developed by third party consultants for the HPC service and has since served as the basis for the services below. The base wage rate used in the independent rate model was set using the average of the BLS job categories of Home Health Aides (31-1011) and Nursing Aides, Orderlies and Attendants (31-1012). This model was adjusted based on the specific service and BLS information specific to Ohio's job market. Inflation was adjusted by .98% in 2013 and an additional 6% in 2016. ERE was projected at 30% of the base wage for agencies and 32% for independent providers. Productivity adjustments of 1.02 and 1.10 for agencies and independents, respectively, were used. Overhead was estimated at 18% for agencies and 7% for independents. With the exception of the Support Brokerage service, this results in a statewide ceiling for each service. Rates for PD-HPC can then be negotiated by the participant and Support Brokerage but cannot exceed the rate ceiling.

Services that use the independent model include:

Adult Day Support (current maximum billable rate established 7/2024)
 Assistive Technology Consultation/Supports (current maximum billable rate established 7/2024)
 Community and Residential Respite (current maximum billable rate established 7/2024)
 Group Employment (current maximum billable rate established 7/2024)
 Non-Medical Transportation (per mile) (current maximum billable rate established 2025)
 Participant-Directed HPC (current maximum billable rate established 7/2024)
 Remote Supports (Current maximum billable rate established 7/2024)
 Support Brokerage (Current maximum billable rate established 2018)
 Vocational Habilitation (current maximum billable rate established 7/2024)

The following services have rate add-ons based on the individual needs of the person: Adult Day Support, Participant Directed HPC, Vocational Habilitation. The competency based add-on is for DSPs who meet certain criteria, detailed below are not a part of the person's waiver budget.

Categories are:

- Behavioral:(current maximum billable rate established 7/2024)
- Medical Assistance:(current maximum billable rate established 7/2024)
- Competency-based:(current maximum billable rate established in7/2024)

Equipment Rate Model- The services that use an Equipment Rate Model. These services are based on the manufacturer's suggested retail price or usual and customary charge as determined by the manufacturer or vendor. Statewide maximum rates are in place for Assistive Technology Equipment and is the lower of the provider's usual charge or the established statewide maximum.

Assistive Technology Equipment, Service Animal Training (current service maximum billable rate established 2019 and 2025, respectively)

Functional Behavioral Assessment (current maximum billable established 2018)

Home Delivered Meals (current maximum billable rate established 1/2024)

Participant-Directed Goods and Services (Current service maximum established 2018)

Participant/Family Stability Assistance (current maximum billable rate established 2018)

Vehicle Modification (current maximum billable rate established 2025)

Service-Specific models- The following services are paid using their own, individually customized, rate models, based on industry standards and Bureau of Labor Statistics)

Career Planning and Adult Day Quality Payment for CP-job development (current maximum billable rates established in 2022 and 7/2024, respectively)

Clinical/Therapeutic Intervention (current maximum billable rate established in 2022)

Individual Employment Supports (including Adult Day Quality payments for IES) (current maximum billable rate established in 7/2024)

Nursing Delegation (current maximum billable rate aligned with ODM established 1/2024)

Transportation (current maximum billable rate established 7/2024)

Health Care Assessment (current maximum billable rate established 2025)

Rate Setting for Waiver Services:

For Support Brokerage, the rate is a fixed statewide rate because the Support Brokerage is the only person allowed to negotiate rates on the participant's behalf. For all independent rates, there is no adjustment for administrative overhead or non-billable work time. Administrative overhead is assumed to be incurred by the Financial Management Service, which will be paid separately (contract) for their services. Independent providers are assumed to be 100% productive, thus all time spent with the participant is assumed to be billable work time.

As with the independent provider model, the agency provider rate model begins with Bureau of Labor Statistics information specific to Ohio's job market and incorporates factors for employee-related expenses, administrative overhead, and non-billable work time. The model's assumptions for employee-related expenses, non-billable work time, and administrative overhead are similar to previously approved rate models. For all agency providers, the rate is a fixed statewide rate with no cost of doing business adjustment or negotiation.

For routine PD-HPC services rendered by direct support professionals, rates may be adjusted using "add-ons" for individuals who meet certain medical or behavioral care needs. An add-on for DSPs who have at least 2 years experience and 60 hours accredited competency-based training is termed the competency-based" add on.

Adult Day Support and Vocational Habilitation was provisioned in integrated settings in groups of four or fewer individuals. Staff providing the service must demonstrate successful completion of a DODD approved program instruction in community integration to be eligible for the add-on. Ohio assumed that 70% of all employment services are for retention and 30% for placement. The agency and independent rates are adjusted by the cost of doing business factors.

Participant Direction: PD-HPC rates are based on the independent rate model discussed above. The Appendix to OAC 5123-9-32 also includes details information concerning common law employee and agency with choice rates. For both common law and agency with choice on-site/on-call PD-HPC, these rates are synchronous with minimum wage in Ohio. These rates adjust based on changes to Ohio's minimum wage, with an addition of 13% to cover employer-related expenses. Additional information for PD-HPC is in Appendix E.

ODM engaged an actuary to study factors such as labor market data, education, licensure status and length of service visit in the development of the waiver nursing and nursing delegation rates. The model begins with BLS information specific to Ohio's job market and incorporates reimbursement for employee related expenses, administrative overhead, and non-billable work time. Clinical/Therapeutic Intervention rates were developed based on industry standards and Bureau of Labor Statistics (BLS) average cost/pay for providers at the varying professional levels. Waiver Nursing

Delegation rates were developed to align with Ohio Department of Medicaid's (ODM) rates.

Career planning services were developed in collaboration with Opportunities for Ohioans with Disabilities and through an in-depth review of the SELF waiver service integrated employment.

Rates for employment quality were developed as the product of the hours of service required to achieve the outcome for each individual and the cost of the services that result in the desired outcome. The Employment Quality Program applies to Career Planning and Individual Employment Support providers. The source of the non-Federal share of the supplemental payment is paid according to the standards specified in Appendix I-4-a. Eligible providers will retain 100% of the computable expenditure claimed.

Users for Adult Day Quality Payments is set equal to the user count for the Job Development and Individual Employment Support services, respectfully. DODD projected one unit per user during the waiver period and the average cost per unit is set to the Tier C rate of \$730 or \$650 for the respective service. For this service, the trend throughout the waiver years aligns with the methodology explained above.

Non-medical transportation to competitive integrated employment rates were developed in consultation with stakeholders and use an independent rate model; a provider survey was used to capture costs and service delivery experience. The rates are organized into these mileage bands, each with 4 rates under each band (non-modified vehicles for agency providers, non-modified vehicles for independent providers, modified vehicles for agency providers, modified vehicles for independent providers): 0-15 miles, 16-30 miles, 31+ miles.

**See Main B Optional for additional information on rate methodologies*

See Main B Optional for additional information for January 1, 2026 Amendment

****See Main B Optional for additional information for July 1, 2026 Amendment****

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Claims are submitted electronically from all types and classes of SELF service providers to the Department of Developmental Disabilities (DODD), who have voluntarily reassigned DODD to submit claims to the Ohio Department of Medicaid (ODM) on their behalf. Claims for services over which a participant has chosen to exercise employer authority through either the Common Law Employer option or through Co-employer option using the Financial Management Services (FMS) as the co-employer are submitted directly to the FMS. On a weekly basis, DODD compiles all claims received from providers and from the FMS during that week into one billing file which is submitted to ODM for processing and adjudication through the state's Medicaid claims payment system.

Electronic Visit Verification (EVV)

Ohio's EVV program requirements are outlined in chapter 5160-32 of the Ohio administrative code.

ODM operates an EVV system to electronically document services furnished to individuals. Providers of personal care and nursing type services verify service delivery using the EVV system. EVV captures and logs visit data electronically and includes visit elements required under Section 1903 of the Social Security Act (42 U.S.C. 1396b). ODM, ODA, DODD or their designee edits against visit information before provider payment processing.

The Ohio Department of Medicaid and Department of Developmental Disabilities established EVV claims adjudication processes on October 1, 2025 to ensure proper payment of claims paid by each entity in accordance with EVV guidelines. Claims cannot be substantiated for payment until all exceptions are resolved by the service provider and EVV visit data supports the claim. Unsubstantiated claims may result in denial of payment or post payment review penalty.

The state offers assistance and education to service providers and program participants for claims adjudication.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures** (select one):

No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services

and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Certified public expenditures are incurred by County Boards when the waiver services are delivered by the boards. The claims for these services are accompanied by an attestation that the services delivered were fully paid for with public funds and are eligible expenditures for FFP. Claims delivered by County Boards are reimbursed at the lower of the County Board's usual and customary charge for the service or the statewide rates established for those services as described in Section I-2-a of this Appendix.

It is the State of Ohio's responsibility to monitor and audit its subrecipients as Federally required. Ohio Department of Developmental Disabilities (DODD) monitors and audits the cost reports that are prepared as a result of the cost based activity. It is the responsibility of DODD to ensure timely reviews and audits of its subrecipients in order to settle the associated costs for the period under review.

Adult Day Services Reconciliation:

The total annual cost of providing services to the Medicaid consumers will be derived from the cost report. The annual revenue will be derived by taking reimbursement received for the units of services delivered multiplied by unit rates approved by CMS. The total annual cost of providing services will be reconciled to reimbursement received.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

The Fiscal Management Services (FMS) is required to verify that the service a provider is billing for was included in the individual's approved service plan. DODD uses its Medicaid Services System Payment Authorization for Waiver Services (MSS/PAWS) system to validate that the individual was enrolled on the SELF Waiver on the date the service was delivered. The MSS/PAWS system is electronically linked with DODD's Waiver Management System (WMS), which indicates that the individual has a current level of care determination. In addition to the validation by the FMS and DODD, Ohio Department of Medicaid's, Medicaid provider network management system adjudicates all claims for reimbursement and makes the determination that both the individual receiving the service and the provider delivering the service were eligible for Medicaid waiver payment on the date the service was delivered. Further validation is accomplished through various post reviews that track backward from paid claims to actual service delivery documentation.

As part of the monthly billing, the FMS invoices based on a monthly fee per participant served. As part of the reviews DODD will select a sample of those individuals served and ensure what FMS billed DODD for was accurate, supported, in compliance with our Administrative Rules and statute. As part of the review, DODD will ensure what they are billing for is supported by documentation. That documentation would be for the services they billed the providers on behalf of the individuals and would be supported by service documentation. The service documentation which supports the payments to the providers would be reviewed as part of the review to ensure FMS is billing DODD appropriately.

Ohio's EVV system captures and logs visit data electronically and includes visit elements required under Section 1903 of the Social Security Act (42 U.S.C. 1396b). Providers of participant directed homemaker/personal care, residential respite (when billed in fifteen-minute units) and waiver nursing delegation services verify service delivery using the EVV system. EVV does not apply to residential respite when billed as a daily rate. ODM, ODA, DODD or their designee edits against visit information before provider payment processing. As of the date of submission of this waiver application, claims payment is not impacted by EVV status.

The state is in the process of implementing EVV compliance as a condition of payment, with an anticipated effective in late 2025.

Ohio's EVV requirements are outlined in chapter 5160-32 of the Ohio administrative code.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (select one):

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on

the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

The limited fiscal agent makes payments for the following services: Participant-Directed Homemaker/Personal Care, Transportation when it is the self-directed model, and Participant Directed Goods and Services. Once Payments have been approved by Participants and submitted to the fiscal agent for payment to providers of persons served, the fiscal agent will gather reports that outline what was approved and submitted. These reports include:

- a. Payroll Journal
- b. Vendor Billing Report
- c. FMS Encounter Data
- d. Active Client Report

The FMS will use the above reports to calculate billable cost, based on the calculated rate authorized on the daily spending plan filed received by the FMS. Once the billable cost is calculated, the FMS will create a claims file and ensure required fields are present. These files are created based on DODD guidelines. Services will be billed under the authorized code unless specified otherwise. The FMS will submit service claims to DODD weekly to allow for pre-judication prior to service claims being sent to Medicaid.

DODD audits the FMS each 'review cycle' for the SELF Waiver which typically spans a 3-year period. Our last review was for State Fiscal Years 20/21/22. Next review will cover State Fiscal Years 23/24/25.

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

The nature of the Employment Quality Program payment will be outcome-based and rely on the achievement of pre-planned goals and measures. The payments will vary based on the acuity of the individual receiving services and the goal achieved. The nature of the payments will be as follows:

- Job placement in competitive, integrated settings will result in one supplemental payment for acuity levels A1, A, and B and a higher supplemental payment for acuity level C.
- Job placement in competitive, integrated settings (at least \$12 an hour, or 30 hours per week) will result in one supplemental payment for acuity levels A1, A, and B and a higher supplemental payment for acuity level C.
- Job retention at 90 days will result in one supplemental payment for acuity levels A1, A, and B and a higher supplemental payment for acuity level C.
- Job retention at 180 days will result in one supplemental payment for acuity levels A1, A, and B and a higher supplemental payment for acuity level C.

The rates were developed as the product of the hours of service required to achieve the outcome for each individual and the cost of the services that result in the desired outcome.

The Employment Quality Program only applies to Career Planning and Individual Employment Support providers. The source of the non-Federal share of the supplemental payment is paid according to the standards specified in Appendix I-4-a. Eligible providers will retain 100% of the computable expenditure claimed.

All supplemental payment amounts that are discussed are published in the Ohio Administrative Code.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

County Boards of Developmental Disabilities (CBDD) receive payment for waiver services provided. County boards of developmental disabilities (county boards) receive payments for waiver services provided only when no other qualified or available provider is found for the purposes of service provisioning: Non-Medical transportation (token/voucher). This is noted in Appendix D-1-b.

Refer to Appendix C, containing the detail for waiver services delivery, including specifying which services may be provided by county boards when there is no other qualified and willing provider.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

The Ohio Department of Developmental Disabilities

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid

ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

Appropriation of State Tax Revenues to the State Medicaid Agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

The Department of Developmental Disabilities (DODD) provides a portion of the non-federal share of computable waiver costs through funds appropriated in its budget. These funds are not transferred to the State Medicaid Agency (Ohio Department of Medicaid), as DODD makes the requests for provider payment to the Auditor and Treasurer of State.
DODD attests to ODM that expenditures included in Intra-State Transfer Vouchers (ISTVs) are based on the state's accounting of actual recorded expenditures.

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

County Boards provide a portion of the non-federal share of computable waiver costs. The Department of Developmental Disabilities (DODD) operates as the Fiscal Agent and will maintain the administrative control of the non-federal share. The non-federal share will be comprised of various funds appropriated through the state legislation and funds generated through local levies. Ohio utilizes a Certified Public Expenditure (CPE) arrangement for the non-federal share when County Boards of DD are the providers.

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

County Boards provide a portion of the non-federal share of computable waiver costs. DODD operates as the Fiscal Agent and will maintain the administrative control of the non-federal share. The non-federal share will be comprised of various funds appropriated through the state legislation and funds generated through local levies. Ohio utilizes a Certified Public Expenditure (CPE) arrangement for the non-federal share when County Boards are the providers.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

- c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. Select one:

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

The rate setting methodology does not include any factors that represent costs associated with room and board.

Appendix I: Financial Accountability**I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver****Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** Select one:

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)****a. Co-Payment Requirements.** Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

Nominal deductible

Coinurance

Co-Payment

Other charge

Specify:

--

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

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Appendix J: Cost Neutrality Demonstration**J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	18716.36	16845.46	35561.82	113452.47	10145.36	123597.83	88036.01
2	19370.79	17350.82	36721.61	116288.78	10449.72	126738.50	90016.89
3	19947.88	17871.34	37819.22	119196.00	10763.21	129959.21	92139.99
4	20543.77	18407.48	38951.25	122175.90	11086.11	133262.01	94310.76
5	21157.30	18959.70	40117.00	125230.30	11418.69	136648.99	96531.99

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (1 of 9)**

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	4000		4000
Year 2	4000		4000
Year 3	4000		4000
Year 4	4000		4000
Year 5	4000		4000

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (2 of 9)**

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Ohio assumed a consistent enrollment of individuals in the SELF waiver program over the 5 years.

Ohio will accrue total person-days of service:

Waiver Year 1: 1,364,000

Waiver Year 2: 1,364,000

Waiver Year 3: 1,364,000

Waiver Year 4: 1,364,000

Waiver Year 5: 1,364,000

The average number of days each person is served:

Waiver Year 1: 341

Waiver Year 2: 341

Waiver Year 3: 341

Waiver Year 4: 341

Waiver Year 5: 341

Actual waiver experience for July 1, 2023 to June 30, 2024 based on FFS claims and enrollment experience was utilized to develop projected experience for Factor D. If experience was not available for a specific service from that time period, currently filed WY5 values were reported for WY1 of the renewal period.

Ohio estimates the average number of days based on information summarized from WY4, State Fiscal Year 2024. The ALOS of 341 days was calculated based on actual waiver experience observed in the FFS claims data for July 1, 2023 to June 30, 2024 using a total number of members (2,008) observed in the eligibility data for a total of 683,861 days. This was rounded to the nearest whole number. As this experience represented the most recently available experience for the waiver from actual claims data, it was determined that it was most appropriate for use in the waiver renewal submission. As the state did not anticipate changes in actual waiver enrollment over the 5 years, there is no indication of a change in ALOS over that 5-year period.

The State reviewed enrollment data from SFY 2020 to the end of 2024 between developmental disability waiver programs resulting in a restructuring of unduplicated slots for the SELF program. Average enrollment for the SELF has been less than twenty per quarter over the lifespan of the waiver. The Department of Developmental Disabilities (DD) projects 4,000 slots per waiver year for the renewal to accommodate current allocation and enrollment trends. Year 5 (SFY2025) of the current SELF waiver was projected at 5,700, which was an increase of 700 people from the current waiver's WY4 projected slots. Further analysis of the enrollment trends revealed a possible correlation to increased flexibilities on spending caps and benefits of traditional Homemaker/Personal Care (HPC) service over self-directed HPC in other DD programs. Based on historical experience, the number of participants that phase in and phase out of the waiver during the year result in a number for participants being served at any one time below the total unduplicated participant count projection. No participant is expected to experience a reduction in services or loss of access to services as a result of the projected changes.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Ohio assumes all SELF waiver services will be utilized by differing percentages of the total waiver population based on past service utilization patterns and the individual's choice of the new services.

Development of the Factor D estimates for the Self-Empowered Life Funding (SELF) waiver program is based on actual waiver experience for July 1, 2023 to June 30, 2024 based on FFS claims and enrollment experience.

The values filed in the currently approved SELF waiver reflect information from historical 372 reports from SFY 2021 to SFY 2023. This historical information was utilized in developing projections included in amendments to the SELF waiver during the current waiver period. Additional data sources include the following:

- February 2022 to June 2024 telemedicine pilot project was utilized to develop values for Health Assessment services
- CY 2023 data for non-medical transportation was utilized to develop values for Competitive Integrated Employment (CIE)

The state reviewed actual waiver experience for July 1, 2023 to June 30, 2024 to develop values for information to utilize in the WY4 372 report development.

Factor D estimates for the new 5-year waiver period for the renewal (July 1, 2025 through June 30, 2030) were developed in the following manner:

- Base number of users was estimated by determining the allocated number of users from actual waiver experience for July 1, 2023 to June 30, 2024 based on FFS claims and enrollment experience. No adjustments were made for the number of users as those were held constant over the 5-year waiver period. For the SELF waiver services, the expected percentage of members identified as using a service was derived by summarizing utilization during SFY 2024 (July 1, 2023 through June 30, 2024).

The values filed in the currently approved SELF waiver, including those for WY5, reflect information from historical 372 reports from SFY 2021 to SFY 2023. This historical information was utilized in developing projections included in amendments to the SELF waiver during the current waiver period. Additional data sources include the following:

- February 2022 to June 2024 telemedicine pilot project was utilized to develop values for Health Assessment services
- CY 2023 data for non-medical transportation was utilized to develop values for Competitive Integrated Employment (CIE)

The projected number of users for WY 1 of the waiver renewal represents the expected percentage of utilization multiplied by the projected unduplicated participant count for WY 1. The state has not reflected increases in the projected number of users from WY 1 to WY 5 of the renewal period based on maintaining the same projected numbers of unduplicated participants (4,000) over the course of the 5 year renewal period.

- Baseline average units per user was calculated by adjusting the actual waiver experience for July 1, 2023 to June 30, 2024 of average units per user by projected growth in the Average Length of Stay (ALOS). No adjustments were applied to the historical data to develop projected average units per users. SFY 2024 experience was utilized as the basis for the cost per unit on services where experience for SFY 2024 was available. The cost per unit for services where experience was not reported in SFY 2024 utilized the previously approved WY5 cost per unit values. The experience was utilized as the starting point for WY1 of the new waiver period with the 3.0% annual trend growth applied from that time period forward.

The ALOS of 341 days was calculated based on actual waiver experience from FFS claims and enrollment data for July 1, 2023 to June 30, 2024 using a total number of members (2,008) for a total of 683,861 days. There was no assumed change in ALOS over the 5 years of the waiver.

The average cost per unit varies for services based on the trends observed in the actual waiver experience for July 1, 2023 to June 30, 2024 from FFS claims and waiver enrollment and historically filed average cost per unit. This served as the basis for experience with the currently approved WY5 values utilized for services where actual experience was not reported in SFY 2024. A 3.0% annual cost per unit trend was applied to trend experience from WY1 to WY5. The 3.0% annual growth trend was selected based on a review of emerging experience in the Ohio Medicaid managed care program for CY 2023 and 2024 along with historical and projected National Health Expenditure data.

For Adult Day Quality Payments, Functional Behavioral Assessment and Participant/Family Stability Assistance,

the average cost per unit is held constant over the 5 years of the waiver. The fees associated with the Functional Behavioral Assessment and Participant/Family Stability Assistance services are based on a usual and customary amount per Ohio state regulations. There is a \$1,500 per waiver period limit on Functional Behavior Assessment, but no limit on Participant/Family Stability Assistance.

For Adult Day Quality Payments, the average cost per unit is set to the Tier C rate of \$730 or \$650 for the respective service. These were based on legislative changes under Ohio House Bill 33 targeting the direct support workforce shortage and the ability to provide quality home and community-based services.

For all other services the state applied an annual trend of 3% based on a review of emerging experience in the Ohio Medicaid managed care program for CY 2023 and 2024 along with historical and projected National Health Expenditure data. Over the 5 year renewal period, the cost per unit for these services continues to trend at the same annual rate. Services that receive the 3% annual trend include all three Assistive Technology services.

New Services:

Both Service Animal Training and Vehicle Modification were split out from the Participant Directed Goods and Service(s).

Users for Service Animals: The number of annual projected users is based on data reviewed from 2017 through 2024. The source of the information utilized to develop Service Animal Training was experience from DODD Certified Subject Matter Expert Provider-Independent individuals which bill for service animals for the noted time period. Additionally, there was no specific billing code for this service, thus DODD relied on non-scientific anecdotal Participant Directed Goods and Services spreadsheets from scenarios in which DODD was sent a request to approve. DODD was not required to approve service animals under PDGS therefore, there could be additional instances approved by county boards. For Service Animal training, the state projected one user per year, a total of five users for the 5-year waiver period and an average cost per unit of \$8,200 based on the average cost in utilization data reviewed from 2021 through 2024.

Vehicle Modification: The number of annual projected users is based on data reviewed from 2021 through 2024. The source of the information utilized to develop Vehicle Modifications was based on anecdotal experience from qualified Vehicle Modification providers that were identified from the Participant Directed Goods and Services experience for the noted time period.

As there was no specific billing code for this service, DODD relied on non-scientific anecdotal Participant Directed Goods and Services spreadsheets from scenarios in which DODD was sent a request to approve. DODD was not required to approve vehicle mods under PDGS therefore, there could be additional instances approved by county boards. For the Vehicle Modification service, the state projected one user per year for a total of five users for the 5-year waiver period and a cost per unit of \$10,000, which aligns with the maximum allowed amount per unit. For both services, the average unit cost is set and held constant for all 5 years in the waiver renewal period.

January 1, 2026 Amendment

New Billing Increments: Support Brokerage and Remote Supports were changed from an hourly billing increment to a 15-minute billing increment for the second half of WY 1 through WY 5 (January 1, 2026 through June 30, 2030). This change in billing increment is intended to be budget neutral.

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Base Year data reflects state plan costs identified for SELF waiver members in the actual waiver experience for July 1, 2023 to June 30, 2024 from FFS claims and waiver enrollment which serve as the basis for experience with the currently approved WY5 values utilized for services where actual experience was not reported in SFY 2024.

There was no change in ALOS with no impact on the costs of Factor D' values between SFY 2024 and the projected waiver years of the renewal

Factor D' was trended at a rate of 3.0% per year based on a review of emerging experience in the Ohio Medicaid managed care program for CY 2023 and 2024 along with historical and projected National Health Expenditure data.

- iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Base Year data reflects historical Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) costs in the Ohio Medicaid data during SFY 2024 (July 1, 2023 through June 30, 2024). This population excludes DODD waiver members and only includes member months with a claim at an ICF/IID. This serves as the proxy population for the ICF/IID level of care costs represented by Factor G in this waiver. Factor G costs were trended at a rate of 2.5% per year based on a review of historical and projected National Health Expenditure data. Additionally, the Medicaid market trends specific to the ICF/IID population and was selected based on current budgetary trends utilized in Ohio.

- iv. Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Base Year data reflects historical state plan service costs for members with Intellectual Disabilities residing in an Intermediate Care Facility in the Ohio Medicaid data during SFY 2024 (July 1, 2023 through June 30, 2024). This population excludes DODD waiver members and only includes member months with a claim at an ICF/IID. This serves as the proxy population for the ICF/IID level of care costs represented by Factor G' in this waiver. Factor G' costs were trended at a rate of 3.0% per year based on a review of emerging experience in the Ohio Medicaid managed care program for CY 2023 and 2024 along with historical and projected National Health Expenditure data.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

Waiver Services	
Participant-Directed Homemaker/Personal Care	
Residential Respite	
Participant-Directed Goods and Services	
Participant/Family Stability Assistance	
Support Brokerage	
Assistive Technology	
Career Planning	
Clinical/Therapeutic Intervention	
Community Respite	
Environmental Accessibility Adaptations	
Functional Behavioral Assessment	
Group Employment Support	
Habilitation - Adult Day Support	
Habilitation - Vocational Habilitation	
Health Care Assessment	
Home Delivered Meals	
Individual Employment Support	
Non-Medical Transportation	
Remote Supports	
Transportation	
Vehicle Modification	
Waiver Nursing Delegation	

Appendix J: Cost Neutrality Demonstration

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Participant-Directed Homemaker/Personal Care Total:						47273396.20
Participant-Directed Homemaker/Personal Care	Hour	2602	1873.00	9.70	47273396.20	
Residential Respite Total:						198329.04
Residential Respite	Day	42	26.00	181.62	198329.04	
Participant-Directed Goods and Services Total:						2580610.68
Participant-Directed Goods and Services	Item	829	18.00	172.94	2580610.68	
Participant/Family Stability Assistance Total:						2880.00
Participant/Family Stability Assistance	Hour	2	12.00	120.00	2880.00	
Support Brokerage Total:						87678.00
Support Brokerage 15 Minute	15 Minutes	30	150.00	9.68	43560.00	
Support Brokerage Hour	Hour	30	38.00	38.70	44118.00	
Assistive Technology Total:						621504.72
Assistive Technology Equipment	Item	504	6.00	200.98	607763.52	
Assistive Technology Support	Hour	4	2.00	5.45	43.60	
Assistive Technology Consultation	Per evaluation	40	1.00	137.44	5497.60	
Service Animals Training	Per service	1	1.00	8200.00	8200.00	
Career Planning Total:						624867.32
Career Discovery	Per evaluation	94	1.00	2140.79	201234.26	
GRAND TOTAL: 74865445.52 Total Estimated Unduplicated Participants: 4000 Factor D (Divide total by number of participants): 18716.36 Average Length of Stay on the Waiver: 341						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Worksite Accessibility	Hour	50	6.00	77.82	23346.00	
Job Development	Hour	10	45.00	30.01	13504.50	
Self-Employment Launch	Hour	44	71.00	77.82	243109.68	
Benefits Education and Analysis	Item	10	1.00	413.13	4131.30	
Adult Day Quality Payment- Job Development	Per outcome	102	1.00	730.00	74460.00	
Situational Observation and Assessment	Per service	4	1.00	1015.40	4061.60	
Employment/Self-Employment Plan	Item	42	1.00	1167.71	49043.82	
Career Exploration	Hour	14	37.00	23.12	11976.16	
Clinical/Therapeutic Intervention Total:						161141.40
Clinical/Therapeutic Intervention	Hour	18	245.00	36.54	161141.40	
Community Respite Total:						221376.90
Community Respite	Hour	131	43.00	39.30	221376.90	
Environmental Accessibility Adaptations Total:						0.00
Environmental Accessibility Adaptations	Item	0	0.01	0.01	0.00	
Functional Behavioral Assessment Total:						6000.00
Functional Behavioral Assessment	Item	4	1.00	1500.00	6000.00	
Group Employment Support Total:						232121.12
Group Employment Support	Hour	56	294.00	6.22	102406.08	
Group Employment Support	Day	52	59.00	42.28	129715.04	
Habilitation - Adult Day Support Total:						6567081.57
Habilitation-Adult Day Support	Day	805	213.00	35.79	6136732.35	
Habilitation-Adult Day Support	Hour	181	153.00	15.54	430349.22	
Habilitation -						2572702.30
GRAND TOTAL: 74865445.52 Total Estimated Unduplicated Participants: 4000 Factor D (Divide total by number of participants): 18716.36 Average Length of Stay on the Waiver: 341						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Vocational Habilitation Total:						
Habilitation- Vocational Habilitation	Day	390	199.00	32.55	2526205.50	
Habilitation- Vocational Habilitation	Hour	46	56.00	18.05	46496.80	
Health Care Assessment Total:						75520.50
Health Care Assessment	Month	199	11.00	34.50	75520.50	
Home Delivered Meals Total:						395326.36
Home Delivered Meals	Per Meal	143	244.00	11.33	395326.36	
Individual Employment Support Total:						844242.70
Adult Day Quality Payment- Individual Employment Support	Per outcome	777	1.00	650.00	505050.00	
Individual Employment Support	Hour	341	35.00	28.42	339192.70	
Non-Medical Transportation Total:						8895438.11
Non-Medical Transportation	Trip	1271	199.00	25.57	6467394.53	
Non-medical transportation to Competitive Integrated Employment	Trip	171	6.00	58.59	60113.34	
Non-Medical Transportation	Mile	996	1524.00	1.56	2367930.24	
Remote Supports Total:						502619.88
Remote Supports 15 Minutes	15 Minutes	141	1086.00	2.88	441002.88	
Remote Supports Hour	Hour	141	38.00	11.50	61617.00	
Transportation Total:						2982925.20
Transportation	Mile	1524	529.00	3.70	2982925.20	
Vehicle Modification Total:						10000.00
Vehicle modification	Item	1	1.00	10000.00	10000.00	
Waiver Nursing Delegation Total:						9683.52
Waiver Nursing Delegation- Assessment	Per assessment	2	6.00	45.16	541.92	
GRAND TOTAL: 74865445.52 Total Estimated Unduplicated Participants: 4000 Factor D (Divide total by number of participants): 18716.36 Average Length of Stay on the Waiver: 341						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Waiver Nursing Delegation- Consultation	Hour	2	120.00	38.09	9141.60	
GRAND TOTAL: 74865445.52 Total Estimated Unduplicated Participants: 4000 Factor D (Divide total by number of participants): 18716.36 Average Length of Stay on the Waiver: 341						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Participant-Directed Homemaker/Personal Care Total:						48686724.54
Participant-Directed Homemaker/Personal Care	Hour	2602	1873.00	9.99	48686724.54	
Residential Respite Total:						204280.44
Residential Respite	Day	42	26.00	187.07	204280.44	
Participant-Directed Goods and Services Total:						2369348.32
Participant-Directed Goods and Services	Item	829	16.00	178.63	2369348.32	
Participant/Family Stability Assistance Total:						2880.00
Participant/Family Stability Assistance	Hour	2	12.00	120.00	2880.00	
Support Brokerage Total:						89733.60
Support Brokerage 15 Minute	15 Minutes	30	309.00	9.68	89733.60	
Support Brokerage Hour	Hour	0	0.00	0.01	0.00	
Assistive Technology Total:						639905.52
Assistive Technology					625998.24	
GRAND TOTAL: 77483167.28 Total Estimated Unduplicated Participants: 4000 Factor D (Divide total by number of participants): 19370.79 Average Length of Stay on the Waiver: 341						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Equipment	Item	504	6.00	207.01		
Assistive Technology Support	Hour	4	2.00	5.61	44.88	
Assistive Technology Consultation	Per evaluation	40	1.00	141.56	5662.40	
Service Animals Training	Per service	1	1.00	8200.00	8200.00	
Career Planning Total:						641361.34
Career Discovery	Per evaluation	94	1.00	2205.01	207270.94	
Worksite Accessibility	Hour	50	6.00	80.15	24045.00	
Job Development	Hour	10	45.00	30.91	13909.50	
Self-Employment Launch	Hour	44	71.00	80.15	250388.60	
Benefits Education and Analysis	Item	10	1.00	425.52	4255.20	
Adult Day Quality Payment- Job Development	Per outcome	102	1.00	730.00	74460.00	
Situational Observation and Assessment	Per service	4	1.00	1045.86	4183.44	
Employment/Self- Employment Plan	Item	42	1.00	1202.74	50515.08	
Career Exploration	Hour	14	37.00	23.81	12333.58	
Clinical/Therapeutic Intervention Total:						165992.40
Clinical/Therapeutic Intervention	Hour	18	245.00	37.64	165992.40	
Community Respite Total:						228023.84
Community Respite	Hour	131	43.00	40.48	228023.84	
Environmental Accessibility Adaptations Total:						288400.00
Environmental Accessibility Adaptations	Item	40	2.00	3605.00	288400.00	
Functional Behavioral Assessment Total:						6000.00
Functional Behavioral Assessment	Item	4	1.00	1500.00	6000.00	
Group Employment Support Total:						239145.64
GRAND TOTAL: 77483167.28 Total Estimated Unduplicated Participants: 4000 Factor D (Divide total by number of participants): 19370.79 Average Length of Stay on the Waiver: 341						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group Employment Support	Hour	56	294.00	6.41	105534.24	
Group Employment Support	Day	52	59.00	43.55	133611.40	
Habilitation - Adult Day Support Total:						6763564.83
Habilitation-Adult Day Support	Day	805	213.00	36.86	6320199.90	
Habilitation-Adult Day Support	Hour	181	153.00	16.01	443364.93	
Habilitation - Vocational Habilitation Total:						2650151.14
Habilitation- Vocational Habilitation	Day	390	199.00	33.53	2602263.30	
Habilitation- Vocational Habilitation	Hour	46	56.00	18.59	47887.84	
Health Care Assessment Total:						77797.06
Health Care Assessment	Month	199	11.00	35.54	77797.06	
Home Delivered Meals Total:						407189.64
Home Delivered Meals	Per Meal	143	244.00	11.67	407189.64	
Individual Employment Support Total:						854387.45
Adult Day Quality Payment- Individual Employment Support	Per outcome	777	1.00	650.00	505050.00	
Individual Employment Support	Hour	341	35.00	29.27	349337.45	
Non-Medical Transportation Total:						9167894.40
Non-Medical Transportation	Trip	1271	199.00	26.34	6662149.86	
Non-medical transportation to Competitive Integrated Employment	Trip	171	6.00	60.35	61919.10	
Non-Medical Transportation	Mile	996	1524.00	1.61	2443825.44	
Remote Supports Total:						908807.04
Remote Supports 15 Minutes	15 Minutes	141	2238.00	2.88	908807.04	
Remote Supports Hour	Hour	0	0.00	0.01	0.00	
GRAND TOTAL: 77483167.28 Total Estimated Unduplicated Participants: 4000 Factor D (Divide total by number of participants): 19370.79 Average Length of Stay on the Waiver: 341						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation Total:						3071606.76
Transportation	Mile	1524	529.00	3.81	3071606.76	
Vehicle Modification Total:						10000.00
Vehicle modification	Item	1	1.00	10000.00	10000.00	
Waiver Nursing Delegation Total:						9973.32
Waiver Nursing Delegation-Assessment	Per assessment	2	6.00	46.51	558.12	
Waiver Nursing Delegation-Consultation	Hour	2	120.00	39.23	9415.20	
GRAND TOTAL: 77483167.28 Total Estimated Unduplicated Participants: 4000 Factor D (Divide total by number of participants): 19370.79 Average Length of Stay on the Waiver: 341						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Participant-Directed Homemaker/Personal Care Total:						50148788.34
Participant-Directed Homemaker/Personal Care	Hour	2602	1873.00	10.29	50148788.34	
Residential Respite Total:						210406.56
Residential Respite	Day	42	26.00	192.68	210406.56	
Participant-Directed Goods and Services Total:						2449064.96
Participant-Directed Goods and Services	Item	829	16.00	184.64	2449064.96	
Participant/Family Stability Assistance						2880.00
GRAND TOTAL: 79791531.12 Total Estimated Unduplicated Participants: 4000 Factor D (Divide total by number of participants): 19947.88 Average Length of Stay on the Waiver: 341						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:						
Participant/Family Stability Assistance	Hour	2	12.00	120.00	2880.00	
Support Brokerage Total:						92637.60
Support Brokerage 15 Minute	15 Minutes	30	319.00	9.68	92637.60	
Support Brokerage Hour	Hour	0	0.00	0.01	0.00	
Assistive Technology Total:						658855.92
Assistive Technology Equipment	Item	504	6.00	213.22	644777.28	
Assistive Technology Support	Hour	4	2.00	5.78	46.24	
Assistive Technology Consultation	Per evaluation	40	1.00	145.81	5832.40	
Service Animals Training	Per service	1	1.00	8200.00	8200.00	
Career Planning Total:						658351.90
Career Discovery	Per evaluation	94	1.00	2271.16	213489.04	
Worksite Accessibility	Hour	50	6.00	82.55	24765.00	
Job Development	Hour	10	45.00	31.84	14328.00	
Self-Employment Launch	Hour	44	71.00	82.55	257886.20	
Benefits Education and Analysis	Item	10	1.00	438.29	4382.90	
Adult Day Quality Payment- Job Development	Per outcome	102	1.00	730.00	74460.00	
Situational Observation and Assessment	Per service	4	1.00	1077.24	4308.96	
Employment/Self- Employment Plan	Item	42	1.00	1238.82	52030.44	
Career Exploration	Hour	14	37.00	24.52	12701.36	
Clinical/Therapeutic Intervention Total:						170975.70
Clinical/Therapeutic Intervention	Hour	18	245.00	38.77	170975.70	
Community Respite Total:						234839.77
Community Respite					234839.77	
GRAND TOTAL: 79791531.12 Total Estimated Unduplicated Participants: 4000 Factor D (Divide total by number of participants): 19947.88 Average Length of Stay on the Waiver: 341						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Hour	131	43.00	41.69		
Environmental Accessibility Adaptations Total:						288400.00
Environmental Accessibility Adaptations	Item	40	2.00	3605.00	288400.00	
Functional Behavioral Assessment Total:						6000.00
Functional Behavioral Assessment	Item	4	1.00	1500.00	6000.00	
Group Employment Support Total:						246292.88
Group Employment Support	Hour	56	294.00	6.60	108662.40	
Group Employment Support	Day	52	59.00	44.86	137630.48	
Habilitation - Adult Day Support Total:						6967183.62
Habilitation-Adult Day Support	Day	805	213.00	37.97	6510526.05	
Habilitation-Adult Day Support	Hour	181	153.00	16.49	456657.57	
Habilitation - Vocational Habilitation Total:						2729979.80
Habilitation- Vocational Habilitation	Day	390	199.00	34.54	2680649.40	
Habilitation- Vocational Habilitation	Hour	46	56.00	19.15	49330.40	
Health Care Assessment Total:						80139.29
Health Care Assessment	Month	199	11.00	36.61	80139.29	
Home Delivered Meals Total:						419401.84
Home Delivered Meals	Per Meal	143	244.00	12.02	419401.84	
Individual Employment Support Total:						864890.25
Adult Day Quality Payment- Individual Employment Support	Per outcome	777	1.00	650.00	505050.00	
Individual Employment Support	Hour	341	35.00	30.15	359840.25	
Non-Medical Transportation Total:						9445460.57
Non-Medical Transportation	Trip	1271	199.00	27.13	6861963.77	
GRAND TOTAL: 79791531.12 Total Estimated Unduplicated Participants: 4000 Factor D (Divide total by number of participants): 19947.88 Average Length of Stay on the Waiver: 341						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Non-medical transportation to Competitive Integrated Employment	Trip	171	6.00	62.16	63776.16	
Non-Medical Transportation	Mile	996	1524.00	1.66	2519720.64	
Remote Supports Total:						936420.48
Remote Supports 15 Minutes	15 Minutes	141	2306.00	2.88	936420.48	
Remote Supports Hour	Hour	0	0.00	0.01	0.00	
Transportation Total:						3160288.32
Transportation	Mile	1524	529.00	3.92	3160288.32	
Vehicle Modification Total:						10000.00
Vehicle modification	Item	1	1.00	10000.00	10000.00	
Waiver Nursing Delegation Total:						10273.32
Waiver Nursing Delegation- Assessment	Per assessment	2	6.00	47.91	574.92	
Waiver Nursing Delegation- Consultation	Hour	2	120.00	40.41	9698.40	
GRAND TOTAL: 79791531.12 Total Estimated Unduplicated Participants: 4000 Factor D (Divide total by number of participants): 19947.88 Average Length of Stay on the Waiver: 341						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Participant-Directed Homemaker/Personal Care Total:						51659587.60
Participant-Directed					51659587.60	
GRAND TOTAL: 82175099.43 Total Estimated Unduplicated Participants: 4000 Factor D (Divide total by number of participants): 20543.77 Average Length of Stay on the Waiver: 341						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Homemaker/Personal Care	Hour	2602	1873.00	10.60		
Residential Respite Total:						216718.32
Residential Respite	Day	42	26.00	198.46	216718.32	
Participant-Directed Goods and Services Total:						2531169.12
Participant-Directed Goods and Services	Item	829	16.00	190.83	2531169.12	
Participant/Family Stability Assistance Total:						2880.00
Participant/Family Stability Assistance	Hour	2	12.00	120.00	2880.00	
Support Brokerage Total:						95251.20
Support Brokerage 15 Minute	15 Minutes	30	328.00	9.68	95251.20	
Support Brokerage Hour	Hour	0	0.00	0.01	0.00	
Assistive Technology Total:						678385.68
Assistive Technology Equipment	Item	504	6.00	219.62	664130.88	
Assistive Technology Support	Hour	4	2.00	5.95	47.60	
Assistive Technology Consultation	Per evaluation	40	1.00	150.18	6007.20	
Service Animals Training	Per service	1	1.00	8200.00	8200.00	
Career Planning Total:						675884.46
Career Discovery	Per evaluation	94	1.00	2339.29	219893.26	
Worksite Accessibility	Hour	50	6.00	85.03	25509.00	
Job Development	Hour	10	45.00	32.80	14760.00	
Self-Employment Launch	Hour	44	71.00	85.03	265633.72	
Benefits Education and Analysis	Item	10	1.00	451.44	4514.40	
Adult Day Quality Payment- Job Development	Per outcome	102	1.00	730.00	74460.00	
Situational Observation and	Per service	4	1.00	1109.56	4438.24	
GRAND TOTAL: 82175099.43 Total Estimated Unduplicated Participants: 4000 Factor D (Divide total by number of participants): 20543.77 Average Length of Stay on the Waiver: 341						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assessment						
Employment/Self-Employment Plan	Item	42	1.00	1275.98	53591.16	
Career Exploration	Hour	14	37.00	25.26	13084.68	
Clinical/Therapeutic Intervention Total:						176091.30
Clinical/Therapeutic Intervention	Hour	18	245.00	39.93	176091.30	
Community Respite Total:						241881.02
Community Respite	Hour	131	43.00	42.94	241881.02	
Environmental Accessibility Adaptations Total:						288400.00
Environmental Accessibility Adaptations	Item	40	2.00	3605.00	288400.00	
Functional Behavioral Assessment Total:						6000.00
Functional Behavioral Assessment	Item	4	1.00	1500.00	6000.00	
Group Employment Support Total:						253727.48
Group Employment Support	Hour	56	294.00	6.80	111955.20	
Group Employment Support	Day	52	59.00	46.21	141772.28	
Habilitation - Adult Day Support Total:						7176223.29
Habilitation-Adult Day Support	Day	805	213.00	39.11	6705996.15	
Habilitation-Adult Day Support	Hour	181	153.00	16.98	470227.14	
Habilitation - Vocational Habilitation Total:						2812162.52
Habilitation-Vocational Habilitation	Day	390	199.00	35.58	2761363.80	
Habilitation-Vocational Habilitation	Hour	46	56.00	19.72	50798.72	
Health Care Assessment Total:						82547.19
Health Care Assessment	Month	199	11.00	37.71	82547.19	
Home Delivered Meals Total:						431962.96
Home Delivered					431962.96	
GRAND TOTAL: 82175099.43 Total Estimated Unduplicated Participants: 4000 Factor D (Divide total by number of participants): 20543.77 Average Length of Stay on the Waiver: 341						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Meals	Per Meal	143	244.00	12.38		
Individual Employment Support Total:						875631.75
Adult Day Quality Payment- Individual Employment Support	Per outcome	777	1.00	650.00	505050.00	
Individual Employment Support	Hour	341	35.00	31.05	370581.75	
Non-Medical Transportation Total:						9728136.62
Non-Medical Transportation	Trip	1271	199.00	27.94	7066836.26	
Non-medical transportation to Competitive Integrated Employment	Trip	171	6.00	64.02	65684.52	
Non-Medical Transportation	Mile	996	1524.00	1.71	2595615.84	
Remote Supports Total:						964846.08
Remote Supports 15 Minutes	15 Minutes	141	2376.00	2.88	964846.08	
Remote Supports Hour	Hour	0	0.00	0.01	0.00	
Transportation Total:						3257031.84
Transportation	Mile	1524	529.00	4.04	3257031.84	
Vehicle Modification Total:						10000.00
Vehicle modification	Item	1	1.00	10000.00	10000.00	
Waiver Nursing Delegation Total:						10581.00
Waiver Nursing Delegation- Assessment	Per assessment	2	6.00	49.35	592.20	
Waiver Nursing Delegation- Consultation	Hour	2	120.00	41.62	9988.80	
GRAND TOTAL: 82175099.43 Total Estimated Unduplicated Participants: 4000 Factor D (Divide total by number of participants): 20543.77 Average Length of Stay on the Waiver: 341						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Participant-Directed Homemaker/Personal Care Total:						53219122.32
Participant-Directed Homemaker/Personal Care	Hour	2602	1873.00	10.92	53219122.32	
Residential Respite Total:						223215.72
Residential Respite	Day	42	26.00	204.41	223215.72	
Participant-Directed Goods and Services Total:						2615660.80
Participant-Directed Goods and Services	Item	829	16.00	197.20	2615660.80	
Participant/Family Stability Assistance Total:						2880.00
Participant/Family Stability Assistance	Hour	2	12.00	120.00	2880.00	
Support Brokerage Total:						98155.20
Support Brokerage 15 Minute	15 Minutes	30	338.00	9.68	98155.20	
Support Brokerage Hour	Hour	0	0.00	0.01	0.00	
Assistive Technology Total:						698495.68
Assistive Technology Equipment	Item	504	6.00	226.21	684059.04	
Assistive Technology Support	Hour	4	2.00	6.13	49.04	
Assistive Technology Consultation	Per evaluation	40	1.00	154.69	6187.60	
Service Animals Training	Per service	1	1.00	8200.00	8200.00	
Career Planning Total:						693923.58
Career Discovery	Per evaluation	94	1.00	2409.47	226490.18	
Worksite Accessibility	Hour	50	6.00	87.58	26274.00	
Job Development	Hour	10	45.00	33.78	15201.00	
Self-Employment Launch	Hour	44	71.00	87.58	273599.92	
Benefits Education and Analysis	Item		1.00	464.98	4649.80	
GRAND TOTAL: 84629199.94 Total Estimated Unduplicated Participants: 4000 Factor D (Divide total by number of participants): 21157.30 Average Length of Stay on the Waiver: 341						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		10				
Adult Day Quality Payment- Job Development	Per outcome	102	1.00	730.00	74460.00	
Situational Observation and Assessment	Per service	4	1.00	1142.85	4571.40	
Employment/Self- Employment Plan	Item	42	1.00	1314.26	55198.92	
Career Exploration	Hour	14	37.00	26.02	13478.36	
Clinical/Therapeutic Intervention Total:						181383.30
Clinical/Therapeutic Intervention	Hour	18	245.00	41.13	181383.30	
Community Respite Total:						249147.59
Community Respite	Hour	131	43.00	44.23	249147.59	
Environmental Accessibility Adaptations Total:						288400.00
Environmental Accessibility Adaptations	Item	40	2.00	3605.00	288400.00	
Functional Behavioral Assessment Total:						6000.00
Functional Behavioral Assessment	Item	4	1.00	1500.00	6000.00	
Group Employment Support Total:						261284.80
Group Employment Support	Hour	56	294.00	7.00	115248.00	
Group Employment Support	Day	52	59.00	47.60	146036.80	
Habilitation - Adult Day Support Total:						7390960.77
Habilitation-Adult Day Support	Day	805	213.00	40.28	6906610.20	
Habilitation-Adult Day Support	Hour	181	153.00	17.49	484350.57	
Habilitation - Vocational Habilitation Total:						2896725.06
Habilitation- Vocational Habilitation	Day	390	199.00	36.65	2844406.50	
Habilitation- Vocational Habilitation	Hour	46	56.00	20.31	52318.56	
GRAND TOTAL: 84629199.94 Total Estimated Unduplicated Participants: 4000 Factor D (Divide total by number of participants): 21157.30 Average Length of Stay on the Waiver: 341						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Health Care Assessment Total:						85020.76
Health Care Assessment	Month	199	11.00	38.84	85020.76	
Home Delivered Meals Total:						444873.00
Home Delivered Meals	Per Meal	143	244.00	12.75	444873.00	
Individual Employment Support Total:						886731.30
Adult Day Quality Payment- Individual Employment Support	Per outcome	777	1.00	650.00	505050.00	
Individual Employment Support	Hour	341	35.00	31.98	381681.30	
Non-Medical Transportation Total:						10018462.10
Non-Medical Transportation	Trip	1271	199.00	28.78	7279296.62	
Non-medical transportation to Competitive Integrated Employment	Trip	171	6.00	65.94	67654.44	
Non-Medical Transportation	Mile	996	1524.00	1.76	2671511.04	
Remote Supports Total:						994083.84
Remote Supports 15 Minutes	15 Minutes	141	2448.00	2.88	994083.84	
Remote Supports Hour	Hour	0	0.00	0.01	0.00	
Transportation Total:						3353775.36
Transportation	Mile	1524	529.00	4.16	3353775.36	
Vehicle Modification Total:						10000.00
Vehicle modification	Item	1	1.00	10000.00	10000.00	
Waiver Nursing Delegation Total:						10898.76
Waiver Nursing Delegation- Assessment	Per assessment	2	6.00	50.83	609.96	
Waiver Nursing Delegation- Consultation	Hour	2	120.00	42.87	10288.80	
GRAND TOTAL: 84629199.94 Total Estimated Unduplicated Participants: 4000 Factor D (Divide total by number of participants): 21157.30 Average Length of Stay on the Waiver: 341						