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 §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 waivers 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:
Integrated Care Delivery System (ICDS) Waiver (MyCare Ohio) - 2024 Amendment

C. Waiver Number:OH.1035

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
09/03/24

Approved Effective Date of Waiver being Amended: 01/01/24

2. Purpose(s) of Amendment

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

ODM is filing the amendment to the Integrated Care Delivery System (MyCare Ohio) Waiver with the goal of making program updates and maintaining alignment with the other Nursing Facility Level of Care 1915(c) waivers with an effective date of September 3rd, 2024. The amendment proposes the addition of structured family caregiving services. This amendment proposal also incorporates OHCW proposed changes to services which can be self-directed and how those services are delivered. Finally, the waiver amendment proposes clarifying changes to waiver eligibility, qualifications to administer level of care assessments, and electronic visit verification.

Appendix B
Changes include clarifying the eligibility criteria for the waiver by specifying the type of monthly communication a member must engage in with their waiver service coordinator if they use waiver services annually rather than monthly. It also expands the provider types who can perform the initial level of care assessment to include licensed practice nurses and social worker trainees.

Appendix C
-Adds a new Structured Family Caregiving service
-Adds Self-Direction service delivery option to Home Care Attendant, Personal Care Aide, and Waiver Nursing
-Adds a new Self-Directed service called Self-Directed Goods and Services

Appendix E
Describes new processes for implementing services eligible for self direction identified in Appendix C. Procedural changes allow an additional route for individuals to utilize self-direction providing them greater clarity on details such as budget setting and authority, enrollment processes, background checks.

Appendix I
Clarifies the role of Ohio's electronic visit verification system in the flow of claims and billings.

Appendix J
Updates the J tables as a result of including additional services.

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**	
☐ **Appendix A Waiver Administration and Operation**	
☒ **Appendix B Participant Access and Eligibility**	B-6
☒ **Appendix C Participant Services**	C-1, C-2
☐ **Appendix D Participant Centered Service Planning and Delivery**	
☒ **Appendix E Participant**	

Component of the Approved Waiver	Subsection(s)
Direction of Services	
☐ Appendix F Participant Rights	
☐ Appendix G Participant Safeguards	
☐ Appendix H	
☒ Appendix I Financial Accountability	I-2
☒ Appendix J Cost-Neutrality Demonstration	J-2

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 §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*):

Integrated Care Delivery System (ICDS) Waiver (MyCare Ohio) - 2024 Amendment

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.024.02.02**

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 01/01/24

Approved Effective Date of Waiver being Amended: 01/01/24

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: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 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:

N/A

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 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:

N/A

○ **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 §1915(a)(1)(a) of the Act and described in Appendix I**
- ☒ **Waiver(s) authorized under §1915(b) of the Act.**

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

The 1915(b) waiver renewal was approved with a 1/1/2019 effective date and was submitted 9/29/23 for renewal, effective 1/1/24. Dual Eligible individuals living in the covered geographic area who do not choose an ICDS health plan will be passively enrolled in an ICDS plan that is selectively procured by CMS and the State of Ohio for both Medicare and Medicaid services. Dual Eligible individuals may opt out of the ICDS plan for Medicare, but will be mandatorily enrolled after the 60-day choice period for Medicaid benefits.

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

- ☒ **§1915(b)(1) (mandated enrollment to managed care)**
- ☐ **§1915(b)(2) (central broker)**
- ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
- ☒ **§1915(b)(4) (selective contracting/limit number of providers)**

- ☐ **A program operated under §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 §1915(i) of the Act.**
- ☐ **A program authorized under §1915(j) of the Act.**
- ☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity 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.

More than 275,000 Ohioans are currently enrolled in both Medicare and Medicaid, of which over 150,000 are enrolled in MyCare. Historically, the two programs were designed and managed with little connection to one another, and without a single point of accountability. The MyCare waiver is part of the the Integrated Care Delivery System (ICDS) demonstration through the Centers for Medicare and Medicaid Innovation (CMMI) designed to best meet the needs of members who are dually eligible by using a capitated managed care model that oversees the delivery of all medically necessary services. As part of the ICDS demonstration, Ohio is requesting to renew concurrent 1915(b)/(c) waivers in conjunction with the authority granted from CMMI to offer care to individuals with full dual eligibility for Medicare and Medicaid. Among other things, the 1915(c) ICDS Waiver will:

* Authorize home and community-based services (HCBS) not otherwise available through Ohio's Medicaid State plan for individuals who meet either a hospital or nursing facility level of care (LOC), thus enabling them to maximize their independence and live in settings of their choice.
* Waive §1902(a)(1) of the Social Security Act (statewideness) in order to furnish Medicaid HCBS only to those individuals who reside in the following counties: Fulton, Lucas, Ottawa, Wood, Lorain, Cuyahoga, Lake, Geauga, Medina, Summit, Portage, Stark, Wayne, Trumbull, Mahoning, Columbiana, Union, Delaware, Franklin, Pickaway, Madison, Clark, Green, Montgomery, Butler, Warren, Clinton, Hamilton and Clermont.
* Assure continuity of care by offering HCBS that are consistent with the services available in Ohio's three NF-based fee-for-service LOC waivers (i.e., the PASSPORT and Assisted Living waivers administered by the Ohio Department of Aging (ODA) and the Ohio Home Care waiver administered by the Ohio Department of Medicaid (ODM).
* Provide for participant-direction of selected HCBS.

The ICDS demonstration was implemented in March 2014 beginning with voluntary enrollment. Enrollment in selected regions began in April 2014. ODM competitively selected health plans that demonstrated an ability to effectively manage a comprehensive benefit package for Medicare and Medicaid enrollees.

If an individual is dually eligible and is residing in a participating county, they are mandated to enroll into the ICDS Plan through the 1915(b) waiver, as well as its accompanying 1915(c) waiver. The 1915(c) waiver reserves all slots for the 1915(b) enrollees. The 1915(c)waiver prioritized members who are dual eligible in the 1915(c) waiver's Appendix B.3.f and reserved capacity for individuals in the ICDS 1915(b) waiver.

Care Management and Waiver Service Coordination
Ohio's extensive experience administering HCBS waivers has demonstrated that the coordination of HCBS is extremely important to keeping an individual in the community. It has also been found that the relationship between the individual and his or her waiver service coordinator has a significant impact on outcomes. As a part of the ICDS demonstration, the individual is assigned both an ICDS plan care manager and a waiver service coordinator. The ICDS care manager leads and coordinates the individual's trans-disciplinary team and ensures overall coordination between acute care and waiver services. The waiver service coordinator is the waiver service expert who ensures that all functions under the waiver occur and ensures the health and welfare checks are made as needed for each individual.

Specific responsibilities of the ICDS plan care manager includes, but is not limited to, the following: serving as the accountable point of contact for the individual; identifying and negotiating roles and responsibilities for all team members; arranging for, or conducting, the comprehensive assessment; developing, implementing and monitoring the comprehensive care plan; directing all care management activities (e.g., delegating tasks to team members, completing the care gap analysis, and structuring the in-person contacts to ensure alignment with the care plan goals/interventions).

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 §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 §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. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ○ **No**
- ◉ **Yes**

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

☒ **Geographic Limitation.** A waiver of statewideness 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:

The ICDS Waiver will be limited to the following counties: Fulton, Lucas, Ottawa, Wood, Lorain, Cuyahoga, Lake, Geauga, Medina, Summit, Portage, Stark, Wayne, Trumbull, Mahoning, Columbiana, Union, Delaware, Franklin, Pickaway, Madison, Clark, Green, Montgomery, Butler, Warren, Clinton, Hamilton and Clermont.

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness 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 §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 in-patients 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 §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §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. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, 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 §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:

ODM makes it a priority to work with individuals, providers and advocates on issues related to the HCBS waivers it administers. ODM follows a protocol to advance-publish, and invite public comment on proposed new rules and rule amendments. Final rules are approved by a special committee comprised of Ohio legislators.

Public Notification and Public Input Process for a Waiver Renewal or Amendment

For each required public comment period, Ohio uses the following methods to notify the public of the opportunity to review and comment on a proposed waiver renewal or amendment:

Electronic Methods: Ohio posts a public notice, summary of the draft waiver and the draft waiver itself on the Ohio Department of Medicaid (ODM) website. ODM's contracted case management agencies and provider oversight contractor post public notices on their websites, which link to the ODM website. ODM also shares the link via email with its stakeholders.

The specific links used for public comment for this MyCare Ohio Waiver 2024 amendment were:
https://medicaid.ohio.gov/about-us/notices/mycare-amendment-07142023
https://medicaid.ohio.gov/about-us/notices/mycare-renewal-08292023

Non-electronic Methods: The local County Department of Job and Family Services offices 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 proposed waiver renewal or amendments. ODM also verbally informs stakeholders on the various workgroups it maintains or participates on.

For each required public comment period, Ohio provides five methods for the public to provide input on the proposed waiver renewal or amendment and/or request a non-electronic copy of the waiver renewal or amendment:

E-mail - Ohio has established a dedicated e-mail box: MyCarefeedback@medicaid.ohio.gov.

Written comments - Ohio also provides a U.S. Postal Service address, which is ATTN: MyCare Ohio Waiver, Ohio Department of Medicaid 4th Floor, P.O. Box 182709, Columbus, OH 43218.

Fax - Ohio provides a fax number, which is (614) 752-7701.

Toll-free phone number - Ohio provides a toll-free number, 1 (888) 433-6755, with a recorded message advising callers they have five minutes in which to leave to provide input.

Courier or in-person submission to: Attn: Ohio Department of Medicaid, MyCare Ohio Amendment, Lazarus Building, 50 West Town Street, Columbus OH 43218.

Below is a recap of the public comments received when the waiver renewal was completed effective January 1st, 2024.
Public Comment Summary for the Waiver Renewal July 2023 and August 2023

Date of the formal public comment period: July 14, 2023 through August 12, 2023 and August 29, 2023 through September 27,2023.

The state received three comments on the MyCare Ohio Waiver amendment during the first formal public comment period. The following are the comments received:
Appendix B:
Question: Regarding the change in requirement from one waiver service per month to annually if the following criteria are met; Will this require all 3 elements to be met or just one of the 3?
ODM Response: Thank you for the question. All three conditions will be required for the annual service option to be available. We will clarify this in the waiver document.

- Appendix D:

What action(s) on the part of the WSC would meet the expectation for WSC assuring that consumer/representative trains the providers to meet the consumer's health care needs and/or specifies additional training the provider must complete?
ODM Response: The WSC would use clinical judgement to determine what actions are needed to assure the member's needs will be met by the provider training. The training needed is member-centric.

Does the WSC responsibility to complete the initial LTSS assessment for individuals who present a need (ie CW) refer to the completion of the assessment at the point in time when consumer meets LoC? (Note - A WSC is not assigned prior to determination of LoC eligibility)
ODM Response: Thank you for the feedback. ODM will review this language and clarify the initial and ongoing assessment responsibilities.

During the second comment period, ODM received many comments about the legally responsible family member provisions. These are included in the "Optional" section.

ODM again received comments from one respondent regarding the use of only one PASSPORT Administrative Agency in area of the state.
ODM Response: While no changes were made to the waiver at this time, the State acknowledged the responder's comments and feedback. We noted that we will take this information into consideration as we look to expand the MyCare program state-wide.

Additional descriptions of ODM's efforts to solicit public input on the Appendix K updates are included in the "Optional" section.

Besides this formal public input process, ODM also engages affected stakeholders in advance by seeking input, advice and support for intended changes. Examples include, but are not limited to the following:

Ohio Olmstead Task Force and Breaking Silences Advisory Council
ODM meets periodically with the Ohio Olmstead Task Force and Breaking Silences Advisory Council to share information and solicit input. The committees are an important conduit for direct communication and involvement of individuals, caregivers and key stakeholders in the development of the structure, function, training components, oversight and administrative policies and procedures related to the MyCare Waiver.

Other Feedback Opportunities
ODM operates a Medicaid Consumer Hotline and an email box on its website to obtain ongoing feedback.

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: Wyatt

First Name: Jesse

Title: Chief

Agency: Ohio Department of Medicaid, Bureau of Long-Term Services and Supports

Address: 50 West Town Street, Fifth Floor

Address 2: P.O. Box 182709

City: Columbus

State: **Ohio**

Zip: 43218

Phone: (317) 612-4294 **Ext:** ☐ **TTY**

Fax: (614) 387-7661

E-mail: Jesse.Wyatt@medicaid.ohio.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Ohio**

Zip:

Phone: **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 §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:

Ohio is sensitive to the magnitude of the proposed changes and is committed to implementing the ICDS Waiver in a manner that allows for the safe transition of individuals, emphasizing continuity of care, and minimizing service disruption. As such, the ICDS plans will be required to adhere to specific transition requirements. The State has developed these requirements with the assistance of individuals and providers who voiced their concerns about continuity of care and risks to health outcomes if enrollment in the ICDS demonstration resulted in abrupt changes to care plans and providers.

Ohio projects there will be four groups of individuals who will meet the ICDS Waiver eligibility criteria and may each need special transition processes:

1. Individuals currently enrolled on the PASSPORT and Assisted Living Waivers administered by ODA; and individuals currently enrolled on the Ohio Home Care Waiver administered by ODM;

2. "Community Well" individuals participating in the ICDS demonstration who experience a significant change that presents a new need for LTSS;

3. Current NF residents who are transitioning into the community and have a need for LTSS; and

4. Individuals who are newly eligible for either or both Medicare and Medicaid, are otherwise eligible for the ICDS demonstration, and are enrolled on an HCBS waiver during their fee-for-service (FFS) Medicaid period before they are enrolled on an ICDS plan. Individuals who present a need for HCBS, prior to their enrollment in the ICDS program will receive services on a FFS basis until a plan selection is made.

It is anticipated that individuals in groups 2 and 3 will move directly onto the ICDS demonstration without a "transition period".

For individuals in groups 1 and 4, however, ICDS plans will be required to contract with each individual's established providers upon enrollment in the ICDS demonstration for the periods of time described below at the rate approved under the individual's currently approved waiver service plan. Additionally, each individual's service plan shall be updated to reflect the service nomenclature in this waiver utilizing the cross-walk in the Service Crosswalk located on the Optional Page of this application.

Transition Periods:

- Waiver personal care assistance, nursing, out-of-home respite, enhanced community living, adult day services, social work/counseling and community integration providers will be maintained for 365 days unless a change is required.

- All other waiver service levels will be maintained for 365 days, and providers will be maintained for 90 days.

Changes in Provider During Transition Periods:

Individuals may initiate a change in waiver service provider at any time. However, any change in services or service providers (initiated by either the individual or the ICDS plan) may occur only after an in-home assessment and the development of a plan for the transition to a new provider. In cases where the health and welfare of the individual is judged to be in danger, expedited service authorization time frames will apply per 42 CFR 438.210.

During the transition periods listed above, an ICDS plan-initiated change from an existing provider may occur in the following circumstances:

- The individual has a significant change in status as defined in Ohio Administrative Code (OAC) rule 5101:3-45-01;

- The provider gives appropriate notice of intent to discontinue services to an individual; or

- Provider performance issues that affect an individual's health and welfare are identified. If the ICDS plan detects a quality of care issue, the ICDS plan will work with the provider and individual to satisfactorily resolve the issues. If resolution is not possible, the ICDS plan will assist the individual in choosing a provider willing and able to comply with quality of care requirements.

Prior to the conclusion of the transition period, the individual shall meet with his/her waiver service coordinator and other trans-disciplinary care team members to review the current care plan and discuss any required changes in services or providers. If a change in HCBS provider is required for any reason, the individual will be provided information regarding other available

providers and an individualized transition plan will be developed and integrated into the comprehensive care plan.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

HCBS Settings Transition Plan

State’s Response

The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

PROGRAM DESCRIPTION (continued)

Specific responsibilities of the waiver service coordinator (who is directly employed by the ICDS plan or is employed through a contracted arrangement) include, but are not limited to, the following: the ongoing assessment of LTSS for individuals currently receiving waiver services; the LTSS level of care assessment for individuals who present a need (i.e., community well); waiver service plan development, review and updates; crisis intervention, event-based visits, provider monitoring to ensure member needs are met and assisting individuals with self-directed care. The waiver service coordinator is accountable to the ICDS plan care manager who is ultimately responsible for ensuring the appropriate development of the waiver service plan and its integration to the comprehensive plan of care.

Ohio recognizes both the right of the individual to choose his or her waiver service coordinator and the importance of the role entities in the state already play in the coordination of HCBS waiver services. Thus, in order to maintain continuity of care and assist in transitioning from a traditional fee-for-service environment to a managed care environment, the ICDS plans are required to contract with Area Agencies on Aging (AAA) to perform waiver service coordination for, at a minimum, those individuals age 60 and older. ICDS plans may also choose to subcontract waiver service coordination to additional entities that have experience working with people with disabilities and/or chronic conditions including, but not limited to, centers for independent living and disability-oriented case management agencies. The ICDS plans may also provide waiver service coordination themselves.

Individuals are given the right to choose from available entities that will provide waiver service coordination for traditional 1915(c) HCBS, as well as their specific waiver service coordinator. Individuals age 60 and older who do not choose a waiver service coordinator will be assigned a waiver service coordinator from the AAA.

ICDS plans are responsible for ensuring that members of the individual's trans-disciplinary team, including staff who are directly employed by the plan or a delegated entity who are completing care management activities, are appropriate for responding to and managing the individual's needs, and follow the State's licensure/credentialing requirements. ODM does not dictate minimum requirements for ICDS plan care managers, however they must have the skills necessary to coordinate the full array of services required by the individual. Waiver service coordinators are required to demonstrate at least one year of experience working with persons with disabilities/chronic conditions and LTSS. Depending on the structure of the ICDS plan's comprehensive care management program, the roles of the waiver service coordinator and the care manager may be filled by the same person. In this scenario, the minimum qualifications for the waiver service coordinator still apply.

ELIGIBILITY:

Ohio projects there will be four groups of individuals who will meet the ICDS Waiver eligibility criteria:

* Individuals currently enrolled on one of Ohio's five NF-based waivers (i.e., the PASSPORT, and Assisted Living Waivers administered by ODA; and individuals currently enrolled on the Ohio Home Care Waiver administered by ODM);

* "Community Well" individuals participating in the ICDS demonstration who experience a significant change that presents a new need for LTSS;

* Current NF residents who are transitioning into the community and have a need for LTSS; and

* Individuals who are newly eligible for either or both Medicare and Medicaid, are otherwise eligible for the ICDS demonstration, and are enrolled on an HCBS waiver during their fee-for-service (FFS) period before they are enrolled on an ICDS plan.

ENROLLMENT:

All capacity in this waiver is reserved for enrollees in the ICDS 1915(b) waiver and its associated ICDS plans.

WAIVER SERVICES:

The ICDS Waiver offers an array of services that are consistent with Ohio’s NF-based LOC waivers in order to assure continuity

of care for individuals transferring from one of those waivers to the ICDS Waiver. The full range of services are available to the individual based upon identified need, regardless of the waiver from which he or she transfers. A crosswalk of the services offered in Ohio's NF-based waivers and the ICDS Waiver is provided below:

- Assisted Living Services: encompasses Assisted Living Services found in the ALW (0446).

- Adult Day Health Services: encompasses Adult Day Health Services found in the OHCW (0337) and PASSPORT (0198) Waiver.

- Personal Care Services: encompasses Personal Care Services found in the OHCW and PASSPORT.

- Homemaker: encompasses Homemaker services found in PASSPORT.

- Home Medical Equipment and Supplemental Adaptive and Assistive Devices: encompasses Supplemental Adaptive and Assistive Devices found in OHCW; and Specialized Medical Equipment and Supplies found in PASSPORT.

- Home Modifications: encompasses Home Modifications found in OHCW and PASSPORT.

- Personal Emergency Response Services: encompasses Personal Emergency Response Services found in OHCW and PASSPORT.

- Home Delivered Meals: encompasses Home Delivered Meals found in OHCW and PASSPORT.

- Alternative Meals: encompasses Alternative Meals found in PASSPORT.

- Waiver Transportation: encompasses Supplemental Transportation found in OHCW; and Non-Medical Transportation found in PASSPORT.

- Waiver Nursing: encompasses Waiver Nursing found in OHCW and PASSPORT.

- Home Care Attendant Services: encompasses Home Care Attendant Services found in OHCW and PASSPORT.

- Out-of-Home Respite: encompasses Out-of-Home Respite found in OHCW and PASSPORT.

- Enhanced Community Living: encompasses Enhanced Community Living found in PASSPORT.

- Social Work Counseling: encompasses Social Work Counseling found in PASSPORT.

- Nutritional Consultation: encompasses Nutritional Consultation found in PASSPORT.

- Community Integration Services: encompasses Community Integration found in OHCW and PASSPORT.

- Community Transition: encompasses Community Transition found in OHCW and PASSPORT.

- Home Maintenance and Chore: encompasses Home Maintenance and Chore found in OHCW and PASSPORT.

- Structured Family Caregiving: encompasses Structured Family Caregiving found in OHCW and PASSPORT

FIREWALLS:

ODM works with the ICDS plans, and the entities responsible for conducting level of care assessments/reassessments, and for providing waiver service coordination and/or waiver services, to develop necessary firewalls to eliminate the possibility of any potential conflicts of interest regarding each entity's responsibilities under the ICDS Waiver.

Conflicts of interest are avoided and/or diminished within the ICDS Plans via a variety of safeguards.

Plans are required to attest that care managers and waiver service coordinators are not:

- Related by blood or marriage to the individual or any paid caregiver;
- Financially responsible for the individual;
- Empowered to make financial or health related decisions on behalf of an individual; and
- Providers of any HCBS services.

Additionally, consistent with Ohio's approved provider agreement, each plan must establish an advisory committee in each region in which they are contracted. The advisory committee must reflect the diversity of the ICDS enrollee population the plan is serving and must provide for meaningful input of individuals into program management issues.

Plans are also required to notify all individuals enrolled on the ICDS waiver at the time of their enrollment and at least annually (in writing and verbally) the process for filing grievances and appeals.

In addition, safeguards are utilized to ensure that consumer choice is honored in the service planning process by assuring that waiver service plans are developed with the individual in accordance with their stated preferences and by documenting that the individual was presented with the choice among in-network providers.

ODM engages in a variety of activities to insure individuals' rights are safeguarded including:

- Using state staff to monitor plan's efforts to detect over- and under-utilization of services as documented within the plan's quality assessment and performance improvement programs;
- Using state staff to review the number and types of appeals and grievances related to waiver service plan development/updates and/or long term care services and supports;
- Using the state contracted EQRO to review service planning activities;
- Administering a state-developed care management survey (in the first and third years of the demonstration) that evaluates the individuals' satisfaction and experience with care management services. This will include questions related to individuals' involvement in waiver service planning.

Because the ICDS plan/contracted waiver service coordinator and the ICDS plan care manager are not providers of direct service and do not make enrollment eligibility decisions, the state does not believe a conflict of interest exists.

However, since the AAAs, through their contractual relationship with ODM, will be performing level of care functions for the ICDS waiver as well as providing waiver service coordination, each AAA will be required to implement state developed firewalls to address conflicts of interest.

The state assures that the settings transition plan included with any waiver renewal or amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Public Comment Summary for the Waiver Renewal July 2023 and August 2023 additional details:

Date of the formal public comment period: July 14, 2023 through August 12, 2023 and August 29, 2023 through September 27, 2023.

Throughout the development of the Appendix K unwinding policies, the Ohio Department of Medicaid (ODM) engaged partner agencies for their continuous review and feedback. During bi-weekly meetings, ODM partnered with Ohio Department of Developmental Disabilities (DODD) and Ohio Department of Aging (ODA) to discuss drafted regulations.

To engage a wider population of providers and participants, ODM also held nine stakeholder webinars targeting Nursing Facility-Based Waiver participants, stakeholders and Case Management Entities, Developmental Disability-Based Waiver Participants and Stakeholders, and MyCare Plans. These webinars were attended by well over 1,000 individuals. During these webinars, ODM provided an overview of anticipated changes to flexibilities and solicited feedback. Additional webinars were held to provide additional information on a proposed draft rule and extraordinary care assessment tool for legally responsible family members and relatives to serve as direct care workers in Medicaid state plan and waiver programs. At these webinars, ODM solicited feedback and questions from attendees.

The state has continued to maintain active communication with stakeholders, through additional stakeholder engagement webinars, such as attending meetings with advocacy and provider groups, receiving informal and formal public feedback and comments to proposed rules and waiver amendments, etc.

Additionally, ODM developed an email address specifically to receive feedback from stakeholder and waiver participants and created a Home and Community Based Program listserv on Subscribe Form (ohio.gov), in which individuals may opt to receive communications regarding Appendix K unwinding activities. ODM has utilized this communication strategy to ensure the maximum amount of stakeholder participation and has had the opportunity to receive and consider feedback from organizations and stakeholders who likely would not otherwise become actively involved in this public feedback process.

General Comments and questions received during the first MyCare Ohio Waiver Renewal public comment period:
Comment: In the most recent biennial budget that was signed into law, MyCare's geographic limitations were removed and thus the program can be expanded to all 88 counties in Ohio. Therefore, ODM should drop the request of the waiver of state wideness and expand the program to all counties in January 2024 which would end the current bifurcated system of choice. Individuals will be empowered to make their own decisions on how health care is provided to them.
ODM Response: Thank you for the feedback. ODM is currently evaluating and planning for the MyCare Expansion. The waiver will need renewed with the current geographic limitations and will be amended for the implementation of the state-wide expansion.

Question: ODM has stated that the current MyCare program will be sunset and transitioned to a new FIDE program no later than January 2026. If that is still the plan, why did ODM request a 5-year waiver extension instead of a 3-year waiver extension? It appears that a 3-year waiver extension would be more appropriate since ODM will have to make major modification to the waiver for the launch of the new program in 2026.
ODM Response: ODM is currently working through the changes for the end of the MyCare Ohio Demonstration. There are many details pending, including the impact to the MyCare 1915c waiver. The decision to renew the waiver for five years will give us the option to renew or amendment the 1915c waiver when the program design is more complete.

During the second comment period, ODM received multiple comments.

A significant majority of public comments received were related to allowing legally responsible family members to serve as direct care workers in MyCare waiver programs. Feedback received has been incorporated throughout the development of Ohio Administrative Code (OAC) rule 5160-44-32 Home and community based medicaid waiver program provider and direct care worker relationships. The language contained within the waiver applications have been drafted in alignment with waiver technical guidelines and incorporate OAC rule draft 5160-44-32 for reference. Stakeholders will continue to have the opportunity to participate in the ongoing development of this and other HCBS waiver program rules throughout the stages of the state's legislative processes. The process governs the program rule development and legislative action needed to implement all proposed waiver amendment changes with an effective date of January 1, 2024.

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:

   The ICDS Waiver will be administered by the Ohio Department of Medicaid's Long-Term Service and Supports Bureau

   (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:

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:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

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 1915(b) ICDS Waiver authorizes mandatory enrollment in an ICDS plan for covered services. Through a three-way contract with CMS under a CMMI dual eligible integration demonstration, and a Medicaid provider agreement, the Ohio Department of Medicaid (ODM)(i.e., the State Medicaid Agency), oversees the ICDS plans as they manage Medicaid services, including acute care services and home and community-based services under this waiver. The ICDS plans pay for covered health services to enrolled qualified Medicaid providers furnishing services to individuals enrolled in Medicaid.

ODM is ultimately responsible for the oversight and day-to-day waiver operational and administrative functions performed by the ICDS plans in the waiver. However, the ICDS plans shall be responsible for:

- Coordination of waiver enrollment with the county department of job and family services
- Managing waiver expenditures against approved levels
- ICDS comprehensive care management
- Waiver service plan reviews
- Prior authorization of waiver services
- Utilization management
- Quality assessment and improvement activities
- Assuring the health and welfare of enrolled individuals
- Assuring that the policies and procedures established by ODM for the ICDS waiver are followed.

The ICDS plans, as part of their waiver administrative and operational responsibilities, shall:

- At the time of initial waiver enrollment, provide information to waiver participants about their rights and protections.
- Assure family/recipient awareness and freedom of choice for all available waiver services, including the right to select from among contracted providers.
- Resolve issues related to the enrolled individual’s health and safety and service delivery.
- Contract with a network of waiver service providers.
- Pay claims for authorized services furnished in accordance with the individual’s waiver service plan.
- Maintain a list of approved waiver service providers, recruit providers to address unmet needs, and provide training and technical assistance to providers contracted to provide waiver services.
- Provide utilization management through prior authorization and the review of paid claims data with follow-up as necessary.
- Quality management.
- Grievances and appeals.
- Provide or arrange for 24/7/365 care coordination and crisis response system.
- Conduct ongoing monitoring of contracted providers.

ODM also contracts with a single provider oversight vendor that is responsible for investigating critical incidents as set forth in Appendix G of the ICDS Waiver. The provider oversight contract was in place 7/1/13. Responsibilities include: performing incident management and investigation activities for the ICDS waiver. Required Activities include: providing a secure data repository and tracking system where all ICDS plans will report their data on incidents for ICDS waiver program individuals, providing the Office of Medical Assistance staff access to the system for reporting purposes, investigating incidents as specified by the Office of Medical Assistance for ICDS participants, including abuse, neglect, and death, developing prevention plans for incidents which they investigate, and reviewing prevention plans that are developed by the ICDS Plans.

Additionally the provider oversight contractor is responsible for monitoring provider compliance for the ICDS waiver. Required provider monitoring activities include: tracking and performing structural reviews of ODA-certified or ODM-approved providers who are providing services to individuals in the Integrated Care Delivery System waiver program and are not providers of services in the Ohio Home Care or any Ohio Department of Aging waiver program.

Provider oversight contractors must have a minimum of five years provider oversight and/or case management experience with community based services programs in the past ten years. Provider oversight conducted by the selected contractor is a comprehensive service comprised of a variety of specific tasks and activities including: performing incident management and investigation, operating an alerts process, managing provider non-compliance,

monitoring providers including structural reviews of providers, etc.

○ **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:

ODA and the State's PASSPORT Administrative Agencies(PAA) perform LOC determinations and redeterminations for individuals enrolled in waivers operated by ODA pursuant to a three-party agreement with ODM. Twelve of the PAAs are also Area Agencies on Aging (AAAs). PAAs will perform the LOC determinations and redeterminations for individuals enrolled in the ICDS Waiver. Additionally, in the ICDS Waiver, the PAAs will be responsible for entering pertinent waiver enrollment information into the State's eligibility system to trigger the Medicaid eligibility determination process.

The PAAs will have the capacity to perform the projected increase in the number of LOC determinations and redeterminations performed for the populations served by the ICDS Waiver in all of the counties served.

☐ **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:

ODM shall be responsible for assessing the performance of contracted ICDS plans, local/regional non-state entities, and case management and provider oversight contractors related to their involvement in conducting waiver operational and administrative functions.

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 State will employ a variety of methods to oversee the performance of those entities responsible for the ICDS Waiver's operational and administrative functions. These include:

- External Quality Review activities (e.g., participant satisfaction surveys, administrative reviews, performance improvement projects, etc.);
- Data Reporting and Analysis;
- Semi-Annual quality Briefings;
- Annual Review of Contracted Entities (site visit and desk review)
- Performance Measures; and
- Ongoing Review.

This waiver operates concurrently with the Ohio ICDS 1915(b) Waiver and is monitored consistent with the Quality Improvement Strategy described in both waivers.

Performance expectations and methods of evaluation and oversight by the State are also delineated in the contract between the ICDS plans and ODM. These contracts require that the ICDS plans report data to the State detailing various program administrative activities including, but not limited to, individual requests for services and access to care, the number of grievances and appeals, waiver enrollment and disenrollment figures, as well as certain waiver service coordination requirements such as compliance with contact schedules. Following the receipt and review of the information reported by the ICDS plans, the State may take corrective action, as needed, to assure compliance with state and federal requirements and to identify any necessary program changes.

In addition to the ICDS plans, as indicated in Appendix A,3 and A,4 the state will contract with a provider oversight contractor to perform a variety of tasks including: incident management and investigation, operating an alerts process (for incidents) and performing structural reviews of providers to monitor provider compliance with applicable conditions of participation. Ohio will also utilize the State's twelve Area Agencies on Aging to perform level of care evaluations for individuals in the ICDS. These entities perform important quality and program integrity functions, and the state will closely monitor and assess the quality of their work.

To assess the AAAs' performance, ODM will require that the AAAs report data to the State indicating the number of LOCs performed, the timeliness of those LOCs completed within 365 days, and the outcome of the LOCs conducted. This information will be submitted to ODM on a quarterly basis and analyzed by ODM. Should areas of noncompliance be identified, ODM will work with the AAAs to implement corrective action as needed. Additionally, through the on-going review process ODM will verify accuracy of level care determinations.

Monitoring, tracking and investigating critical incidents are essential to ensuring the health and welfare of individuals enrolled in the ICDS. As described in Appendix G, the State will utilize the provider oversight contractor in a variety of ways to monitor and investigate critical incidents as well as to evaluate the effectiveness of ICDS plans' interventions on behalf of individuals enrolled on the waiver. ODM will be an active participant in this process and provide oversight through regular meetings with the contractor in addition to quarterly reports submitted by the contractor according to the performance measures in the Appendix G quality improvement strategy.

In addition to monitoring and investigating critical incidents, the provider oversight contractor will perform structural compliance reviews of waiver providers serving individuals enrolled in the ICDS waiver. These reviews verify provider compliance with required conditions of participation. The frequency of the reviews varies based on the type of provider and the service they furnish. Additional information is provided in Appendix C of this waiver application regarding the frequency in which a review is conducted. ODM will require the oversight contractor to report information to the State on both the frequency and outcome of those reviews. This information will be used by ODM to identify provider trends and to determine if disciplinary action is needed on an individual provider basis. The State will review, on an ongoing basis, the performance of the provider oversight contractor, against the contract standards and state requirements. Minimally, this review will entail review of quarterly reports submitted to the State in accordance with the contractor's contract and pursuant to the performance measure in Appendix A of this waiver. Additionally, ODM will conduct an annual review of the provider oversight contractor that will include both an on-site visit and desk reviews.

Oversight of the concurrent waivers is performed by ODM. ODM's Bureau of Managed Care maintains a Compliance Assessment System that assures compliance with Medicaid program requirements for both the 1915(b) and (c) waivers. Identified areas of noncompliance are subject to sanctions including but not limited to corrective action plans, fines and

potential termination. ICDS plans are required to implement corrective action for any program violation whether identified by the plan or by ODM.

ODM will use the EQRO, as required by federal managed care regulations, to evaluate the ICDS plan's compliance with state and federal regulations. An Independent Assessment of the State will also be conducted in accordance with 1915(b) waiver requirements.

Lastly, ODM will also utilize the Ongoing Review to monitor compliance with waiver assurances. Through the Ongoing Review process ODM will use a standard tool that can be applied across systems to all waivers administered by ODM. For this waiver, the tool will be used to gather data to measure compliance and performance in regard to administrative authority and level of care assurances. This process includes record review and face-to-face interviews with waiver individuals. ODM selects a random sample of individuals each year, conducts reviews, and compiles the data for reporting and trend analysis. As part of this process, ODM conducts enough reviews to produce findings that can be reported with 95% confidence of being within a margin of +/- 5%.

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.*

Function	Medicaid 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 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	☒	☒	☐
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 States quality improvement strategy, provide information in the following fields to detail the States 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:
(5) Number and percent of required reports submitted by the ICDS plans in a complete and timely manner. Numerator: Number of required reports submitted by the ICDS plans in a complete and a timely manner. Denominator: Total number of required reports.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
ICDS plans

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: ICDS plans	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: As specified for each performance measure	

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:
(6) Number and percent of findings of ICDS plans' noncompliance that were remediated through an approved corrective action plan or other method as required by the ODM/ICDS provider agreement. Numerator: Number of findings of ICDS plans' non-compliance that were remediated as required by the ODM/ICDS provider agreement. Denominator: Number of findings of non-compliance of ICDS plans.

Data Source (Select one):
Trends, remediation actions proposed / taken
If 'Other' is selected, specify:
ICDS plans

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: As problems are detected	

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:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
(3) The number and percent of provider structural reviews due that were completed within required timeframes. Numerator: The number of provider structural reviews due that were completed within required timeframes. Denominator: The number of provider structural reviews that were required.

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: Provider oversight vendor and the Ohio Department of Aging	☒ **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:
(7) Number and percent of performance reports submitted by the level of care vendor in the correct format and in a timely manner. Numerator: Number of performance reports submitted by the level of care vendor in the correct format and in a timely manner. Denominator: Number of performance reports required to be submitted by the level of care vendor.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
Level of care vendor

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**	☐ **Annually**	☐ **Stratified**

Specify: Level of care vendor		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: As specified for each performance measure	

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:
(1) Percent of sampled ICDS Waiver participants reviewed each year who are verified to meet Level of Care eligibility requirements. Numerator: Number of ICDS waiver participants reviewed who are verified to meet level of care eligibility requirements. Denominator: Total number of participants reviewed.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:
Data from ODM Ongoing Review

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 = 95% within MOE +/- 5%
☐ **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:
(2) Number and percent of ICDS Waiver participants reviewed who had their level of care determined or redetermined within the past 12 months. Number of ICDS waiver participants who had their level of care determined or re-determined within the past 12 months. Denominator: Number of ICDS waiver participants who required a LOC determination or redetermination within the past 12 months.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
ODM Ongoing Review

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 = 95% within MOE of +/- 5%
☐ **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:
(4) The number and percent of reported ICDS Waiver participant incidents investigated by the provider monitoring vendor that were found to have been resolved. Numerator: Number of reported incidents investigated by the provider monitoring vendor that were found to have been resolved. Denominator: Total number of reported incidents invesitgated by the provider monitoring vendor.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
ODM Ongoing Review

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 = 95% within MOE of +/- 5%
☐ **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.

ODM reviews reports from the ICDS plans and AAAs. The ICDS plans also provide ODM with updates on waiver quality processes and HCBS issues as they arise.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Oversight of the concurrent waivers is performed by ODM. ODM's Bureau of Managed Care maintains a Compliance Assessment System that assures compliance with Medicaid program requirements for both the 1915(b) and (c) waivers. ODM will compile, trend and review analyzed data gathered through the QIS processes detailed in this waiver application.

Individual remediation will occur on a case-by-case basis. Should the State, upon reviewing aggregated and analyzed data, determine that systemic deficiencies exist the State will require corrective action. Identified areas of noncompliance are subject to sanctions including but not limited to corrective action plans, fines and potential termination. ICDS plans are required to implement corrective action for any program violation, whether identified by the plan or by ODM.

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 SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					
	☒	**Aged**	65		☒
	☒	**Disabled (Physical)**	18	64	
	☐	**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**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

To be eligible for enrollment in the ICDS Waiver, an individual must reside in one of the following ICDS counties in Ohio: Fulton, Lucas, Ottawa, Wood, Lorain, Cuyahoga, Lake, Geauga, Medina, Summit, Portage, Stark, Wayne, Trumbull, Mahoning, Columbiana, Union, Delaware, Franklin, Pickaway, Madison, Clark, Green, Montgomery, Butler, Warren, Clinton, Hamilton and Clermont.

The individual must also be determined to have a NF-based LOC (intermediate or skilled) pursuant to rule 5101:3-3-08 of the Ohio Administrative Code (OAC), and need at least one ICDS Waiver service monthly.

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:

Once an individual who is disabled reaches the maximum age limit in Appendix B.1.a, he or she transitions into the aged target group and continue enrollment on the ICDS waiver. As indicated in Appendix B.1.a there is no maximum age limit for the target group.

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 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:

Appendix B: Participant Access and Eligibility

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

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

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:

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:

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	40921
Year 2	40921
Year 3	40921
Year 4	40921
Year 5	40921

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

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

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
Reserved Capacity for Eligible Waiver Individuals with Spouse/Parent/Legal Guardian Who is Active Duty Military and Transferred to Ohio
Individuals Enrolled on the 1915(b) ICDS Waiver

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):*

Reserved Capacity for Eligible Waiver Individuals with Spouse/Parent/Legal Guardian Who is Active Duty Military and Transferred to Ohio

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 Ohio Home Care Waiver is projected at 25 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	25
Year 2	25
Year 3	25
Year 4	25
Year 5	25

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):*

Individuals Enrolled on the 1915(b) ICDS Waiver

Purpose *(describe):*

The State is reserving participant capacity of the ICDS waiver for only those individuals meeting targeting and level of care criteria who are enrolled in the ICDS 1915(b) waiver and its associated ICDS plans.

Describe how the amount of reserved capacity was determined:

All slots in this waiver are reserved for members of the 1915(b) ICDS Waiver who meet the targeting criteria and level of care criteria for this 1915(c) Waiver.

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

Waiver Year	Capacity Reserved
Year 1	40921
Year 2	40921
Year 3	40921
Year 4	40921
Year 5	40921

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:

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

The ICDS Waiver provides for the entrance of all eligible persons. To be eligible for enrollment in the ICDS Waiver, the individual must be enrolled in the 1915(b) waiver. The individual must also be determined to have a NF-based LOC (intermediate or skilled) pursuant to rule 5160-3-08 of the Ohio Administrative Code (OAC), and need at least one ICDS Waiver service monthly. No cost limits will be applied when determining eligibility for the ICDS Waiver.

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)*:

- (●) **§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)

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **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 §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §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 §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)**
- [x] **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:

42 CFR 435.210

42 CFR 435.110

42 CFR 435.116

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, 2019 (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 §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 §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §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 periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under §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 §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 (SSI 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 §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 periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

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:

◉ **Other**

Specify:

For individuals enrolled in the waiver and receiving any waiver service, except for the assisted living service, the formula for the allowance for the personal needs of the waiver participant is 65% of 300% of SSI. For individuals enrolled in the waiver and receiving the assisted living service, the standard is the current SSI benefit for the duration of time in which they receive assisted living services.

The county department of job and family services will determine patient liability. For those individuals who have a patient liability, the state will communicate to the ICDS plan the person's name and the amount of liability. Individuals enrolled on this waiver will be responsible for remitting their patient liability to their waiver providers. For individuals who have selected the Area Agency on Aging (AAA) to provide waiver service coordination, the individual will remit their patient liability amount to the AAA for collection.

The capitation rates calculated for the ICDS includes a long term services and supports (LTSS) component. When the capitation rates were developed, the LTSS long-term care component was calculated with consideration given to patient liability as a possible source of funds used to pay a portion of the services provided through the waiver.

This component of the capitation rate is available only for individuals who have been assessed to need long-term services and supports. With that requirement in place, the State can isolate the amount of the capitation rate paid to the ICDS plans that applies to an individual's LTSS services. As a result, the State is able to monitor and apply any income remaining after deductions are calculated through the post-eligibility treatment of income process towards the cost of the LTSS component of the capitation payment made to an ICDS plan.

In accordance with CMS' guidance, neither providers nor the AAAs shall collect patient liability from an individual in an amount that exceeds the LTSS component of the capitation rate certified by the State's actuary.

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 §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 periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

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 periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §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 §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:
- ◉ **Other**

  Specify:

  For all individuals except for those transitioning from the Assisted Living Waiver, the standard is 65% of 300% of SSI. For individuals transitioning from the Assisted Living Waiver, the standard is the current SSI benefit.

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:

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 five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

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 five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

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 five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §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: 1

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 individual must have a need for continuous nursing services more than four hours in length, and at least one waiver service annually, and monthly monitoring of the individual's health and welfare through a combination of telephonic and in-person contacts with the case manager, and agrees to cooperate with the monthly monitoring, the need for monitoring must be specified in the person's service plan and its performance recorded in the waiver record.

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 a government agency under contract with the Medicaid agency.**

Specify the entity:

- ◉ **Other**

Specify:

Evaluations for Level of Care

Individuals enrolling in the ICDS Waiver directly from one of Ohio's three NF-based waivers will carry their level of care determination with them for the period it would have been effective in their previous waiver, absent a change of condition. This will also include those individuals who are newly eligible for either or both Medicare and Medicaid, are otherwise eligible for the ICDS demonstration, and are enrolled on one of the three NF waivers during their fee-for-service (FFS) period immediately preceding their enrollment on an ICDS plan.

The State will, through the interagency agreement, designate the PAAs to perform LOC determinations and redeterminations for individuals enrolled in the ICDS waiver who, prior to enrollment, did not present a need for HCBS.

The PAAs will perform both LOC determinations and redeterminations for "Community Well" individuals participating in the ICDS demonstration who experience a significant change that presents a new need for LTSS, and for current NF residents who are transitioning into the community and have a need for LTSS.

Reevaluations for Level of Care

LOC redeterminations will be performed outside of the ICDS by the PAAs for all individuals enrolled in ICDS. These redeterminations will be conducted annually or more frequently for individuals who experience a significant change in condition requiring adjustments to service plans.

The county departments of jobs and family services, county government agencies under contract with the Medicaid agency, are responsible for determining final waiver program eligibly criteria are met.

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:

Must be employed by the county department of job and family services, county government agencies under contract with the Medicaid agency.

Registered Nurses (RN), Licensed Practical Nurses (LPN), Social Workers (LSW or LISW), and Social Work Trainee (SWT) licensed to practice in the State of Ohio complete the initial level of care evaluation for waiver applicants. All RN and LPNs are licensed by the Ohio Board of Nursing and all social workers and SWT are licensed by the Counselor, Social Worker, Marriage and Family Therapists Board to practice in Ohio. The PAAs verify the current licensure status of applicants during the hiring process and PAAs provide training to enable staff to be certified by ODA as assessors/case managers. ODA reviewers verify that this activity has been completed during biennial reviews that include a review of personnel qualifications.

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 either the intermediate level of care (ILOC) or skilled level of care (SLOC) criteria set forth in Ohio Administrative Code rule 5160-3-08.

The level of care for an individual seeking ODM-administered nursing facility-based ICDS waiver services is determined through use of the ODM form 3697 Ohio Department of Medicaid Level of Care Assessment tool for individual of all ages within the spectrum of the ICDS waiver.

The ILOC criteria for individuals is met when long-term services and supports needs exceed the criteria for the protective level of care. The ILOC criteria includes skilled nursing service needs, skilled rehabilitation service needs, ADL assistance needs, assistance with medication self-administration, and the need for twenty-four hour support in order to prevent harm due to a cognitive impairment and can be met in one of the following ways:

- Assistance with a minimum of at least two ADLs.
- Assistance with a minimum of at least one ADL and assistance with medication self-administration.
- A minimum of at least one skilled nursing service or skilled rehabilitation service.
- Twenty-four hour support in order to prevent harm due to a cognitive impairment.

The SLOC criteria for individuals are met when their long-term services and supports needs exceed the criteria for the intermediate level of care or the developmental disabilities level of care. They must have an unstable medical condition and either one skilled nursing service need at least seven days per week or one skilled rehabilitation service need at least five days per week.

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:

In the ICDS waiver program, the State will accept the LOC determined for an individual entering the ICDS from an existing CMS-approved HCBS waiver for eligibility and enrollment in the ICDS waiver.

Once an individual is enrolled in the ICDS waiver, his or her LOC will be redetermined annually, per state and federal requirements, by a PAA. The PAAs will also be responsible for determining the LOC of individuals enrolled in the ICDS who, prior to their enrollment in the demonstration, did not have a need for HCBS services.

The PAAs will employ licensed RNs, LSWs or LISWs to conduct in-person interviews with each waiver applicant and/or his or her authorized representative. The LOC assessment will be completed using the ODM form 3697 Ohio Department of Medicaid Level of Care Assessment tool.

Once the LOC determination/redetermination is completed, the PAAs will communicate the results of the determination with the individual, ODM and the ICDS plan selected by the individual. The information gathered through this process will inform ICDS waiver service plan development. The individual is informed of his or her hearing/appeals rights in accordance with OAC Rule 5101:6 at the time the determination is made.

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):*

Tracking of LOC due dates will occur at the ICDS plan. They will also be tracked by the PAAs for individuals enrolled on the ICDS waiver.

The PAAs will be required to submit quarterly performance reports that include timeliness data. ODM will also require, as an element of its comprehensive care management of individuals enrolled, the ICDS plan selected by the individual track LOC due dates and engage in ongoing dialogue with the PAAs and ODM to ensure the timeliness of LOC determinations/redeterminations.

ODM will review the LOC reports submitted by the PAAs and any additional information on timeliness provided by the ICDS plans. ODM does this to determine if the PAAs are achieving performance benchmarks. Should deficiencies be identified, ODM may require corrective action, or if necessary, initiate sanctions.

Timeliness of LOC determinations/redeterminations will also reviewed by ODM staff during ongoing and annual site reviews.

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:

Documentation of all LOC evaluations and reevaluations is maintained by the PAAs, as well as by the ICDS plans, 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 States quality improvement strategy, provide information in the following fields to detail the States 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:
(1) Number and percent of new ICDS Waiver participants who had a level of care indicating a need for institutional level of care prior to receipt of waiver services. Numerator: Number of LOC detereminations made for new ICDS participants indicating a need for institutional LOC prior to receipt of waiver services. Denom: Total number of initial LOC determinations made for new waiver participants.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
Data from the level of care vendor

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 = 95% within MOE of +/- 5%
☒ **Other** Specify: Level of care vendor	☐ **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:

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.

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:
(1) The number and percent of sampled ICDS Waiver participants whose initial level of care determinations were completed with ODM-approved processes and instruments. Numerator: Number of initial level of care determinations reviewed that were completed with ODM approved processes and instruments. Denominator: Number of initial level of care determinations reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
ODM Ongoing Review

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 = 95% within MOE of +/- 5%
☐ **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:
(2) The number and percent of sampled ICDS Waiver participants whose reassessment of level of care were completed with ODM-approved processes and instruments. Numerator: Number of level of care reassessment determinations reviewed that were completed with ODM approved processes and instruments. Denominator: Number of level of care reassessment determinations reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
ODM Ongoing Review

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 = 95% within MOE of +/- 5%
☐ **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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **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 reviews reports from the ICDS plans and PAAs. The ICDS plans also provide ODM with updates on waiver quality processes and HCBS issues as they arise.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Oversight of the concurrent waivers is performed by ODM. ODM's Office of Managed Care maintains a Compliance Assessment System that assures compliance with Medicaid program requirements for both the 1915(b) and (c) waivers. ODM will compile, trend and review analyzed data gathered through the QIS processes detailed in this waiver application.

Should the State, upon reviewing aggregated and analyzed data, determine that deficiencies exist, the State will require the LOC vendor to address those deficiencies. The State will require individual remediation and offer technical assistance that may include plans of correction to ensure compliance.

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 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).

An individual participating in the State's ICDS demonstration will receive a member handbook or evidence of coverage (EOC) from his or her selected ICDS plan at the time of enrollment. The handbook/EOC will include information about waiver services and enrollment. The individual will also receive a copy of the handbook/EOC or be provided with information about individual choice at the time of annual reassessment. The handbook/EOC details feasible alternatives that are available to the individual, including the option to receive waiver services or institutional care. It also informs the individual of his or her right to request a state hearing. An individual enrolling in the ICDS waiver must sign an agreement documenting his or her choice of waiver services in lieu of institutional services. This agreement can be made available to CMS upon request.

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.

Documentation of Freedom of Choice forms is maintained by the individual's selected ICDS plan in accordance with state and federal regulations.

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 will have access to language resources at the county, state and ICDS plan levels at the time of application and upon enrollment. County departments of job and family services (CDJFS) will make translators available as early as at the time of initial application for assistance; numerous ODJFS forms are available in several languages; and ODJFS contracts with an entity that offers “near-instant interpretation services” in as many as 110 different languages.

The ICDS plan must comply with ODM requirements for providing assistance to LEP members and eligible individuals. In addition, the ICDS plan must provide written translations of certain ICDS plan materials in the prevalent non-English languages of members and eligible individuals in accordance with the following:

If ODM identifies that five percent or more of the eligible individuals in the ICDS plan’s service area have a common primary language other than English, the ICDS plan must translate all ODM-approved marketing materials into the primary language of that group and make these marketing materials available to eligible individuals.

When five percent or more of an ICDS plan's members in the ICDS plan’s service area have a common primary language other than English, the ICDS plan must translate all ODM-approved member materials into the primary language of that group. The ICDS plan must monitor its membership and conduct a quarterly assessment to determine which, if any, primary language groups meet the five percent threshold. When the five percent threshold is met, the ICDS plan must report this information to ODM, in a format as requested by ODM, translate their member materials, and make these materials available to their members. ICDS plans must submit to ODM, upon request, its prevalent non-English language member analysis and the results of this analysis.

The ICDS plan must utilize a centralized database which records the special communication needs of all ICDS plan members, including those individuals enrolled on the ICDS waiver, and the provision of related services. ICDS plans shall also provide assistance to hearing-impaired, vision-impaired, Limited Reading Proficiency, and LEP members and eligible individuals pursuant to OAC rules.

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	**Adult Day Health**		
Statutory Service	**Homemaker**		
Statutory Service	**Personal Care**		
Other Service	**Alternative Meals Service**		
Other Service	**Assisted Living Service**		
Other Service	**Choices - Home Care Attendant Service**		
Other Service	**Community Integration Service**		
Other Service	**Community Transition Service**		
Other Service	**Enhanced Community Living Service**		
Other Service	**Home Care Attendant**		
Other Service	**Home Delivered Meals**		
Other Service	**Home Maintenance and Chore**		
Other Service	**Home Medical Equipment and Supplemental Adaptive and Assistive Device Services**		
Other Service	**Home Modification**		
Other Service	**Nutritional Consultation**		
Other Service	**Out-of-Home Respite**		
Other Service	**Personal Emergency Response System**		
Other Service	**Self-directed goods and services**		
Other Service	**Social Work Counseling**		
Other Service	**Structured Family Caregiving Services**		

Service Type	Service
Other Service	Waiver Nursing
Other Service	Waiver Transportation

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:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04050 adult day health
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Adult Day Health Services (ADHS) are regularly scheduled services delivered at an ADHS center to individuals age eighteen or older. Services are provided in a non-institutional, community-based setting. The ADHS provider may provide waiver nursing and/or personal care services. The provider must also furnish recreational and educational activities to support individual health and independence. Providers must also furnish at least one meal, but no more than two meals, per day that meet the individual's dietary requirements. The ADHS center may also make available skilled therapy services and transportation of the individual to and from ADHS center.

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

*ADHS do not duplicate coverage provided under the State plan and EPSDT services are not duplicated

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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	Adult Day Center, Social Service Agency, Nursing facilities, Community Action Agency, Churches Medicare-certified HHA; ACHC-, CHAP- or Joint Commission-accredited agency.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Adult Day Center, Social Service Agency, Nursing facilities, Community Action Agency, Churches Medicare-certified HHA; ACHC-, CHAP- or Joint Commission-accredited agency.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers furnishing services in the ICDS waiver will be required to adhere to the following requirements as outlined in the Ohio Administrative Code:

ODA certified provider:
Compliance with OAC chapters 5160-44, 173-39, including 173-02

ODM approved provider:
Compliance with OAC Chapters 5160-44, 5160-45, and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODA or its designee for ODA-certified providers.
ODM or its designee for ODM-approved providers.
The ICDS plan will verify that the provider has an active Medicaid provider agreement and is eligible to furnish this waiver service.

Frequency of Verification:

ODM: Verification of provider qualifications is conducted in accordance with OAC 5160-45-06.
ODA: Verification of provider qualifications is conducted in accordance with OAC 173-39-04

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:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08050 homemaker
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Homemaker services consist of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemaker service providers shall meet such standards of education and training as are established by the State for the provision of these activities.

Homemaker service providers may also help the individual manage personal appointments, day-to-day household activities, and to ensure that the individual maintains his/her current living arrangement by acting as a travel attendant.

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**

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	Home Health Agency, Social Service Agency, Hospitals

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Home Health Agency, Social Service Agency, Hospitals

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ODA certified provider:
Compliance with OAC chapters 5160-44 and 173-39, including 173-39-02.8

Verification of Provider Qualifications

Entity Responsible for Verification:

ODA or its designee for ODA-certified providers

The ICDS plan will verify that the provider has an active Medicaid provider agreement and is eligible to furnish this waiver service.

Frequency of Verification:

ODA - Verification of provider qualifications is conducted in accordance with OAC 173-39-04

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):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

The service furnishes hands-on assistance with activities of daily living (ADLs) in the home and in the community. Tasks include: Bathing, dressing, grooming, nail care, hair care, oral hygiene, shaving, deodorant application, skin care, foot care, feeding, toileting, assisting with ambulation, positioning in bed, transferring, range of motion exercises, and monitoring intake and output.

The service also furnishes hands-on assistance with instrumental activities of daily living (IADLs) in the home and in the community that are incidental to the provision of the hands-on assistance with ADLs, but may not comprise the entirety of the service. Tasks include: general homemaking activities including, but not limited to: meal preparation and cleanup, laundry, bed-making, dusting, vacuuming, washing floors and waste disposal;

The service does not include: tasks performed by a licensed health professional, including skilled or nursing care.

While the waiver personal care service and state plan home health aide service have some interventions in common, the two services are authorized for different purposes.

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

Personal Care Aide Services are intended to complement, not replace, similar services available under the Medicaid State Plan. They do not duplicate coverage provided under the State plan, including EPSDT services. They do not include tasks performed, or services provided as part of the home maintenance and chore services included in this waiver. They shall not be used in lieu of the Medicaid State Plan home health benefit when it has been determined the individual meets the eligibility criteria to receive that benefit as defined in Rule 5160-12-01 of the Administrative Code. Personal Care Aide Services shall not be authorized as an alternative when the individual refuses to utilize Medicaid home health benefits they have been determined eligible to receive. In these instances, the waiver service coordinator is responsible for assisting the individual in assessing the risks associated with their decisions and exploring options for meeting the individual's identified needs.

Personal Care Aide Services and the provider of such services must be identified on the person-centered service plan. Personal Care Aide Services do not include services performed in excess of the number of hours approved pursuant to the person-centered service plan.

If the provider cannot perform IADLs, the provider must notify ODM or the waiver service coordinator in writing of the service limitations before inclusion on the individual's person-centered service plan.

*Personal Care Aide Services do not duplicate coverage provided under the State plan and EPSDT services are not duplicated.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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	Home Health Agency, Social Service Agency, Hospitals,
Individual	Self-directed caregiver
Agency	Medicare-certified home health agency; ACHC-, CHAP- or Joint Commission-accredited agency
Individual	Qualified consumer-employed provider
Individual	Non-agency employed personal care aide

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Home Health Agency, Social Service Agency, Hospitals,

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ODA certified provider:

Compliance with OAC chapters 5160-44 and 173-39, including 173-39-02.11.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODA or its designee for ODA-certified providers
The ICDS plan will verify that the provider has an active Medicaid provider agreement and is eligible to furnish this waiver service.

Frequency of Verification:

ODA - Verification of provider qualifications is conducted in accordance with OAC 173-39-04.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Individual

Provider Type:

Self-directed caregiver

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

FMS enrolled self-directed caregiver.

Compliance with OAC chapters 5160-44 and 5160-45, as well as 5160-46-04.

As designated by the member-employee and agreed to by the self-directed caregiver, qualifications include:
1. Certificate of completion within the last 24 months for either a competency evaluation program or training and competency evaluation program approved or conducted by the Ohio Department of Health in accordance with section 3721.31 of the Revised Code; or
2. the Medicare competency evaluation program for HHAs as specified in 42 CFR 484.80; or
3. another equivalent training program that includes training in the following areas:
*Personal Care Aide Services;
*Basic home safety; and
*Universal precautions for the prevention of disease transmission, including hand-washing and proper disposal of bodily waste and medical instruments that are sharp or may produce sharp pieces if broken.
*First aid certification; or
4. other training as designated by the individual employer and documented on the written agreement in accordance with rule 5160-45-03.2. If the only training received is individual-specific, the self-directed caregiver must be trained by each individual who chooses them as a caregiver.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMS will verify that the self-directed caregiver is currently enrolled with ODM as a waiver personal care aide or has met the criteria for a personal care aide as defined above and verifies the self-directed caregiver is eligible to furnish this waiver service in accordance with 5160-46-04 of the Administrative Code.

Frequency of Verification:

FMS initially completes verification of self-directed caregiver qualifications and as needed or requested by the individual employee.

Additionally, ODM verifies self-directed caregiver qualifications in accordance with OAC 5160-45-03.2 within the first twelve to twenty-four months of service and then at least every three years. Self-directed caregiver reviews are conducted by the individual with support from ODM's provider oversight contractor and assess caregiver performance, including compliance with the conditions of participation outlined in rule 5160-4-31 of the Administrative Code.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Medicare-certified home health agency; ACHC-, CHAP- or Joint Commission-accredited agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

ODM approved provider:

Medicare-certified HHA; ACHC-, CHAP- or Joint Commission-accreditation

Other Standard *(specify):*

ODM approved provider:
Compliance with OAC Chapters 5160-44, 5160-45, and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM or its designee for ODM-approved providers
The ICDS plan will verify that the provider has an active Medicaid provider agreement and is eligible to furnish this waiver service.

Frequency of Verification:

ODM - Verification of provider qualifications is conducted in accordance with OAC 5160-45-06

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Individual

Provider Type:

Qualified consumer-employed provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ODA certified provider:

Compliance with OAC chapters 5160-44 and 173-39, including 173-39-02.11
Consumer

Verification of Provider Qualifications

Entity Responsible for Verification:

ODA or its designee for ODA-certified providers
The ICDS plan will verify that the provider has an active Medicaid provider agreement and is eligible to furnish this waiver service.

Frequency of Verification:

ODA - Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Individual

Provider Type:

Non-agency employed personal care aide

Provider Qualifications

License *(specify):*

Certificate *(specify):*

ODM Approved Providers:

Certificate of completion within the last 24 months for either a competency evaluation program, or training and competency evaluation program approved or conducted by the Ohio Department of Health in accordance with section 3721.31 of the Revised Code; or the Medicare competency evaluation program for HHAs as specified in 42 CFR 484.36; or another equivalent training program that includes training in the following areas:

*Personal Care Aide Services;
*Basic home safety; and
*Universal precautions for the prevention of disease transmission, including hand-washing and proper disposal of bodily waste and medical instruments that are sharp or may produce sharp pieces if broken.

First aid certification.

Other Standard *(specify):*

ODM Approved Providers:
Compliance with OAC Chapters 5160-44, 5160-45, and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM or its designee for ODM-approved providers
The ICDS plan will verify that the provider has an active Medicaid provider agreement and is eligible to furnish this waiver service.

Frequency of Verification:

ODM - Verification of provider qualifications is conducted in accordance with OAC 5160-45-06

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:

Alternative Meals Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

The alternative meals service assists the individual with procuring one to two nutritious meals per day. Alternative meals service offers the individual the option to obtain meals from non-traditional providers, such as restaurants.

Alternative meals are not meals served at an Adult Day Center. Unlike the agency-based home delivered meals service, the alternative meals service is a self-directed service.

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**

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	Restaurants, Senior Centers, Social service agency, Churches

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Alternative Meals Service

Provider Category:

Agency

Provider Type:

Restaurants, Senior Centers, Social service agency, Churches

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers furnishing services in the ICDS waiver will be required to adhere to the following requirements as outlined in the Ohio Administrative Code.

ODA certified provider:
Compliance with OAC chapters 5160-44 and 173-39, including 173-39-02.02

Verification of Provider Qualifications

Entity Responsible for Verification:

ODA or its designee for ODA certified providers

The ICDS plan will verify that the provider has an active Medicaid provider agreement and is eligible to furnish this waiver service.

Frequency of Verification:

ODA - Verification of provider qualifications is conducted in accordance with OAC 173-39-04.

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:

Assisted Living Service

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
02 Round-the-Clock Services	02013 group living, other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

The service furnishes 24-hour on-site response capability, personal care, supportive services (homemaker and chore), and the coordination of the provision of three meals a day and snacks.

Nursing and skilled therapy services are incidental, rather than integral, to the provision of the assisted living service. Required nursing services include health assessment and monitoring, medication management including medication administration, and the delivery of part-time intermittent nursing and skilled nursing up to the maximum allowed in Ohio Administrative Code (OAC) Rule 3701:17-59 and 3701-17-59.1, when not available through a third party.

The scope of the service does not include 24-hour skilled care, one-on-one supervision, or the provision of items of comfort or convenience, disposable medical supplies, durable medical equipment, prescription medications or over the counter medications.

Individuals reside in single occupancy living units with full bathrooms in a setting that provides supervision and staffing to meet planned and unscheduled needs. The individual is required to pay the room and board obligation directly to the provider. The maximum room and board payment the provider may collect is established in OAC 5160-33.

Shared occupancy of a living unit is only permitted under these circumstances:
- The waiver participant requests the double occupancy at the time of the assessment AND
- There is an existing relationship between the waiver participant and the individual.

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

The service is limited to one unit per calendar day.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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	Residential Care Facility

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assisted Living Service

Provider Category:

Agency

Provider Type:

Residential Care Facility

Provider Qualifications

License *(specify):*

Ohio Department of Health Residential Care Facility (RCF) License per Ohio Administrative Code rules 3701-16-01 through 3701-16-18.

Certificate *(specify):*

Other Standard *(specify):*

Providers furnishing services in the ICDS waiver will be required to adhere to the following requirements as outlined in the Ohio Administrative Code.

ODA certified provider:
Compliance with OAC chapters 5160-44 and 173-39, including 173-39-02.16.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODA or its designee for ODA-certified providers

The ICDS plan will verify that the provider has an active Medicaid provider agreement and is eligible to furnish this waiver service.

Frequency of Verification:

ODA - Verification of provider qualifications is conducted in accordance with OAC 173-39-04

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:

Choices - Home Care Attendant Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

The Choices - Home Care Attendant Service consists of supportive activities specific to the needs of a medically stable, disabled adult, which are designed to address ADL and IADL impairments. Choices Home Care Attendant substitutes for the absence, loss, diminution or impairment of a physical or cognitive function and may include one or more of the following types of activities:

1) Personal Care including: assistance with bathing, dressing, and grooming, caring for nail, hair and oral hygiene, shaving, deodorant application, skin care with lotions and/or powders, foot care and ear care, feeding, assistance with elimination, assistance with ambulation, changing position in bed, assistance with transfers, normal range of motion, and adequate nutrition and fluid intake;

2) General Household Activities including: planning, preparation and clean-up of meals, laundry, bed making, dusting, vacuuming, shopping and other errands, replacing furnace filters, waste disposal, seasonal yard care and snow removal, and other routine household maintenance activities and other routine household chores;

3)Heavy Household Chores including: washing floors, windows, and walls, tacking down loose rugs and tiles, moving heavy items or furniture to provide safe access and egress, and other heavy household activities;

4) Assistance with money management and correspondence;

5) Escort services and transportation to enable consumers to gain access to waiver and other community services, activities, and resources. This activity is offered in addition to medical transportation available under the State Plan and does not replace it. Whenever possible, other sources will be utilized.

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

This service cannot be used concurrently with personal care services.

Home Care Attendant Services do not duplicate coverage provided under the State plan and EPSDT services are not duplicated.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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
Agency	Home Health Agency, Social Service Agency, Hospitals

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Choices - Home Care Attendant Service

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

Motor Vehicle (as needed)

Certificate *(specify):*

Other Standard *(specify):*

Providers furnishing services in the ICDS waiver will be required to adhere to the following requirements as outlined in the Ohio Administrative Code.

ODA certified provider:
Compliance with OAC chapters 5160-44 and 173-39, including 173-39-02.04

Verification of Provider Qualifications

Entity Responsible for Verification:

ODA or its designee for ODA-certified providers
Waiver beneficiaries for ODA-certified providers
The ICDS plan will verify that the provider has an active Medicaid provider agreement and is eligible to furnish this waiver service.

Frequency of Verification:

ODA - Verification of provider qualifications is conducted in accordance with OAC 173-39-04

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Choices - Home Care Attendant Service

Provider Category:

Agency

Provider Type:

Home Health Agency, Social Service Agency, Hospitals

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers furnishing services in the ICDS waiver will be required to adhere to the following requirements as outlined in the Ohio Administrative Code.

ODA certified provider:
Compliance with OAC chapters 5160-44 and 173-39, 173-39-02.04

Verification of Provider Qualifications

Entity Responsible for Verification:

ODA or its designee for ODA-certified providers
The ICDS plan will verify that the provider has an active Medicaid provider agreement and is eligible to furnish this waiver service.

Frequency of Verification:

ODA - Verification of provider qualifications is conducted in accordance with OAC 173-39-04.

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 Integration Service

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community Integration includes independent living assistance and community support coaching activities that are necessary to enable individuals to live independently and have access to, choice of, and an opportunity to participate in a full range of community activities.

Independent Living assistance helps individuals manage their households and personal affairs, self-administer medications and retain their community living arrangements. Tasks include: medication reminders, wellness checks, assistance with banking, assistance with business correspondence, organizing and coordinating health records, assistance with applications for public programs, accompanying individuals to appointments, on errands, and other community activities.

Community support coaching provides information and training to an individual in order to achieve the community integration goals identified in the person-centered plan. Coaching and training topics include how to manage finances, identifying and accessing community resources such as legal, employment, leisure, educational, recreational and transportation.

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**

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	Social Workers; Nurses; Homemakers; Individual workers
Agency	Home Health Agency, Social Service Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Integration Service

Provider Category:

Individual

Provider Type:

Social Workers; Nurses; Homemakers; Individual workers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers furnishing services in the ICDS waiver will be required to adhere to the following requirements as outlined in the Ohio Administrative Code.

ODA certified provider:
Compliance with OAC chapters 5160-44 and 173-39, including 173-39-02.15.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODA or its designee for ODA-certified providers
The ICDS plan will verify that the provider has an active Medicaid provider agreement and is eligible to furnish this waiver service.

Frequency of Verification:

ODA - Verification of provider qualifications is conducted in accordance with OAC 173-39-04

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Integration Service

Provider Category:

Agency

Provider Type:

Home Health Agency, Social Service Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers furnishing services in the ICDS waiver will be required to adhere to the following requirements as outlined in the Ohio Administrative Code.

ODA certified provider:
Compliance with OAC chapters 5160-44 and 173-39, including 173-39-02.15.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODA or its designee for ODA-certified providers
The ICDS plan will verify that the provider has an active Medicaid provider agreement and is eligible to furnish this waiver service.

Frequency of Verification:

ODA - Verification of provider qualifications is conducted in accordance with OAC 173-39-04

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 Transition Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services

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

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

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

Community Transition Services are non-recurring set-up expenses for individuals who are transitioning from an institutional setting or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. The service is available when no other person, including a landlord, has a legal or contractual responsibility to fund the expenses and if family, neighbors, friends, or community resources are unable to fund the expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

Essential household furnishings needed to occupy and use a community residence, including furniture, window coverings, food preparation items, and bed/bath linens; set up fees or deposits for utility or service access, including telephone/cell phone service, electricity, gas, garbage, and water; moving expenses, pre-transition transportation necessary to secure housing and benefits, cleaning and household supplies, and activities to arrange for and procure needed resources.

The service does not include ongoing monthly rental or mortgage expenses, ongoing grocery expenses, ongoing utility or service expenses, ongoing cable and/or internet expenses, electronic and other household appliances or items intended to be used for entertainment or recreational purposes.

The service may be authorized up to 180 consecutive days before an individual's transition from an institutional setting to an HCBS setting.

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

The service may be used one time per individual per waiver enrollment.

The service must be provided no later than 30 days after the date on which an individual enrolls on the waiver.

The total cost of the service may not exceed $2000.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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	Social Workers; healthcare professionals; Community-based social service provider
Agency	Human Service Agencies; Social Service Agencies; Senior Centers; Community Action Organizations;

Provider Category	Provider Type Title
	Home Health Agencies; ODM contracted Transition Coordinators

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Service

Provider Category:

Individual

Provider Type:

Social Workers; healthcare professionals; Community-based social service provider

Provider Qualifications

License *(specify):*

License as required by profession.

Certificate *(specify):*

Other Standard *(specify):*

Providers furnishing services in the ICDS waiver will be required to adhere to the following requirements as outlined in the Ohio Administrative Code.

ODA certified provider:
Compliance with OAC chapters 5160-44 and 173-39, including 173-39-02.17

Verification of Provider Qualifications

Entity Responsible for Verification:

ODA or its designee for ODA-certified providers
The ICDS plan will verify that the provider has an active Medicaid provider agreement and is eligible to furnish this waiver service.

Frequency of Verification:

ODA - Verification of provider qualifications is conducted in accordance with OAC 173-39-04.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Service

Provider Category:

Agency

Provider Type:

Human Service Agencies; Social Service Agencies; Senior Centers; Community Action Organizations; Home Health Agencies; ODM contracted Transition Coordinators

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers furnishing services in the ICDS waiver will be required to adhere to the following requirements as outlined in the Ohio Administrative Code.

ODA certified provider:
Compliance with OAC chapters 5160-44 and 173-39, including 173-39-02.17

Verification of Provider Qualifications

Entity Responsible for Verification:

ODA or its designee for ODA-certified providers
The ICDS plan will verify that the provider has an active Medicaid provider agreement and is eligible to furnish this waiver service.

Frequency of Verification:

ODA - Verification of provider qualifications is conducted in accordance with OAC 173-39-04.

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:

Enhanced Community Living Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08020 home health aide
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

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

The Enhanced Community Living service is provided by a designated team of nurses and direct care staff in a multi-family housing setting, and integrates the delivery of direct service interventions and health status monitoring activities. The ECL service includes eight elements:

• The establishment of measurable health goals;

• The identification of modifiable healthcare risks;

• The implementation and regular monitoring of specific interventions related to achieving the measurable health goals and modifiable healthcare risks;

• Assistance with accessing additional allied health services;

• The provision of, or arrangement for, education on self-managing chronic diseases or chronic health conditions;

• Daily wellness checks. "Daily wellness check" means a component of the service through which a direct-service staff member has face-to-face contact with the individual to observe any changes in the individual's level of functioning and determine what, if any, modifications to the day's service delivery plan are needed;

• Access to planned and intermittent assistance with the personal care service (PCS) under rule 173-39-02.11 of the Administrative Code.

The scope of personal care tasks includes assistance with ADLs (mobility, bathing, grooming, toileting, dressing, and eating) and the provision of any component of the homemaker service (HMK)under rule OAC 173-39-02.8 to assist the consumer with IADLs if the component is incidental to the care furnished or essential to the health and welfare of the consumer. The
scope of homemaker tasks include assistance with meal planning, laundry, and house cleaning. Since personal care and homemaker service tasks are included in the scope of the enhanced community living service, the concurrent use by an individual of either the personal care service or the homemaker service as a distinct additional service is not permitted. The service authorization process will prevent the case manager from authorizing PCS and HMK services that are concurrent with an ECL service authorization.

• Activities to assist an individual who is returning home following a hospital or nursing facility stay.

The ECL service does not provide 24 hour on-site protective oversight, 24 hour supervision or 24 hour assistance.

Access to the Enhanced Community Living service is not contingent upon the individual’s receipt of the state plan home health service.

(2) The Enhanced Community Living (ECL) service provides the individual who resides in their own private residence in a multi-family housing setting, with on-site access throughout the day to individually-tailored supportive and health-related interventions necessary to avoid institutionalization and maintain optimal health status.

• Multi-family housing is defined as a housing site that uses a landlord-tenant rental agreement, provides a minimum of six units of housing under one roof; and receives assistance through a federally-assisted housing program (as defined under 24 C.F.R.5.100), a project-based voucher program (as defined in 24 C.F.R. 983) or a low-income housing tax credit program (that is based on Section 42 of the Internal Revenue Code). This waiver service is not furnished in facilities that are subject to Section 1616(e) of the Social Security Act.

• On-site access to the service produces increased service flexibilities for an individual by delivering the elements of the service in smaller blocks of time and more frequently throughout the day; and the scope/duration/and frequency of the service delivery can be quickly modified in response to the individual’s intermittent and/or unplanned needs.

• The integration of the delivery of direct service interventions and health status monitoring activities is intended to support the transition of individuals from institutional settings and to reduce the risk for permanent institutionalization by: expanding access to services and supports delivered on an intermittent basis; empowering the individual to be an active participant in achieving his/her health care goals and reducing modifiable health risks; increasing the likelihood of timely identification of changes in health status; reducing the risks for acute

exacerbation of chronic health conditions that result in hospitalization or nursing facility care; and increasing the continuity of care across sites of care.

(3) The service differs from the Medicaid state plan benefits, specifically private duty nursing and home health aide, in these areas:

• The waiver service provides interventions which focus on the prevention of deteriorating or worsening medical conditions and the management of stabilized chronic conditions; and

• The waiver service does not provide continuous (more than four hours) blocks of service to individuals.

The mechanisms to prevent duplicate billing for similar services include:

• Prior authorization requirement by the state Medicaid agency for the private duty nursing; and

• Requirement for the waiver service plan to include home health aide service in order for the service to be reimbursable.

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**

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	Medicare-certified home health agency, Home Health Agencies, Human Service Agencies, Social Service Agencies,Senior Centers.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Enhanced Community Living Service

Provider Category:

Agency

Provider Type:

Medicare-certified home health agency, Home Health Agencies, Human Service Agencies, Social Service Agencies,Senior Centers.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers furnishing services in the ICDS waiver will be required to adhere to the following requirements as outlined in the Ohio Administrative Code.

ODA certified provider:
Compliance with OAC chapters 5160-44 and 173-39, including 173-39-02.20

Verification of Provider Qualifications

Entity Responsible for Verification:

ODA or its designee for ODA-certified providers
The ICDS plan will verify that the provider has an active Medicaid provider agreement and is eligible to furnish this waiver service.

Frequency of Verification:

ODA - Verification of provider qualifications is conducted in accordance with OAC 173-39-04

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 Care Attendant

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

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

Home care attendant services include all of the following tasks when provided by an unlicensed home care attendant, and authorized by a licensed physician or an RN (hereafter referred to as the authorizing health care professional):

* Assistance with the self-administration of medications in accordance with OAC rule 5160-44-27;

* The performance of certain nursing tasks in accordance with OAC rule 5160-44-27; and

* Personal care aide tasks as set forth in OAC rule 5160-46 or 173-39-02.11.

While this service includes personal care aide tasks, it is more involved because of the provision of assistance with self-administration of medication and the performance of certain nursing tasks - tasks that have, until the passage of RC 5111.88-5111.8811 (Am. Sub. H.B. 1, 128th General Assembly), and the addition of this service, had to be performed by an RN, or licensed practical nurse at the direction of an RN, as waiver nursing, private duty nursing or home health nursing services.

Home care attendants are non-agency providers (i.e., independent contractors) who bill ODM directly for reimbursement for services provided. Unless they are self-directed services in accordance with Appendix E, the service doesn't require a financial management service (FMS) provider, and ODM issues the 1099 directly to the home care attendant. Individuals who are not self-directing home care attendant services do not have employer authority or budget authority, nor do they bear any liability for home care attendant services.

A home care attendant shall assist an individual with the self-administration of only the following medication: oral medications; topical medications; subcutaneous injections of routine doses of insulin; programming of a pump used to deliver routine doses of insulin; medication administered via stable, labeled gastrostomy or jejunostomy tubes using pre-programmed pumps; and doses of schedule II, III, IV and V drugs only when administered orally or topically.

A home care attendant shall not assist an individual with the performance of any of the following nursing tasks: intravenous (IV) insertion, removal or discontinuation; intramuscular injections; IV medication administration; subcutaneous injections (except for routine doses of insulin as described in the previous paragraph); programming of pumps used to deliver medications, including but not limited to epidural, subcutaneous and IV (and except for routine doses of insulin as described in the previous paragraph); insertion and initiation of infusion therapies; and central line dressing changes.

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

* Individuals who receive home care attendant services do not have employer authority or budget authority, nor do they bear any liability for home care attendant services unless they are self-directing services in accordance with Appendix E.

* Individuals cannot receive, and providers cannot bill separately for personal care aide services when personal care aide tasks are performed during a home care attendant service visit.

* A home care attendant who provides home care attendant services to an individual in accordance with the limitations set forth in Sections 5166.30 through 5166.3010 of the Revised Code, and Rule 5160-44-27 of the Administrative Code, including activities in accordance with the authorizing health care professional's authorization, is not considered to be engaging in the practice of nursing as an RN or an LPN in violation of section 4723.03 of the Revised Code (the Ohio Nurse Practice Act).

*Home Care Attendant Services do not duplicate coverage provided under the State plan and EPSDT services are not duplicated.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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	Non-agency Home Care Attendant
Individual	Self-directed caregiver

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Care Attendant

Provider Category:

Individual

Provider Type:

Non-agency Home Care Attendant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

See other standard.

Other Standard *(specify):*

ORC Sections 5111.88 to 5111.8811 and OAC Rule 5160-44. Specifically, the provider must supply ODM with evidence to its satisfaction of all of the following:

1)The home care attendant either meets the personnel qualifications specified in 42 CFR 484.4 for home health aides, or has successfully completed at least one of the following:

* A competency evaluation program, or training and competency evaluation program approved or conducted by the Ohio Department of Health under section 3721.31 of the Revised Code;
* A training program approved by ODM that includes training in at least all of the following and provides training equivalent to that approved or conducted by the Ohio Department of Health under section 3721.31 of the Revised Code or that meets the requirements of 42 CFR 484.36(a), basic home safety, universal precautions for the prevention of disease transmission, consumer-specific personal care aide services and the labeling, counting and storage requirements for schedule medications;

2)Prior to beginning home care attendant services, the home care attendant must have received training and instruction about how to deliver the specific home care attendant services authorized by the individual's authorizing health care professional, and/or the individual or the authorized representative in cooperation with the individual's licensed health care professional.

3)Upon request of the individual, individual's authorized representative, or the individual's authorizing health care professional, the home care attendant has performed a successful return demonstration of the home care attendant service to be provided.

4)The home care attendant has obtained a certificate of completion of a course in first aid that is not solely internet based, includes hands-on training by a certified first aid instructor and requires the home care attendant to perform a successful return demonstration of what was learned in the course.

5)The home care attendant must secure the services of an RN, in agreement with the individual or authorized representative, and participate in a face-to-face visit every ninety days with the individual, authorized representative, and the RN for the purpose of monitoring the individual's health and welfare. During the face-to-face visit, the RN shall serve as a resource for the purpose of answering any questions the home care attendant, individual and/or authorized representative have about individual care needs, medications and other issues. The home care attendant and the RN shall document the activities of the visit in the individual's clinical record. The home care attendant shall also discuss the results of the face-to-face visit with the case manager, and the individual or authorized representative.

6)The home care attendant shall complete at least twelve hours of in-service continuing education regarding home care attendant services annually. Continuing education topics include, but are not limited to, individual health and welfare, CPR, patient rights, emergency preparedness, communication skills, aging sensitivity, developmental stages, nutrition, transfer techniques, disease-specific trainings and mental health issues.

7)The home care attendant shall not provide home care attendant services until the department receives an ODM-approved home care attendant service plan authorization form that contains all of the following:

* Written consent from the individual or the authorized representative allowing the home care attendant to provide home care attendant services;

* Written consent from the individual's authorizing health care professional indicating that the home care attendant has demonstrated the ability to furnish the individual's specific home care attendant service to the individual. The consent must include the individual's name and address; a description of the specific nursing task or self-administration of medication that the attendant will assist with (including name, dosage and route of administration of any medications); the times/intervals when the attendant is to assist the individual; the dates on which the attendant is to begin and cease providing assistance; a list of severe adverse reactions that the attendant must report to the individual's health care professional; at least one telephone number at which the attendant can reach the individual's health care

professional in an emergency for consultation after contacting emergency personnel; at least one fax number at which the attendant can reach the individual's authorizing health care professional when the schedule drugs are missing or cannot be reconciled; and instructions the attendant must follow when assisting the individual (including instructions for maintaining sterile conditions and for the storage of task-related equipment and supplies). ODM will communicate to the waiver service coordinator that the home care attendant has been authorized by the authorizing health care professional to provide home care attendant services to the individual.

ODM Providers: Compliance with OAC Chapters 5160-44, 5160-45, and 5160-46
ODA Providers: Compliance with OAC Chapters 5160-44, 173-39, including 173-39-02.24

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM or its designee for ODM-approved providers

The ICDS plan will verify that the provider has an active Medicaid provider agreement and is eligible to furnish this waiver service. The home care attendant is not enrolled as an approved provider until the information on the ODM-approved home care attendant service plan authorization form has been verified by ODM. A copy of the form is then attached to the provider master file that is accessible to the ICDS plan.

Frequency of Verification:

ODM - Verification of Provider qualifications occurs in accordance with OAC 5160-45-06
ODA - Verification of Provider qualifications occurs in accordance with OAC 173-39-04

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Care Attendant

Provider Category:

Individual

Provider Type:

Self-directed caregiver

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

In accordance with ORC Sections 5166.301-5166.309 and OAC Rule 5160-44-27, the self-directed home care attendant caregivers must supply the FMS the following:

1. Self-directed home care attendant caregivers either meets the personnel qualifications specified in 42 CFR 484.4 for home health aides, or has successfully completed at least one of the following:

a. A competency evaluation program, or training and competency evaluation program approved or conducted by the Ohio Department of Health under section 3721.31 of the Revised Code; or
b. A training program approved by ODM that includes training in at least all of the following and provides training equivalent to that approved or conducted by the Ohio Department of Health under section 3721.31 of the Revised Code or that meets the requirements of 42 CFR 484.36(a), basic home safety, universal precautions for the prevention of disease transmission, consumer-specific personal care aide services and the labeling, counting and storage requirements for schedule medications; and
c. Training and instruction about how to deliver the specific home care attendant services authorized by the individual's authorizing health care professional, and/or the individual or the authorized representative in cooperation with the individual's licensed health care professional.

Return demonstrations are required upon request of the individual employer or the individual's authorizing health care professional.

2. First aid training certificate that is not solely internet based, includes hands-on training by a certified first aid instructor and requires a successful return demonstration of what was learned in the course.

Compliance with OAC Chapters 5160-44, 5160-45, and 5160-46 ORC 5166.301-5166.309

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMS will verify that the self-directed caregiver is currently enrolled with ODM as a home care attendant or has met the criteria for a home care attendant as defined above and verifies the self-directed caregiver is eligible to furnish this waiver service in accordance with 5160-44-27 of the Administrative Code.

Frequency of Verification:

FMS initially completes verification of self-directed caregiver qualifications and as needed or requested by the individual employee.

Additionally, ODM verifies self-directed caregiver qualifications in accordance with OAC 5160-45-03.2 within the first twelve to twenty-four months of service and then at least every three years. Self-directed caregiver reviews are conducted by the individual with support from ODM’s provider oversight contractor and assess the caregiver’s performance, including compliance with the conditions of participation outlined in rule 5160-44-31 of the Administrative Code.

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:	Sub-Category 1:
06 Home Delivered Meals	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" is a meal delivery service based on an individual's need for assistance with activities of daily living and/or instrumental activities of daily living in order to safely prepare meals, or ensure meals are prepared to meet the individual's dietary or specialized nutritional needs as ordered by a licensed professional within his or her scope of practice.

The service includes the preparation, packaging, and delivery of a safe and nutritious meal(s) to an individual at his or her home. This may include a single ready-to-eat meal, or multiple single-serving meals that are frozen, vacuum-packed, modified-atmosphere-packed meal, or shelf-stable. Specialized meals include, but are not limited to, specialized diets due medical conditions (i.e. reduced sodium, diabetic diet), or specialized textures, therapeutic or kosher meals.

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

The service includes no more than 2 meals per day

Planned multiple meal delivery shall not exceed fourteen meals that are compliant with food storage and safety requirements.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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	Non-agency employed provider
Agency	Food preparation agency, home health agency, senior centers, social service agency, churches, hospitals,

Provider Category	Provider Type Title
	and caterers, Agency, e.g., Meals on Wheels, a food vendor, etc.

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:

Non-agency employed provider

Provider Qualifications

License *(specify):*

ODM approved provider:
Current, valid license or certificate from the local health department.

Certificate *(specify):*

Other Standard *(specify):*

ODM approved provider:
Compliance with OAC Chapters 5160-44, 5160-45, and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM or its designee for ODM-approved providers

The ICDS plan will verify that the provider has an active Medicaid provider agreement and is eligible to furnish this waiver service.

Frequency of Verification:

ODM - Verification is conducted in accordance with OAC 5160-45-06

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:

Food preparation agency, home health agency, senior centers, social service agency, churches, hospitals, and caterers, Agency, e.g., Meals on Wheels, a food vendor, etc.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers furnishing services in the ICDS waiver will be required to adhere to the following requirements as outlined in the Ohio Administrative Code.

ODA certified provider:
Compliance with OAC chapters 5160-44 and 173-39, including 173-39-02.14.

ODM approved provider:
Compliance with OAC Chapters 5160-44, 6160-45, and 5160-46

Providers must meet all Federal, State and local regulations for preparation, handling and transport of food; must meet ORC chapter 3117 and OAC chapter 3117-1; must meet Ohio Uniform Food Safety Code; must pass all local health department inspections; and must pass all Ohio department of agriculture meat and poultry inspections.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODA or its designee for ODA-certified providers
ODM or its designee for ODM-approved providers

The ICDS plan will verify that the provider has an active Medicaid provider agreement and is eligible to furnish this waiver service.

Frequency of Verification:

ODA - Verification occurs in accordance with OAC 173-39-04
ODM - Verification occurs in accordance with OAC 5160-45-06

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 Maintenance and Chore

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08060 chore
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Home maintenance and chore maintains a clean, sanitary and safe living environment through the performance of tasks in the individual's home that are beyond the individual's capability. The service includes minor home maintenance and repair, heavy household cleaning, non-routine disposal of garbage posing a threat to the individual's health and welfare, non-routine yard maintenance, pest control and related tasks to prevent, suppress, eradicate or remove pests posing a threat to the individual's health and welfare.

The service does not include tasks that are the legal or contractual responsibility of someone other than the individual, that can be accomplished through existing informal or formal supports, or do not provide a direct medical or remedial benefit to the individual. Additionally, the service does not include tasks performed, or services performed, as part of the homemaker service included in this waiver.

The service may be authorized up to 180 consecutive days prior to an individual's transition from an institutional setting into the community.

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**

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	Social Service Agency, Home Health Agency
Individual	Handymen, House cleaners, Maids, Home Repair Workers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Maintenance and Chore

Provider Category:

Agency

Provider Type:

Social Service Agency, Home Health Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers furnishing services in the ICDS waiver will be required to adhere to the following requirements as outlined in the Ohio Administrative Code.

ODA certified provider:
Compliance with OAC chapters 5160-44 and 173-39, including 173-39-02.5.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODA or its designee
The ICDS plan will verify that the provider has an active Medicaid provider agreement and is eligible to furnish this waiver service.

Frequency of Verification:

ODA - Verification of provider qualifications is conducted in accordance with OAC 173-39-04.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Maintenance and Chore

Provider Category:

Individual

Provider Type:

Handymen, House cleaners, Maids, Home Repair Workers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers furnishing services in the ICDS waiver will be required to adhere to the following requirements as outlined in the Ohio Administrative Code.

ODA certified provider:
Compliance with OAC chapters 5160-44 and 173-39, including 173-39-02.5

Verification of Provider Qualifications

Entity Responsible for Verification:

ODA or its designee
The ICDS plan will verify that the provider has an active Medicaid provider agreement and is eligible to furnish this waiver service.

Frequency of Verification:

ODA - Verification of provider qualifications is conducted in accordance with OAC 173-39-04.

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 Medical Equipment and Supplemental Adaptive and Assistive Device Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 3:	**Sub-Category 3:**

14 Equipment, Technology, and Modifications	14032 supplies

Service Definition *(Scope):*

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

Home Medical Equipment and Supplemental Adaptive and Assistive Device Services are medical equipment, devices and supplies, and vehicle modifications to a vehicle owned by the individual, or a family member, or someone who resides in the same household as the individual, that promote accessibility, enabling the individual to function with greater independence, avoid institutionalization, and reduce the need for human assistance. Adaptive and Assistive Devices, in particular, are contingent upon completion of and recommendations resulting from an evaluation. Some adaptive/assistive devices including, but not limited to, vehicle modifications may be provided prior to the individual's discharge from an institution into the community. In such instances, the adaptive/assistive device can be initiated up to 180 days prior to discharge, and the date of service for allowable expenses shall be the date on which the individual leaves the institution and enrolls on the waiver.

Adaptive and Assistive Devices and Medical Supplies do not include:

* Items considered by the federal Food and Drug Administration as experimental or investigational.

* Funding of down payments toward the purchase or lease of any adaptive and assistive devices.

* New equipment or supplies or repair of previously approved equipment or supplies that have been damaged as a result of apparent misuse, abuse or negligence.

* New vehicle modifications or repair of previously approved modifications that have been damaged as a result of apparent misuse, abuse or negligence.

* Payment toward the purchase or lease of a vehicle except as set forth in the service definition above.

* Routine care and maintenance of vehicle modifications and devices.

* Permanent modification of leased vehicles.

* Vehicle inspection costs.

* Vehicle insurance costs.

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

*Reimbursement for Home Medical Equipment and Supplemental Adaptive and Assistive Device Services shall not exceed a combined total of $10,000 within a calendar year per individual.

*The service prohibits the same type of medical equipment, supplies and devices being purchased for the same individual during the same calendar year, unless there is a documented need for ongoing medical equipment, supplies or devices as documented by a licensed health care professional, or a documented change in the individual's medical and/or physical condition requiring the replacement.

*The service prohibits the same type of vehicle modification for the same individual within a three-year period, unless there is a documented change in the individual's medical and/or physical condition requiring the replacement.

Home Medical Equipment and Supplemental Adaptive and Assistive Device Services do not include:

*Items considered by the federal Food and Drug Administration as experimental or investigational.
*Funding of down payments toward the purchase or lease of any supplemental adaptive and assistive device services.
*Equipment, supplies or services furnished in excess of what is approved pursuant to, and as specified on the individual's All Services Plan.
*New equipment or supplies or repair of previously approved equipment or supplies that have been damaged as a result of apparent misuse, abuse or negligence.
*New vehicle modifications or repair of previously approved modifications that have been damaged as a result of apparent misuse, abuse or negligence.
*Payment toward the purchase or lease of a vehicle except as set forth in the service definition above.
*Routine care and maintenance of vehicle modifications and devices.
*Permanent modification of leased vehicles.
*Vehicle inspection costs.
*Vehicle insurance costs.
*Services performed in excess of what is approved pursuant to, and specified on, the individual's service plan.
*Supplemental Adaptive and Assistive Device Services do not duplicate coverage provided under the State plan and EPSDT services are not duplicated.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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	Pharmacies/drug stores, Medical Equipment & Supplies Company, Durable Medical Equipment Suppliers, and other Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Medical Equipment and Supplemental Adaptive and Assistive Device Services

Provider Category:

Agency

Provider Type:

Pharmacies/drug stores, Medical Equipment & Supplies Company, Durable Medical Equipment Suppliers, and other Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers furnishing services in the ICDS waiver will be required to adhere to the following requirements as outlined in the Ohio Administrative Code.

ODA certified provider:
Compliance with OAC chapters 5160-44 and 173-39-03, including 173-39-02.7
ODM approved provider:
Compliance with OAC Chapters 5160-44, 5160-45, and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODA or its designee for ODA-certified providers
ODM or its designee for ODM-approved providers

The ICDS plan will verify that the provider has an active Medicaid provider agreement and is eligible to furnish this waiver service.

Frequency of Verification:

ODA - Verification of provider qualifications is conducted in accordance with OAC 173-39-04
ODM - Verification of provider qualifications is conducted in accordance with OAC 5160-45-06

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 Modification

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	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):*

"Home modifications" are environmental adaptations to the private residence of an individual family that are necessary to ensure the health, welfare, and safety of the individual or that enable the individual to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom or kitchen facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual. Home modifications also include service calls and the repair of previous modifications. Repairs include the cost of parts and labor.

Home modifications may be provided in advance of an individual's discharge from an institution into the community. In such instances, the modification can be initiated up to one hundred eighty days prior to discharge, and the date of service for allowable expenses shall be the date the individual leaves the institution and enrolls onto the waiver.

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

Home modifications do not include new, replacement, or repair of a previously approved home modification that has been damaged as a result of apparent misuse, abuse or negligence.

Home modification services are limited to $10,000 per twelve-month calendar year.

Home modification services do not duplicate coverage provided under the State plan and EPSDT services are not duplicated.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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	Home Improvement Companies; Builders; Neighborhood Organizations; Community Action Agencies

Provider Category	Provider Type Title
Individual	Independent Contractors and Independent General Contractors,

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modification

Provider Category:

Agency

Provider Type:

Home Improvement Companies; Builders; Neighborhood Organizations; Community Action Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers furnishing services in the ICDS waiver will be required to adhere to the following requirements as outlined in the Ohio Administrative Code.

ODA certified provider:
Compliance with OAC chapters 5160-44 and 173-39, including 173-39-02.9.

ODM approved provider:
Compliance with OAC Chapters 5160-44, 5160-45, and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODA or its designee for ODA-certified providers
ODM or its designee for ODM-approved providers
The ICDS plan will verify that the provider has an active Medicaid provider agreement and is eligible to furnish this waiver service.

Frequency of Verification:

ODA - Verification of provider qualifications occurs in accordance with OAC 173-39-04
ODM - Verification of provider qualifications occurs in accordance with 5160-45-06

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modification

Provider Category:

Individual

Provider Type:

Independent Contractors and Independent General Contractors,

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers furnishing services in the ICDS waiver will be required to adhere to the following requirements as outlined in the Ohio Administrative Code.

ODA certified provider:
Compliance with OAC chapters 5160-44 and 173-39, including 173-39-02.9.
ODM approved provider:
Compliance with OAC Chapters 5160-44, 5160-45, and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODA or its designee for ODA-certified providers
ODM or its designee for ODM-approved providers

The ICDS plan will verify that the provider has an active Medicaid provider agreement and is eligible to furnish this waiver service.

Frequency of Verification:

ODA - Provider Qualifications are verified in accordance with OAC 173-39-04
ODM - Provider Qualifications are verified in accordance with OAC 5160-45-06

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:

Nutritional Consultation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11040 nutrition consultation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Nutritional consultation services are services that provide personalized guidance to an individual who has special dietary needs. Nutritional consultation takes into consideration the individual's health, cultural, religious, ethnic and socioeconomic background and dietary preferences and/or restrictions.

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

Nutritional consultation services shall not:

• Duplicate similar services available under the Medicaid state plan; or

• Include services provided in excess of what is approved on the individual's waiver service plan.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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	Home Health Agency, Social Service Agency
Individual	Licensed dietitians

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nutritional Consultation

Provider Category:

Agency

Provider Type:

Home Health Agency, Social Service Agency

Provider Qualifications

License *(specify):*

Licensure as appropriate

Certificate *(specify):*

Other Standard *(specify):*

Providers furnishing services in the ICDS waiver will be required to adhere to the following requirements as outlined in the Ohio Administrative Code.

ODA certified provider:
Compliance with OAC chapters 5160-44 and 173-39, including 173-39-02.10.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODA or its designee for ODA-certified providers

The ICDS plan will verify that the provider has an active Medicaid provider agreement and is eligible to furnish this waiver service.

Frequency of Verification:

ODA - Verification of provider qualifications is conducted in accordance with OAC 173-39-04

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nutritional Consultation

Provider Category:

Individual

Provider Type:

Licensed dietitians

Provider Qualifications

License *(specify):*

Licensure by Ohio Board of Dietetics

Certificate *(specify):*

Other Standard *(specify):*

Providers furnishing services in the ICDS waiver will be required to adhere to the following requirements as outlined in the Ohio Administrative Code.

ODA certified provider:
Compliance with OAC chapters 5160-44 and 173-39, including 173-39-02.10.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODA or its designee for ODA-certified providers

The ICDS plan will verify that the provider has an active Medicaid provider agreement and is eligible to furnish this waiver service.

Frequency of Verification:

ODA - Verification of provider qualifications is conducted in accordance with OAC 173-39-04

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:

Out-of-Home Respite

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Out-of-Home Respite Services are services delivered to individuals in an out-of-home setting to provide respite for caregivers normally providing care. The service must include an overnight stay. The services the out-of-home respite provider must make available are:

*Waiver nursing
*Personal care aide services
*Three meals per day that meet the consumer's dietary requirements.

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

*The services delivered by an Out-of-Home Respite service provider cannot be reimbursed separately.

*Out-of-Home Respite Services do not duplicate coverage provided under the State plan and EPSDT services are not duplicated.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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	NF and other institutional providers (e.g., hospitals, etc.)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Out-of-Home Respite

Provider Category:

Agency

Provider Type:

NF and other institutional providers (e.g., hospitals, etc.)

Provider Qualifications

License *(specify):*

NF per OAC rule 5160-3-02

Certificate *(specify):*

Other Standard *(specify):*

Providers furnishing services in the ICDS waiver will be required to adhere to the following requirements as outlined in the Ohio Administrative Code.

ODA certified providers: Compliance with OAC Chapter 5160-44, 173-39, including 173-39-02.23
ODM approved providers: Compliance with OAC Chapters 5160-44, 5160-45, and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM or its designee for ODM-approved providers
ODA or its designee for ODA certified providers

The ICDS plan will verify that the provider has an active Medicaid provider agreement and is eligible to furnish this waiver service.

Frequency of Verification:

ODM-approved providers - Verification of provider qualifications is conducted in accordance with OAC 5160-45-06
ODA certified providers: Verification if provider qualification is conducted in accordance with OAC 173-39-04

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:

Personal Emergency Response System

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition (Scope):

Personal Emergency Response System (ERS) are emergency intervention services composed of telecommunications equipment (ERS equipment), an emergency response center and a medium for two-way, hands-free communication between the individual and an emergency response center. Personnel at the emergency response center intervene in an emergency when the center receives an alarm signal from the ERS equipment.

ERS can meet the needs of individuals who live alone, are alone for significant parts of the day, or have no regular caregiver for extended periods of time and would otherwise require extensive routine supervision. ERS includes installation, testing and equipment rental, and monitoring fees.

ERS equipment shall include a variety of remote or other specialty activation devices from which the individual can choose in accordance with their specific needs. All ERS equipment shall have an internal battery that provides at least twenty-four hours of power without recharging and sends notification to the emergency response center when the battery's level is low. Equipment includes, but is not limited to:

*Wearable waterproof activation devices; and

*Devices that offer:

*Voice-to-voice communication capability,
*Visual indication of an alarm that may be appropriate if the consumer is hearing impaired, or
*Audible indication of an alarm that may be appropriate if the consumer is visually impaired.

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

PERS does not include the following:

*Equipment such as a boundary alarm, a medication dispenser, a medication reminder, or any other equipment or home medical equipment or supplies, regardless of whether such equipment is connected to the PERS equipment.

*Remote monitoring services.

*New equipment or repair of previously-approved equipment that has been damaged as a result of apparent misuse, abuse or negligence.

PERS does not duplicate coverage provided under the State plan and EPSDT services are not duplicated.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

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	Social Service Agency , Medical Equipment & Supply Company, Durable Medical Equipment Suppliers, Medicare-certified HHA; ACHC-, CHAP- or Joint Commission-accredited agencies, Other ERS agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:

Agency

Provider Type:

Social Service Agency , Medical Equipment & Supply Company, Durable Medical Equipment Suppliers, Medicare-certified HHA; ACHC-, CHAP- or Joint Commission-accredited agencies, Other ERS agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers furnishing services in the ICDS waiver will be required to adhere to the following requirements as outlined in the Ohio Administrative Code.

ODA certified provider:
Compliance with OAC chapters 5160-44 and 173-39, including 173-39-02.6 (ERS services)

ODM approved provider:
Compliance with OAC Chapters 5160-44, 5160-45, and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODA or its designee for ODA-certified providers
ODM or its designee for ODM-approved providers

The ICDS plan as part of its will verify that the provider has an active Medicaid provider agreement to furnish this waiver service.

Frequency of Verification:

ODA - Verification of provider qualifications occurs in accordance with OAC 173-39-04
ODM - Verification of provider qualifications occurs in accordance with OAC 5160-45-06

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:

Self-directed goods and services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Self-Directed Goods and Services are services, equipment, or supplies not otherwise provided through the medicaid state plan benefit or the home and community-based services (HCBS) waiver program that address an individual's assessed need and authorized in the person-centered services plan, as defined in rule 5160-44-02 of the Ohio Administrative Code. Self-directed goods and services are intended to enhance and supplement the array of Medicaid and HCBS waiver services available to help the individual successfully remain in the community. Self-Directed Goods and Services must meet the following requirements:

(a) Increase the individual's independence, safety, and/or community participation; or

(b) Decrease the individual's need for other medicaid services; or

(c) Support the individual who does not have funds to purchase the services, equipment, or supplies, and they are not available through another source; and

(d) The self-directed goods and services address an assessed need and are included in the person-centered services plan.

To access Self-Directed Goods and Services, the individual must not have the ability to purchase the service or item through other available funds or via another source. Self-Directed Goods and Services will first be submitted to the care management agency for consideration under the Medicaid state plan or another waiver services prior to purchasing the item or service from a Medicaid agreement holder.

Self-Directed Goods and Services are purchased from the self-directed budget. Self-directed goods and services purchased must be clearly linked to an individual's assessed need.

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

Self-directed goods and services cannot be used to pay for:

- Experimental treatments; or
- Items used solely for entertainment or recreational purposes; or
- Monthly utilities or internet service.

Financial limitations for self-directed goods and services are detailed in Appendix C-4.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

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: Other Service
Service Name: Self-directed goods and services

Provider Category:

Agency

Provider Type:

Financial Management Services Entity

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

See additional standard provided in Appendix E.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Ohio Department of Medicaid

Frequency of Verification:

Verification is conducted pursuant to the ODM’s competitive bid process as described in Appendix E-1.

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:

Social Work Counseling

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):*

Social work/counseling services are transitional services provided to the individual, authorized representative, caregiver and/or family member on a short-term basis to promote the individual's physical, social and emotional well-being. Social work/counseling services promote the development and maintenance of a stable and supportive environment for the individual.

Social work/counseling services can include crisis interventions, grief counseling and/or other social service interventions that support the individual's health and welfare.

Social work/counseling services shall not:

* Take the place of case management services; or
* Include services provided in excess of what is approved on the individual's services plan.

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**

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	LISW, licensed professional clinical counselor, psychologist (MA or PhD), master of social service admin., indep. marriage and family therapist, registered nurse with psych-mental health specialty
Agency	Licensed professional clinical counselor, licensed professional counselor, licensed psychologist (MA or PhD), marriage and family therapist, licensed independent social worker, licensed social worker

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Social Work Counseling

Provider Category:

Individual

Provider Type:

LISW, licensed professional clinical counselor, psychologist (MA or PhD), master of social service admin., indep. marriage and family therapist, registered nurse with psych-mental health specialty

Provider Qualifications

License *(specify):*

Licensed by the Ohio Board of Counselors, Social Workers and Marital Family Therapists under Ohio Revised Code Chapter 4757 as one of the following:
LISW, LPCC, LPC, or MSSA; or licensed by the Ohio Board of Psychology as a Psychologist (MA or PhD) under Ohio Revised Code Chapter 4732.

RN under Ohio Revised Code Chapter 4723.

Certificate *(specify):*

Other Standard *(specify):*

Providers furnishing services in the ICDS waiver will be required to adhere to the following requirements as outlined in the Ohio Administrative Code.

ODA certified provider:
Compliance with OAC chapters 5160-44 and 173-39, including 173-39-02.12.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODA or its designee for ODA-certified providers

The ICDS plan as part of its will verify that the provider has an active Medicaid provider agreement to furnish this waiver service.

Frequency of Verification:

ODA - Verification of provider qualifications is conducted in accordance with OAC 173-39-04

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Social Work Counseling

Provider Category:

Agency

Provider Type:

Licensed professional clinical counselor, licensed professional counselor, licensed psychologist (MA or PhD), marriage and family therapist, licensed independent social worker, licensed social worker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers furnishing services in the ICDS waiver will be required to adhere to the following requirements as outlined in the Ohio Administrative Code.

ODA certified provider:
Compliance with OAC chapters 5160-44 and 173-39, including 173-39-02.12.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODA or its designee for ODA-certified providers
The ICDS plan as part of its will verify that the provider has an active Medicaid provider agreement to furnish this waiver service.

Frequency of Verification:

ODA - Verification of provider qualifications is conducted in accordance with OAC 173-39-04

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:

Structured Family Caregiving Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

"Structured Family Caregiving (SFC)" is a service in which an individual at least 18 years of age who is enrolled on a nursing facility-based level of care waiver, as defined in paragraph (D) of rule 5160-3-08 of the Administrative Code, lives with a caregiver who provides daily care and support to the individual based on the individual's daily care needs. The caregiver may be a non-family member or a family member who lives with the individual in the individual's private home or lives with the individual in the caregiver's private home. Covered SFC services may include:

* Assistance with self-administration of medications as set forth in paragraph (E) of rule 5160-44-27 of the Administrative Code.

* Assistance with the performance of nursing tasks as set forth in paragraph (F) of rule 5160-44-27 of the Administrative Code.

* Tasks performed as part of personal care aide services as described in rule 5160-46-04 or 173-39-02.11 of the Administrative Code when performed during a structured family caregiving service visit. Personal care aide tasks are not reimbursable separately as personal care aide services when they are performed during a structured family caregiving service visit.

More information on this service can be found in rule 5160-44-33.

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

SFC services will not be provided on the same day as the following services are delivered:

* Homemaker as described in rules 5160-31-05 and 173-39-02.8 of the Administrative Code.

* Personal care services as described in rules 5160-46-06 and 173-39-02.11 of the Administrative Code.

* Choices home care attendant as described in rules 5160-58-04 and 173-39-02.4 of the Administrative Code.

* Alternative meals as described in rule 173-39-02.2 of the Administrative Code.

* Home care attendant as described in rule 5160-44-27 of the Administrative Code.

* Out-of-home respite as described in rule 5160-44-17 of the Administrative Code.

The provider will provide SFC for only one individual, unless authorized to provide services in a group setting for up to three individuals who reside at the same address. When SFC is provided to more than one individual at the same address, the provider may only bill 75% of the maximum allowable payment rate for each individual.

The maximum allowable payment rates and procedure codes for SFC are listed in Appendix A of this rule.

* When a full day is authorized to provide SFC services, no additional personal care type services are permitted to be authorized on the same calendar day.

* When a ½ day is authorized to provide SFC services, up to two hours of personal care type services may be provided on the same calendar day.

More information on this service can be found in rule 5160-44-33.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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	Medicare certified home health agency or otherwise accredited agency approved by ODM or certified by ODA

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Structured Family Caregiving Services

Provider Category:

Agency

Provider Type:

Medicare certified home health agency or otherwise accredited agency approved by ODM or certified by ODA

Provider Qualifications

License *(specify):*

Rule 5160-44-33 outlines requirements.

Certificate *(specify):*

Rule 5160-44-33 outlines requirements.

Other Standard *(specify):*

Rule 5160-44-33 outlines requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. Ohio Department of Aging
2. ODA's Designee

Frequency of Verification:

Verification of provider qualifications occurs in accordance with rule 173-39-04 of the Ohio Administrative Code.

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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

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

Waiver nursing are part-time, intermittent and/or continuous nursing services provided to individuals who require the skills of a registered nurse (RN) or licensed practical nurse (LPN) at the direction of an RN. Waiver nursing services are furnished 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 thereunder.

The waiver nursing service under the waiver differs in nature and provide type from home health nursing services in the State plan.

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

The service is intended to complement, not replace, similar services available under the Medicaid state plan and EPSDT services.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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	Medicare-certified HHA, ACHC-, CHAP-accredited agency, and Joint Commission-accredited agency
Individual	Non-agency employed RN; non-agency employed LPN
Individual	Self-directed caregiver

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Waiver Nursing

Provider Category:

Agency

Provider Type:

Medicare-certified HHA, ACHC-, CHAP-accredited agency, and Joint Commission-accredited agency

Provider Qualifications

License *(specify):*

RN/LPN

Certificate *(specify):*

Medicare-certified HHA; ACHC, CHAP or Joint Commission-accreditation

Other Standard *(specify):*

Providers furnishing services in the ICDS waiver will be required to adhere to the following requirements as outlined in the Ohio Administrative Code.

ODM approved providers: Compliance with OAC Chapters 5160-44, 5160-45, and 5160-46
ODA certified providers: Compliance with OAC Chapters 5160-44, 173-39, including 173-39-02.22

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for ODM-approved providers: ODM or its designee
Agency for ODA-approved Providers: ODA or its designee

The ICDS plan as part of its will verify that the provider has an active Medicaid provider agreement to furnish this waiver service.

Frequency of Verification:

ODM approved providers: Verification of provider qualifications is conducted in accordance with 5160-45-06.
ODA certified providers: Verification of provider qualifications is conducted in accordance with 173-39-04.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Waiver Nursing

Provider Category:

Individual

Provider Type:

Non-agency employed RN; non-agency employed LPN

Provider Qualifications

License *(specify):*

RN/LPN

Certificate *(specify):*

Other Standard *(specify):*

Providers furnishing services in the ICDS waiver will be required to adhere to the following requirements as outlined in the Ohio Administrative Code.

ODM approved providers: Compliance with OAC Chapters 5160-44, 5160-45, and 5160-46.
ODA certified providers: Compliance with OAC Chapter 5160-44, 173-39, including 173-39-02.22

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM or its designee for ODM-approved providers
The ICDS plan as part of its will verify that the provider has an active Medicaid provider agreement to furnish this waiver service.

Frequency of Verification:

ODM - Verification of provider qualifications is conducted in accordance with OAC 5160-45-06

ODA-certified providers: Verification of provider qualifications is conducted in accordance with OAC 173-39-04

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Waiver Nursing

Provider Category:
Individual
Provider Type:

Self-directed caregiver

Provider Qualifications

License *(specify):*

RN/LPN with current, valid and unrestricted license with Ohio board of nursing

Certificate *(specify):*

Other Standard *(specify):*

FMS-enrolled self-directed caregiver

Compliance with OAC chapters 5160-44 and 5160-45, as well as 5160-44-22.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMS will verify that the self-directed caregiver is currently enrolled with ODM as a waiver nurse or has met the criteria for a waiver nurse as defined above and verifies the self-directed caregiver is eligible to furnish this waiver service in accordance with 5160-44-22 of the Administrative Code.

Frequency of Verification:

FMS initially completes verification of self-directed caregiver qualifications and as needed or requested by the individual employee.

Additionally, ODM verifies self-directed caregiver qualifications in accordance with OAC 5160-45-03.2 within the first twelve to twenty-four months of service and then at least every three years. Self-directed caregiver reviews are conducted by the individual with support from ODM’s provider oversight contractor and assess the caregiver’s performance, including compliance with the conditions of participation outlined in rule 5160-44-31 of the Administrative Code.

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 Transportation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Waiver transportation services promote an individual’s full participation in the community through access to waiver services, community activities, and medical appointments as specified by the individual’s service plan when not otherwise available or funded by state plan or any other source.

The service is offered in addition to transportation service under the State Plan as defined at 42 CFR$440.170(a) (if applicable), and does not replace it. Whenever possible family, neighbors, friends or community agencies that can provide this service without charge are utilized.

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

Waiver transportation services and the provider of such services must be identified on the waiver service plan. Waiver transportation services do not include services performed in excess of what is approved pursuant to, and specified on, the individual's waiver service plan.

* Waiver transportation services do not duplicate coverage provided under the State plan and EPSDT services are not duplicated.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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	Non-agency employed provider
Agency	Social Service Agency, Licensed Ambulette and Transportation Service providers; Senior Centers; Community Action Organizations, Agency, e.g., ambulette companies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Waiver Transportation

Provider Category:

Individual

Provider Type:

Non-agency employed provider

Provider Qualifications

License *(specify):*

Motor vehicle

Certificate *(specify):*

Other Standard *(specify):*

ODM approved provider:
Compliance with OAC Chapters 5160-44, 5160-45, and 5160-46.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM or its designee for ODM-approved providers
The ICDS plan as part of its will verify that the provider has an active Medicaid provider agreement to furnish this waiver service.

Frequency of Verification:

ODM - Verification of provider qualifications is conducted in accordance with OAC 5160-45-06

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Waiver Transportation

Provider Category:

Agency

Provider Type:

Social Service Agency, Licensed Ambulette and Transportation Service providers; Senior Centers; Community Action Organizations, Agency, e.g., ambulette companies

Provider Qualifications

License *(specify):*

Motor Vehicle

Certificate *(specify):*

Other Standard *(specify):*

Providers furnishing services in the ICDS waiver will be required to adhere to the following requirements as outlined in the Ohio Administrative Code.

ODA certified provider:
Compliance with OAC chapters 5160-44 and 173-39, including 173-39-02.18.

ODM approved provider:
Compliance with OAC Chapters 5160-44, 5160-45, and 5160-46.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODA or its designee for ODA-certified providers
ODM or its designee for ODM-approved providers
The ICDS plan as part of its will verify that the provider has an active Medicaid provider agreement to furnish this waiver service.

Frequency of Verification:

ODM Verification of provider qualifications is conducted in accordance with OAC 5160-45-06
ODA - Verification of provider qualifications is conducted in accordance with OAC 173-39-04

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 §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☐ **As a Medicaid state plan service under §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.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Under the 1915(b)/1915(c) concurrent waivers, the ICDS plans shall conduct all care management functions compliant with managed care treatment planning requirements at 42 CFR 438.208(c) using ICDS care managers. The ICDS plan will formulate a team to provide care management services that is led by the ICDS Plan care manager. The team may, with input from the individual and/or authorized representative, consist of the individual, authorized representative, the primary care provider, the care manager, the waiver service coordinator, as appropriate, the individual's family/caregiver/supports, and other providers based on the individual's needs. The role of the ICDS plan care manager will include, but not be limited to, the following: delineating roles and responsibilities for team members; serving as the accountable point of contact; directing all care management activities; developing, implementing and monitoring the care plan; exchanging information between team members; and organizing team meetings.

The ICDS care managers are employed by the ICDS plan and must not be employed by agencies providing direct services to the individual. The ICDS plans are responsible for ensuring that staff who are performing care management functions are operating within their professional scope of practice, are appropriate for responding to the individual's needs, and follow the state's licensure/credentialing requirements.

ICDS plans will be responsible for ensuring that members of the team, including staff who are directly employed by the plan or a delegated entity, who are completing care management activities are operating within their professional scope of practice, are appropriate for responding and managing to the individual's needs, and follow the state's licensure/credentialing requirements. ODM will not dictate minimum requirements for ICDS plan care managers whereas waiver service coordinators will be required to demonstrate at least one year of experience in working with persons with disabilities/chronic conditions and long term services and supports. Depending on the structure of the ICDS plan's comprehensive care management program, the roles of the waiver service coordinator and the accountable care manager may be filled by the same person. In this scenario, the minimum qualifications for the waiver service coordinator will still apply. Like ICDS care managers, waiver service coordinators must not be employed by agencies providing direct services to the individual.

ODM will require that the ICDS plan conduct professional training sessions for its personnel regarding disability competency issues such as access, communication, cultural sensitivity, person-centered approaches, and independent living philosophies.

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):

Each ICDS plan must ensure that it contracts only with providers who have valid Medicaid agreements at all times. Through the Medicaid provider enrollment process, ODM verifies that all ICDS waiver providers have had criminal record checks initially and then on an on-going basis (i.e., for all agencies and all ODA-certified independent and consumer-directed providers, at least every five years or at the time of any employment with a different provider agency even if the period of employment is less than five years; and annually for all ODM-approved non-agency providers). ODM requires all new ICDS waiver service providers to meet ODM's criminal record check requirements at the time of enrollment. Providers certified by ODA or the Ohio Department of Health (ODH) are subject to similar criminal record checks requirements as those approved by ODM. Therefore, such providers are not required to undergo an additional ODM criminal record check in order to be an ODM-approved ICDS waiver service provider.

There are two levels of background checks: background screening against relevant abuse and fraud databases (this screening process is described in detail in Appendix C-2-b of this waiver application) and criminal record checks with Ohio Bureau of Identification and Investigation (BCII). A criminal record check must be conducted by the FBI if the person does not present proof of Ohio residency during the five-year period immediately prior to the date the BCII criminal record check is requested.

If the criminal record check with BCII does find criminal convictions in the ICDS HCBS worker's past, there are tiered exclusionary periods for disqualifying offenses during which individuals convicted of certain crimes may not be hired. These exclusionary periods apply to both agency and non-agency providers. The exclusionary periods include five, seven and ten-year bars, as well as a permanent exclusion for certain disqualifying offenses.

The processes for background checks differ between agency and non-agency providers furnishing ICDS waiver services.

Process for Non-Agency Providers: ODM's MITS system conducts database screenings against exclusionary lists at the time a non-agency provider applicant submits his or her Medicaid application. If the provider applicant appears on an exclusionary list, the application is denied. ODM also requires that non-agency providers, as part of the Medicaid application process, provide a set of fingerprint impressions to BCI and submit to a criminal record check with BCI. If the provider applicant fails to provide fingerprint impressions upon request, he or she cannot be approved as a new Medicaid provider. ODM applies the results of the criminal record check against the tiered exclusionary periods set forth in OAC rule 5160-45-11. ODM also transitioned from annual background checks for independent providers to mandatory use of BCI's Retained Applicant Fingerprint Database (RAPBACK), an ongoing criminal records check. Failure to meet these standards will disqualify a provider.

Process for Agency Employees: Prior to hiring a new employee, the waiver agency must screen the applicant against a list of databases (see C-2-b) for disqualifying information. If the applicant meets certain criteria based on the results of their registry screening, they will not be permitted to furnish HCBS to individuals enrolled on the ICDS waiver and a criminal record check will not be necessary.

Persons who clear the screening are required to furnish a set of fingerprint impressions and submit to a criminal record check with BCII. If the person fails to provide the agency with fingerprint impressions upon request, they cannot be employed by the agency to provide HCBS to individuals on the ICDS Waiver. The agency can conditionally employ the person on a time-limited basis pending the results of the criminal record check, however, the person is only permitted to provide services under supervision. The agency applies the results of the criminal record check against the tiered exclusionary periods. If the results indicate the person has been convicted of, or pleaded guilty to, a disqualifying offense, then employment must be terminated. The waiver agency is responsible for ensuring that employees are subject to the database screening and criminal records recheck procedures every five years. The agency maintains documentation of the screening and records recheck for all employees. ODH reviews the records of agencies providing Medicare services and who are Joint Commission-accredited. ODM reviews agency records of agencies who do not provide Medicare services and who are not Joint Commission-accredited according to a pre-determined monitoring schedule. In addition, ODM follows NCQA-accreditation standards for credentialing/recredentialing agency providers (e.g., on-site visits of Medicare-certified home health agencies), as required in OAC rule 5160-1-42.

For self-directed caregivers who are not currently enrolled waiver providers with ODM, criminal records are verified by the FMS at hiring and at least every five years thereafter. Criminal record checks are conducted in accordance

with rule 5160-1-17.8 of the Administrative Code. Self-directed caregivers may begin rendering services while criminal record checks are pending for up to 60 days under conditional employment.

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; and, (c) the process for ensuring that mandatory screenings have been conducted. 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):

Pursuant to sections 173.38, 5164.342 and 5164.341 of the Ohio Revised Code, Ohio requires registry screens of provider agency applicants or employees prior to the background check being performed. They must also be performed on non-agency providers/applicants as part of the provider enrollment process. If a prospective provider, or existing agency or non-agency provider meets certain criteria based on the results of their registry screen, the person will not be permitted to furnish services to individuals enrolled on the ICDS Waiver. These databases include, but are not limited to the following:

(1) The excluded parties list system maintained by the United States General Services Administration, which tracks individuals who are debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549;

(2) The list of individuals and entities excluded by Medicare, Medicaid, or SCHIP and maintained by the Office of Inspector General in the United States Department of Health and Human Services;

(3) The DODD abuser registry;

(4) Ohio’s internet-based sex offender and child-victim offender database;

(5) Ohio’s internet-based database of inmates;

(6) Ohio’s state nurse aide registry;

(7) Any other database, if any, specified in rules adopted by ODM or the Ohio Department of Aging.

Providers are also prohibited from furnishing waiver services if the screen reveals there are findings by the director of the Ohio Department of Health that the applicant or employee neglected, abused, or misappropriated the property of, a resident of a long-term care facility or residential care facility.

Additionally, in accordance with Section 4723 of the Ohio Revised Code, nurse providers must have current, valid and unrestricted Ohio RN or LPN licenses, and LPN supervisors must hold appropriate licensure. Dietitians, social workers, nurses and counselors cannot have any actions or sanctions pending against them by their respective licensing bodies. This is verified according to the provider qualification verification section in the service definition outlined in Appendix C.

For self-directed caregivers who are not currently enrolled waiver providers with ODM, abuser registry screening is conducted by the FMS at hiring and at least every five years. Abuser registry screening is conducted at the limited level in accordance with rule 5160-1-17 .8 of the Administrative Code.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page (Appendix C-2-c) 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 to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *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 legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure 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 in OAC 5160-44-32.

Type of legally responsible individuals: spouse of an individual may serve as a direct care worker.

Services legally responsible individuals may provide: Choices home care attendant, homemaker, personal care aide, waiver nursing

Eligibility and authorization criteria:
Through assessment and care planning activities, the case manager determines each of the following:
1. Services are needed from the legally responsible individual while a willing and able direct care worker/provider is sought;
2. The health and safety needs of the individual may be assured through the legally responsible family member; and
3. Services authorized to be provided by a legally responsible family member are determined to meet extraordinary care requirements, as determined through an ODM approved exceptional care assessment tool.

The spouse who is paid for the provision of a waiver service must meet the provider qualifications that apply to a service and there must be a properly executed Medicaid provider agreement. In addition, other requirements such as the proper documentation and monitoring of the provision of services also apply.

The Ohio Extraordinary Care Instrument will be implemented statewide to assess if the range of support required by the Medicaid enrollee meets a standard of extraordinary care as defined by CMS and OAC 5160-44-32, and thus demonstrate if a legally responsible individual is eligible to serve as a paid caregiver as described in OAC 5160-44-32.

Limitations:
•The legally responsible individuals must be employed through an agency unless they are providing Choices home care attendant services.
•Service is not authorized for respite purposes.
•The number of hours a legally responsible individual may be authorized is set in accordance with OAC 5160-44-32. The maximum number of hours a spouse may be authorized is forty hours, unless 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 to serve as a direct care worker is in the best interest of the participant. This includes increased case management/waiver service coordination oversight activities when this allowance is implemented.

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.

☒ **Self-directed**

☒ **Agency-operated**

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 specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls 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.*

◉ **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.

Requirements are outlined in OAC 5160-44-32.

Individuals with legal decision-making authority are prohibited from serving as a direct care worker for an individual, except as follows:

A parent of an adult individual, 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 personal care or waiver nursing, 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, if granted court authority to serve as a direct care worker for the individual.
*representative payee (parent of an adult child only)

Services legally responsible relatives or legal guardians may provide: Choices home care attendant, homemaker, personal care aide, waiver nursing

Standard procedures for service authorization, oversight and verification are applied through the case management agency and provider oversight contractor to ensure payment is made only for services furnished in the best interest of the individual.

Legally responsible relative/legal guardian who is paid for the provision of a waiver service must meet the provider qualifications that apply to a service and there must be a properly executed provider agreement. In addition, other requirements such as the proper documentation and monitoring of the provision of services also apply.

The number of hours a relative described above may be authorized is set in accordance with OAC 5160-44-32.The maximum number of hours a relative designated legal decision-making authority may be authorized is forty hours, unless ODA, ODM or their designee determines additional hours are necessary to meet the health and safety needs of the individual.

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

○ **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:

Under its risk contract with ODM, each ICDS plan must establish policies and procedures to monitor the adequacy, accessibility and availability of its provider network to meet the needs of individuals served through the concurrent §1915(b)/ §1915(c) waivers. Each ICDS plan must analyze its provider network and demonstrate an appropriate number, mix and geographic distribution of providers, including geographic access by beneficiaries to practitioners and facilities. ODM reviews provider network adequacy against contractual provider network standards on a quarterly basis. If ODM finds any issues regarding provider access through other methods, including grievance reviews, ICDS plans are required to document a plan of assurance that access can be provided. The ICDS plan must also comply with contracting requirements in each individual's transition plan.

Qualified providers will have an opportunity to enroll as ICDS Waiver providers through ICDS plans. However, they must have an actual Medicaid provider agreement for the service they are authorized to provide. ICDS plans are required to confirm that providers furnishing services in the ICDS Waiver have an active Medicaid provider agreement and are in good standing with ODA or ODM, as appropriate.

Providers seeking to furnish services on those waivers must meet the following criteria for approval/certification:

Any person or agency that wants to provide ICDS Waiver services must complete the waiver service provider enrollment process set forth in OAC rule 5160-45-04 and meet the provider requirements and specifications set forth in OAC rules 5160-44 and 5160-46; or OAC chapter 173-39 (which includes provider conditions of participation, structural compliance reviews and program integrity (sanctioning for non-compliance) and waiver service specifications), as appropriate.

If a waiver individual prefers a particular provider who is not an approved Medicaid waiver provider, the ICDS plan selected by the individual can assist the individual and the potential provider in accessing appropriate informational materials and forms to initiate the provider enrollment process with ODM. The prospective provider is encouraged to contact ODM to initiate the provider enrollment process

Prospective providers are able to access information about the waiver program via the ODM website, ODM provider newsletters and other communications, and through ICDS plans' websites.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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:

(3) The number and percent of independent RNs and LPNs who continue to meet licensure requirements at the time of their structural review. Numerator: Number of independent RNs and LPNs who continue to meet licensure requirements at the time of their structural review. Denominator: Total number of independent RNs and LPNs who had a structural review.

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: Provider oversight vendor	☐ **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:
(4) The number and percent of providers that have an active Medicaid provider agreement with ODM prior to the ICDS plans authorizing the provider to provide waiver services. Numerator:Number of providers that have an active Medicaid provider agreement with ODM prior to the ICDS Plans authorizing the provider to provide waiver services. Denominator:Number of new providers providing waiver services.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
ICDS plans

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: ICDS plans	☐ **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:
(2) The number and percent of new ICDS Waiver agency providers that meet provider enrollment requirements prior to providing waiver services. Numerator: Number of new agency providers that meet provider enrollment requirements prior

to providing waiver services. Denominator: Total number of new agency providers enrolled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ODM review of provider enrollment data

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: Ohio Department of Aging	☐ **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:
(6) The number and percent of existing agency providers that continue to meet certification requirements at the time of Structural Compliance Review (SCR). Numerator: Number of existing agency providers that continue to meet certification requirements at the time of SCR. Denominator: Number of existing agency providers who had a SCR.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Structural Compliance Review

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**	☐ **Annually**	☐ **Stratified**

Specify: Provider Oversight Contractor & Ohio Department of Aging		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:
(5) The number and percent of existing independent/individual providers that continue to meet certification requirements at the time of Structural Compliance Review (SCR). Numerator: Number of existing independent/individual providers that continue to meet certification requirements at the time of SCR. Denominator: Number of existing independent/individual providers who had a SCR.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Structural Compliance Review

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: Provider Oversight Contractor & Ohio Department of Aging	☐ **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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
(1) The number and percent of new independent/individual ICDS Waiver providers who meet provider enrollment requirements prior to providing waiver services. Numerator: Number of new independent/individual providers who meet provider enrollment requirements prior to providing waiver services. Denominator: Total number of new independent/individual providers enrolled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ODM review of provider enrollment data

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:

Ohio Department of Aging		
	☐ **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:

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.

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:
(8) The number and percent of ICDS Waiver agency providers that have been verified to have met training requirements. Numerator: The number of ICDS Waiver agency providers that have been verified to have met training requirements. Denominator: The number of ICDS Waiver agency providers who were reviewed.

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: Provider oversight vendor and the Ohio Department of Aging	☐ **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:
(7)The number and percent of existing independent ICDS Waiver personal care aides (PCA) found not to meet required and continuing education training requirements for whom a corrective action was issued. Numerator:Number of independent PCAs found not to meet training requirements for whom corrective action was issued. Denominator:Number of independent PCAs found not to meet training requirements.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ODM

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 = 95% w/MOE of +/-5%
☒ **Other** Specify: ODM and Ohio Department of Aging (ODA)	☐ **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:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

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 reviews reports from the ICDS plans and the State's provider oversight vendor. The ICDS plan also provides ODM with updates on waiver quality processes and HCBS issues as they arise.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Oversight of the concurrent waivers is performed by ODM. ODM's Office of Managed Care maintains a Compliance Assessment System that assures compliance with Medicaid program requirements for both the 1915(b) and (c) waivers. ODM will compile, trend and review analyzed data gathered through the QIS processes detailed in this waiver application.

In an effort to ensure the continuity of care as individuals transition from fee-for-service Medicaid waivers to the ICDS waiver program, providers seeking to participate in the ICDS waiver must first be eligible to furnish services in the PASSPORT, Choices, Assisted Living, Ohio Home Care, or Transitions II Aging Carve-Out waiver programs. As a result, the ICDS plans will be responsible for verifying that prospective providers meet these criteria prior to serving individuals enrolled on the ICDS waiver.

The aforementioned waiver programs are operated by ODM and ODA. These State departments maintain robust and active provider structural review criteria to ensure HCBS waiver providers meet established conditions of participation including licensure/credentialing status, and continuing education training requirements.

Providers contracting with ICDS plans to furnish waiver services are subject to review by the ICDS plans. Any areas of non-compliance with plan contracting requirements or with conditions of participation are grounds for the ICDS plan to terminate their contract with the provider.

If, during a structural review performed by ODM or ODA of the provider's fee-for-service waiver services, areas of non-compliance with conditions of participation are discovered, each department maintains processes for educating, sanctioning and terminating providers. Should such action be taken by the State, the ICDS plans will be notified of this action and the provider will be terminated from the ICDS waiver, as well. If the provider is terminated, the ICDS plan is required to transition individuals to other service providers, thus insuring their health and welfare.

Collaborative actions the State has taken with the MCOPs to ensure that training requirements are met prior to rendering services include, notifying the plans of those providers who are in compliance with these training requirements and all other requirements in the provider conditions of participation. Additionally, in February, 2018, the State conducted a process improvement study with ODA to identify areas for improvement with the provider structural compliance review processes. As a result, it was acknowledged that more education of providers to help them maintain compliance is an area in which we want to focus. Efforts are underway to proactively remind providers about training requirements to help ensure compliance by the time they receive the monitoring review. Efforts to assist providers include the development of a brochure for new providers to explain what to expect during their first monitoring review, as well as information to make them aware of the most commonly found deficiencies (one of which is training requirements).

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 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.

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.

a) Waiver services to which the limit applies:

*Community Transition Services are limited to $2,000 per individual per waiver enrollment.
* Self-directed goods and services are limited to $2,500 per individual within 365 days.

*Home Maintenance and Chore Services are limited to $10,000 per twelve-month calendar year.

*Home Modification Services are limited to $10,000 per twelve-month calendar year unless there are additional funds available through a self-directed budget as described in Appendix E.

*Under Home Medical Equipment and Supplemental Adaptive and Assistive Device Services, reimbursement for medical equipment, supplies and vehicle modifications shall not exceed $10,000 within a calendar year per individual. The same type of medical equipment, supplies and devices cannot be approved for the same individual during the same calendar year unless there is a documented need for ongoing medical supplies or devices as documented by a licensed health care professional, or there is a documented change in the individual's medical and/or physical condition requiring the replacement.

*Under Supplemental Adaptive and Assistive Device Services, the service prohibits the same type of vehicle modification for the same individual within a three-year period unless there is a documented change in the individual's medical and/or physical condition requiring the replacement.

(b) Basis of limit: The limits that are being established for these services are set forth in the OAC. The limit on vehicle modifications is three years in order to avoid unnecessary replacement of vehicles, upgrades, etc.

(c) Adjustment of the limit: Home Maintenance and Chore services, Home Modifications and Home Medical Equipment and Supplemental Adaptive and Assistive Devices must be prior-approved by the ICDS plan. Home Medical Equipment and Supplemental Adaptive and Assistive Devices in excess of the limit can be approved by the ICDS plan when there is a documented need for ongoing medical supplies, or a documented change in the individual's medical and/or physical condition requiring replacement.

(d) Provision of exceptions: Any exceptions to either vehicle modifications and/or Home Medical Equipment and Supplemental Adaptive and Assistive Devices must be brought to ODM's attention for review and prior approval.

(e) Safeguards: ICDS plans are responsible for monitoring the adequacy of services provided to individuals. Individuals can request Home Maintenance and Chore Services, Home Modifications and/or Home Medical Equipment and Supplemental Adaptive and Assistive Device Services from their ICDS plan at any time. The need for home modification services may require the completion of an in-home evaluation by an occupational therapist or physical therapist as licensed pursuant to Chapter 4755 of the Revised Code. The evaluation shall determine the individual's capacity to utilize the requested service. It may also require the completion of an in-home evaluation by an appropriately qualified professional to determine the suitability of the immediate environment where the modification will be installed and the viability of the completion of the modification to improve independence.

An occupational or physical therapist may also be consulted to evaluate and recommend the most appropriate adaptive and assistive device to meet the individual's identified needs.

An in-home evaluation by an appropriately qualified professional may be required to determine the suitability of the immediate environment where a home maintenance and chore service will be performed and the viability of the completion of the service to improve independence and/or facilitate a healthy and safe environment.

(f) Notification of amount: ICDS plans must notify the individual of the approval of the request for and amount of Home Maintenance and Chore Services, Home Modifications and/or Home Medical Equipment and Adaptive and Assistive Device Services, and must update the individual's service plan accordingly.

(g) Hearing rights: ICDS plans must also notify individuals of their right to request a hearing subsequent to a denial of the individual's request for initial or subsequent Home Maintenance and Chore Services, Home

Modifications and/or Home Medical Equipment and Supplemental Adaptive and Assistive Device Services.

☐ **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.

☐ **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 and how they meet federal HCB Settings requirements, at the time of submission and in the future.

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 ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Beginning in 2015, Ohio completed an initial assessment of the HCBS "settings" rule regulations to determine systemic and program specific regulations and processes requiring modification to achieve compliance with the HCBS settings rule requirements. This assessment process resulted in proposed changes to Ohio regulations, development of provider assessment and provider training tools.

Statute and Administrative Code Updates

Ohio identified and updated Ohio Administrative Code (OAC) regulations needed to assure incorporation of HCBS settings requirements for HCBS programs. Ohio added regulations to the OAC to require individuals enrolled in programs reside in settings that meet HCBS settings rule requirements, provider compliance with the regulations, and person-centered service planning activities to be completed in accordance with the federal regulations. Below is a listing of state statute and administrative code that have been updated or created in response to meet the HCBS settings rule requirements.

- Rule 5160-44-01 | Nursing facility-based level of care home and community-based services programs: home and community-based settings
- Rule 5160-44-02 | Nursing facility-based level of care home and community-based services programs: person-centered planning
- Rule 5160-33-03 | Eligibility for the Medicaid funded component of the assisted living program
- Rule 173-38-01 | Assisted living program (Medicaid-funded component): introduction and definitions
- Rule 5160-33-04 | Enrollment process for Medicaid-funded component of the assisted living waiver program
- Rule 173-38-03 | Assisted living program (Medicaid-funded component): enrollment and reassessment of individuals

Applicable Services

All assisted living waiver services are provided in a provider owned and controlled residential setting.

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: 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

Beginning in 2016, 100% of existing HCBS settings were evaluated to determine compliance with settings criteria. Provider owned and controlled settings (OHC Adult Day Service providers) 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.

In the event a setting that previously demonstrated evidence of compliance cannot (or does not) subsequently produce acceptable evidence of compliance, the State's established relocation team, led by the State Long-Term Care Ombudsman and/or entities responsible for program care coordination, will work with individuals to transition them to a setting of their choice that meets the HCBS characteristics.

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.

Ombudsman

In conjunction with the State Long Term Care Ombudsman Office, the State employed a public education and outreach campaign on the HCBS settings characteristics, including communicating the process for individuals to raise concerns regarding the community nature, or lack thereof, of a specific setting. There also was guidance developed for ombudsman representatives, case managers, and waiver Service coordinators when educating individuals about HCBS settings and person-centered planning. Additional guidance was developed to provide guidance to individuals receiving Assisted Living or Adult Day Services in the Assisted Living, PASSPORT, Ohio Home Care and MyCare Ohio Waivers.

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.

Care Manager

The care manager 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 confident 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 Ombudsman, licensing agency, provider compliance, or protective services. The waiver service coordinator frequently reaches out the 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.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Waiver 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 *(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:

☐ **Social Worker**
Specify qualifications:

☒ **Other**
Specify the individuals and their qualifications:

The ICDS plans will be responsible for managing and coordinating a full continuum of benefits—medical, behavioral and long term care services and supports. These benefits will be coordinated as part of the ICDS plans' comprehensive care management program. Under the 1915(b)/1915(c) concurrent waivers, the ICDS plans, through a trans-disciplinary care management team approach, will conduct comprehensive care management activities in accordance with 42 CFR 438.208(c) and the Medicaid provider agreement. The trans-disciplinary care management team led by an ICDS care manager will, with input from the individual and/or authorized representative, consist of the individual the authorized representative, the primary care provider, the ICDS care manager, the individual's family/caregiver/supports, the waiver service coordinator, and other providers as appropriate.

Specific responsibilities of the ICDS plan care manager will include, but not be limited to, the following: serving as the accountable point of contact for the individual; identifying and negotiating roles and responsibilities for all team members; arranging for, or conducting, the comprehensive assessment; developing, implementing and monitoring the comprehensive care plan; directing all care management activities (e.g., delegating tasks to team members, completing the care gap analysis, and structuring the in-person contacts to ensure alignment with the care plan goals/interventions).

Specific responsibilities of the waiver service coordinator will include, but not be limited to, the following: the ongoing assessment of LTSS for individuals currently receiving waiver services; the initial LTSS assessment for individuals who present a need after a level of care determination has been made ; waiver service plan development, review and updates; crisis intervention, event-based visits, provider monitoring and assisting individuals with self-directed care. The waiver service coordinator will be accountable to the ICDS plan care manager who is ultimately responsible for ensuring the appropriate development of the waiver service plan and its integration to the comprehensive plan of care.

ICDS plans will be responsible for ensuring that staff, including members of the trans-disciplinary care management team, who are performing care management activities are operating within their scope of practice, are appropriate for responding or managing the individual's needs, and follow the state's licensure/credentialing requirements. ODM will not dictate minimum requirements for ICDS plan care managers, however they must have the skills necessary to coordinate the full array of services required by the individual. Waiver service coordinators will be required to demonstrate at least one year of experience working with persons with disabilities/chronic conditions and LTSS. Depending on the structure of the ICDS plan's comprehensive care management program, the roles of the waiver service coordinator and the care manager may be filled by the same person. In this scenario, the minimum qualifications for the waiver service coordinator will still apply.

ODM recognizes the unique needs of this population and will require that the ICDS plan hire a Long-Term Care Services and Supports/Home-and-Community Based Services Director to ensure there is specific focus on meeting the long-term care needs of this population. In addition, ODM will require that the ICDS plans conduct professional training sessions for its personnel regarding disability competency issues, such as access, communication, cultural sensitivity, person-centered approaches, and independent living philosophies.

ODM uses a variety of methods to monitor the MCOPs including, but not limited to, annual training mandates, yearly attestations, health/safety/welfare strategies (e.g., administrative reviews, in-home checks, etc.) and other forms of technical assistance to ensure that care managers have the necessary skills to meet the individuals' needs. ODM also monitors the MCOPs' performance via quarterly record reviews conducted by the EQRO. A list of annual training sessions includes: person-centered care planning process, cultural and disability competence, communication, accessibility and accommodations, independent living and recovery, and wellness principles, Americans with Disabilities Act/Olmstead requirements and other topics specified by the state, etc. ODM also reserves the right to request a description of the MCOP's caseload assignments upon request.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *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.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

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.

Individuals may exercise choice and control over the provision of waiver services they receive as determined during the service planning process. Individuals also have choice and control over who participates in the waiver service planning process. Further, individuals may exercise this authority over the selection and direction of waiver service providers including opportunities to pursue self-direction of certain waiver services. Services and supports furnished to individuals enrolled on the waiver are both planned and implemented in accordance with each individual's needs and expressed preferences. To that end, the ICDS plan through its waiver service coordinator will ensure the following:

* Individuals and/or their authorized representatives participate in the development of the waiver service plan and select or dismiss waiver service providers. Those providers include traditional agency providers such as Medicare-certified HHAs, Joint Commission-, ACHC- and CHAP-accredited agencies, and otherwise approved waiver service providers. They also include non-traditional, non-agency providers such as RNs, LPNs at the direction of an RN, non-legally responsible family members, other non-agency providers (including consumer-directed individual providers).

*If an individual and/or authorized representative elects to receive all or a portion of their waiver services from non-agency providers, the waiver service coordinator must assure that the consumer/representative trains the providers to meet the consumer's health care needs, and/or specifies additional training the provider must successfully complete prior to furnishing waiver services. The individual and his/her selected waiver service coordinator will establish back-up plans for when a provider(s) is unable to furnish services as scheduled. The individual and/or authorized representative will approve timesheets after waiver services have been furnished.

The ICDS plan must assure the health and welfare of the individual, and the competency of the individual and/or his/her representatives. The ICDS plan must verify that the individual and/or his/her representative can successfully demonstrate an ability to understand and communicate the individual's health care needs, advocate on their own behalf, and report provider performance concerns to their selected ICDS managed care plan, ODM, and/or the State Long-Term Care Ombudsman. The ICDS plan will also work with the individual to assist with conflict resolution should circumstances warrant such intervention on behalf of the individual and their chosen non-agency provider.

If an individual elects to receive services from a non-agency provider or consumer-directed individual provider but the ICDS plan determines the individual or their representative cannot successfully communicate their health needs or advocate on their behalf, the ICDS plan may provide or arrange for additional training in order for the individual and/or representative. If, following the completion of the training, the ICDS plan still cannot assure the individual's health and welfare, the ICDS plan may require that the individual only receive services from agency providers. In the event that an individual is required to transition to an agency provider(s), the ICDS plan will work actively with the individual and/or their representative to manage the transition. Individuals will be given additional opportunities to utilize non-agency providers (including self-directed providers).

*All individuals enrolled in the ICDS waiver have the right to request a state hearing anytime they disagree with an action that has been taken by a county department of job and family services or a state agency. Individuals will also have the right to file a grievance regarding quality of care or an appeal regarding any action with the ICDS plan and attempt to settle their dispute through that administrative process. Filing a grievance does not affect their ability to request a state hearing. Individuals will have to exhaust the plan appeal process before requesting a state hearing in accordance with 42 C.F.R. 438.402.

The ICDS plan is the entity that will be accountable for waiver service plan development and monitoring.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. 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; and, (g) how and when the plan is updated, including when the participant's needs change. 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):

Under this program, all individuals enrolled in the ICDS waiver will be eligible to receive care management services that will coordinate his/her medical, behavioral, long term services and supports and social needs. The ICDS plan will use a trans-disciplinary team led by an ICDS care manager to deliver all care management activities, including the completion of the comprehensive assessment and the development, implementation and monitoring of the care plan.

The ICDS plan (through the waiver service coordinator who is either directly employed by the ICDS plan or is employed through a contracted, delegated arrangement) will be responsible for developing the waiver service plan with the individual, sharing the waiver service plan with the trans-disciplinary team for review/ approval, coordinating the approved waiver services, assuring the individual's health and welfare and adequacy of service delivery, and integrating the waiver service plan into the comprehensive care plan.

Individuals who are enrolled in the ICDS waiver program will be afforded the opportunity, as a component of the comprehensive care management furnished through the ICDS plan, to select a waiver service coordinator to facilitate and manage the delivery of waiver services authorized in the individual's waiver service plan.

ICDS plans are required to contract with the AAAs to perform waiver service coordination for individuals age 60 and older. AAAs can also provide waiver service coordination to those under 60. Additionally, ICDS plans may contract with other entities that have experience working with people with disabilities, including, but not limited to centers for independent living and disability-oriented case management agencies, etc. ICDS plans may also perform waiver service coordination as part of comprehensive care management. Individuals age 60 and older are not obligated to receive their waiver service coordination through the AAA, nor are they required to change waiver service coordinators upon reaching age 60.

The individual's LOC determination will be conducted by the PAAs and his or her comprehensive assessment will be conducted by the ICDS plan's care manager in conjunction with the individual and his or her trans-disciplinary care team (including the waiver service coordinator). The comprehensive assessment will evaluate domains such as the following: medical, behavioral, long term services and supports, functional and social needs; individual's preferences; health history; wellness and prevention activities; etc. A single, individualized, person-centered comprehensive care plan that addresses clinical and non-clinical needs, and integrates the waiver service plan, if applicable, will be developed by the ICDS care manager with the individual and members of the team, including the waiver service coordinator, as appropriate.

The ICDS plan will assist the individual with the development of a back-up plan that provides for alternative arrangements for the delivery of services in the event that the responsible provider fails or is unable to deliver them. The back-up plan will reflect both informal (unpaid) and formal (paid) services, and will be incorporated into the individual's comprehensive care plan.

Service Planning for Individuals Transferring from a FFS Waiver to the ICDS Waiver

If an individual was enrolled in a FFS NF-LOC Waiver prior to enrollment in an ICDS plan, the plan will honor the individual's existing service levels and providers for a pre-determined amount of time depending upon the waiver services. Waiver personal care aide, nursing, respite, Choices home care attendant,home care attendant, enhanced community living, adult day services, social work/counseling and independent living skills providers will be maintained for 365 days unless a significant change occurs or individuals express a desire to self-direct. All other waiver services will be maintained for 90 days. Prior to the conclusion of the transition period, the individual shall meet with his or her waiver service coordinator, the ICDS plan care manager, and other trans-disciplinary care management team members, as appropriate, to discuss any required changes in services or providers. If a change in provider is required, the individual will be provided information regarding the choice of new providers and an individualized transition plan describing timelines for transition to the new provider will also be developed and integrated into the care plan. The State will provide the existing waiver service plan for each individual to the enrolling ICDS plan prior to the individual's enrollment effective date.

ICDS Waiver Service Plan Approval

The waiver service plan approval process at the individual's ICDS plan verifies that the services identified are appropriate for meeting the individual's needs. The review and approval of the waiver service plan will be subject to the coverage

and authorization of service requirements established at 42 CFR 438.210. Standard authorization decisions will not exceed 14 calendar days following receipt of the request for the service, or no later than 72 hours for cases in which the provider or the plan determines that the standard timeframe would jeopardize an individual's life or health and ability to attain, maintain or regain maximum functioning.

Once the waiver service plan is approved and services are authorized, the ICDS plan notifies the individual/legally responsible person of the approval and provides information on the services that will be provided and the start date of services. The individual/legally responsible person is given a copy of the approved waiver service plan and individual budget, including crisis plan as applicable. The waiver service plan will be signed by all waiver providers pursuant to 42 CFR 441.301 and effectuated through an implementation plan no later than December 31, 2018.

The ICDS plan will not approve a waiver service plan that exceeds the limitations in any individual service definition, for the sets of services found at C-4 (except where needed to maintain safety as outlined in C-4).

Updates/Changes to the Waiver Service Plan

The ICDS plan works with the individual and the trans-disciplinary care team to ensure that the waiver service plan is updated with current and relevant information. The waiver service plan shall be updated as appropriate based upon the individual's assessed needs or when the ICDS plan becomes aware of any relevant information that should be included in the document (e.g., change in back-up plans, etc.). This will help to assure integrity of and consistency throughout the waiver service administration process. Any updates to the waiver service plan will be provided to the ICDS plan care manager/team to ensure that applicable updates are also made to the comprehensive care plan.

In addition, the State expects that updates to the waiver service plan will be synchronized with updates to the comprehensive assessment and plan of care. The comprehensive assessment must be updated when there is a significant change in the individual's health status or needs, a significant health care event (e.g., hospital admission or transition between care settings, etc.), change in functional status, loss of a caregiver, etc. As a result, the comprehensive plan of care and the waiver service plan, as appropriate, should be updated within 14 calendar days of identifying a change in the individual's needs or circumstances.

New and existing individuals enrolled on the waiver will be informed of the process for requesting additional services if they exceed limitations, but are necessary to maintain safety, by the waiver service coordinator at the time of waiver service plan development and updates. This information will also be included in written materials via a member handbook provided by the ICDS plan to the individual.

ICDS Waiver Contact Schedule

The State established a minimum contact schedule for each care management stratification level to which an individual can be assigned, supporting the use of the trans-disciplinary team approach. The staffing ratio is one full-time equivalent to the number of individuals receiving care management in the specific stratification level. the minimum staffing ratios are as follows: intensive -- 1:25 to 1:50; high -- 1:51-1:75; medium -- 1:76-1:100; and low -- 1:101-1:250. Any team member's time may be used to meet this staffing ratio requirement as long as the time is spent directly on performing care management functions and can be linked directly to an individual in the assigned risk stratification level ICDS plans will consider factors such as chronicity of medical conditions, availability of informal supports, current waiver acuity status, etc., when determining appropriate assignment of an individual to a stratification level. Based on the stratification level assignment, ICDS plans will: develop a contact schedule with each individual based on his/her needs; document the contact schedule in the comprehensive care plan; and ensure that the contact schedule is no less frequent than what is required by the State, in the contract, for each stratification level.

Beneficiaries newly enrolled in the waiver will have a minimum contact schedule no less frequent than the contact schedule established for the High risk stratification level of care management for at least the first six months. To receive services from the waiver, the beneficiary will receive a minimum of one HCBS service monthly.
The content of the telephonic or in-person contact will be directed by the ICDS plan care manager, with input from the team, and will be linked to the goals, interventions and outcomes of the comprehensive care plan. The ICDS plan care

manager, in coordination with the waiver service coordinator, will consider the waiver service plan implementation and monitoring activities that must be addressed during contacts with the individual, and will develop a contact schedule that will documented in the plan of care. It will also identify a primary point of contact for each individual. During a contact, the waiver service coordinator will review the waiver service plan to determine if services are being rendered as intended, gauge participant satisfaction, and identify and discuss changes in the individual's health, family and environmental situations.

It is possible that that the ICDS plan may request that additional members of the team have contact with the individual depending upon the individual's identified needs, however, these efforts will be coordinated through the primary point of contact. Upon discovery of a potential significant change event, telephone contact between the care manager or waiver service coordinator and the individual must occur by the end of the next full calendar day. If it is determined through this telephone contact that a significant change occurred, a face-to-face visit must take place by the end of the third full day following discovery. Reassessment and an update of the comprehensive care plan/waiver service plan shall occur, as needed.

All team members will be responsible for documenting the content of their contacts, reporting back to the ICDS plan care manager, and integrating the information into the care plan. Any member of the team may request a planning meeting in consultation with the ICDS plan care manager.

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.

Strategies to mitigate risk ar identified as part of an individual's comprehensive assessment with agreed upon interventions integrated into an individual's service plan. Risk is monitored on an ongoing basis through face-to-face visits and telephonic monitoring with strategies being modified as needed based on their demonstrated effectiveness.

ICDS plans must make care management supports and assistance available to individuals on a 24-hour, 7-day a week basis. The purpose is for an individual to have an ability to discuss an issue with a qualified staff person (i.e., preferably his or her care manager and/or a member of the team) who has access to the individual's care plan, is familiar with the case, understands his or her unique needs, and can determine the urgency of the issue in order to act appropriately and timely. During a plan's hours of operation, the plan may use conventional methods, such as direct access to the care management department or a transfer from the member services department to care management, to meet this requirement. However, outside of a plan's hours of operation, the plan is expected to develop a solution that allows individuals to access care management support and assistance as described above. Within these parameters, a plan may design a strategy to meet their members' needs in this regard. Examples of methods that plans may use include, but are not limited to the following:

* Establishing one number exclusively for care management and to meet this feature of the ICDS.

* Use of a 24/7 nurse advice line as one of the "front doors" to accept and triage requests for care management; however, there must be staff who are familiar with care management processes in order to appropriately route, or respond to, individuals as needed.

Additionally, where necessary, the ICDS plan may initiate risk and safety planning via the implementation of a "Consumer Acknowledgement of Responsibility" or comparable form, or explore development of a behavior support plan by appropriate personnel.

For both provider-managed and self-directed services, the ICDS plan assists the individual with the development of back-up plans reflected on the individual’s waiver service plan. Individuals may use both informal (unpaid) and formal (paid) services as a part of their back–up plan. Agency based providers may serve as both an individual’s primary service provider or as a back–up provider. The ICDS plan will facilitate discussions with individuals to determine who will provide services in the event of a planned or unplanned absence of the primary service provider. The individual/agency providing the service will be identified on the individual’s back-up plan. The back-up plan will indicate the provider’s status as either the primary or secondary back-up provider as well as if the provider is a formal or informal support to the individual.

The ICDS plan will make certain that individuals understand that anyone they may want to pay for service provision through the waiver must be an approved provider with a valid and active Medicaid provider agreement at the time of service. To ensure service continuity, back-up plans are reviewed and updated as needed, and at a minimum, during the annual reassessment evaluation.

Additionally, the ICDS plans will have staff available to the consumer 24 hours-a-day, 365 days-a-year.

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 ICDS plan will make available to the individual, prior to enrollment, at annual reassessment, and at any time upon request, a summary of each agency, and non-agency provider available through the ICDS plan serving individuals in that region. The provider list also includes current self-directed providers who have expressed an interest being employed by additional individuals enrolled in the ICDS waiver. This information will only be provided to individuals who have expressed an interest in self-direction. The ICDS plan will be required to contract with any qualified provider who is willing to accept the specific negotiated rate chosen by an individual who is directing their own care.

Individuals enrolled in the waiver review this information with the ICDS plan's trans-disciplinary care management team, including the waiver service coordinator, in order to make the best decision for their care needs. If the individual has questions, the ICDS plan will address them and provide any other necessary information requested. The ICDS plan will be responsible for ensuring the information provided is current by updating the document on an ongoing basis. The ICDS plan will explain the information presented to the individual by reviewing each provider type and responding to questions posed by the individual in order to support informed choice.

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):

Each ICDS plan approves service plans following a process approved by ODM. Service plan approval occurs locally at each ICDS plan. ODM authorizes the ICDS plan to approve services. ODM uses the EQRO to conduct audits of service plans maintained by the ICDS plans. ODM may also review the service plans during annual contract compliance visits. ODM may revoke approval authority if it determines that the ICDS plan is not in compliance with the waiver requirements. In the case of a revocation, the plan of care approval would be carried out by the ODM designee.

Individuals can request a state hearing with ODM regarding waiver services and ODM has general authority to provide oversight of the ICDS plan's actions regarding the waiver, which includes waiver services.

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 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:

Copies of the waiver service plan are maintained by the ICDS plans.

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 and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The ICDS Plan care manager will lead the care management team and is ultimately responsible for ensuring all care management activities are performed in order to meet the individual's needs. As a result, the ICDS Plan care manager will ensure that the waiver service coordinator is monitoring the individual's health and welfare and adequacy of service delivery. The ICDS plan should perform these activities and provide the required information back to the ICDS plan care manager so that the comprehensive care plan, which includes the waiver service plan, can be updated accordingly.

In this capacity, the ICDS plan will be responsible for:

*Monitoring and assuring that individuals can exercise free choice of provider from among the ICDS plan's panel of available providers;
*Monitoring and assuring the appropriateness of service delivery and the outcomes identified on the waiver service plan;
*Monitoring and assuring that services meet the needs of the individual;
*Monitoring and assuring that back-up plans are effective;
*Assuring that methods are in place for prompt follow-up and remediation of identified problems; and
*Reporting outcomes of service delivery or unmet needs to the ICDS care manager/trans-disciplinary team.

The monitoring methods include telephone contact and in-person visits with the individual, an ongoing review of needs and supporting documentation, and when a change in the individual's care needs or service provision is indicated. In addition, a reassessment of LTSS needs is conducted with each individual. A contact schedule will be developed for each individual based on his/her assigned risk stratification level and should be documented in the comprehensive care plan; the contact schedule and the mode(s) of communication will be dictated by the needs of the individual. At a minimum, the ICDS plan must adhere to the contact schedule as specified by ODM for the intensive, high and medium stratification levels; contacts can range from 1 in person visit every two months to 1 in person visit every six months. Contacts (in person or telephonic)may be more frequent depending on an individual's circumstances. An individual who is newly enrolled in the waiver will have a minimum contact schedule for the first six (6) months of waiver enrollment that is no less than the contact schedule required for the high risk stratification level. Additionally, the waiver service coordinator is required to contact the member at least once every ninety (90) days. An ICDS Plan must also develop the contact schedule for individuals assigned to the low and monitoring stratification levels which will be approved by ODM.

This contact schedule ensures that a member of the ICDS care management team, such as the waiver service coordinator, is in communication with individuals enrolled in the waiver, and assists with the timely identification of unmet needs or service delivery problems. Modifications to the waiver service plan and service delivery schedule are initiated as soon as the need/issue is identified. The individual enrolled on the waiver chooses from a variety of methods to resolve the identified issues including the selection of alternate providers or direct service workers, negotiation with current providers for service modifications, adding (waiver and non-waiver) services, and changes in the level of involvement of the individual's informal support systems.

The waiver service plan is updated to describe the intervention developed to address the issues, time frames for implementation, entities responsible for implementation and times frames to evaluate the effectiveness of the intervention in resolving the identified need or problem. The ICDS plan is responsible for monitoring and evaluating the effectiveness of services as well as individual's satisfaction with the intervention.

ODM monitors that: services are furnished in accordance with the waiver service plan; individuals enrolled in the waiver have access to both waiver and non-waiver services identified on the waiver service plan; needs identified during the assessment are addressed on the waiver service plan; back-up plans are in place and effective; the individual is satisfied with service delivery; and there is prompt follow-up when problems are identified. ODM monitors and provides oversight through a variety of processes, including reviews performed by the EQRO, data and reports submitted by the ICDS plans, conducted by ODM of the PAA under contract with the state to conduct LOC determinations, and reviews of the ICDS plans, as applicable.

Oversight of the concurrent waivers is performed by ODM. ODM's Office of Managed Care maintains a Compliance Assessment System that assures compliance with Medicaid program requirements for both the 1915(b) and (c) waivers. Identified areas of noncompliance are subject to progressive sanctions which may include, but are not limited to corrective action plans and potential termination, amendment or nonrenewal of the ICDS plan's Provider Agreement. ICDS plans are required to implement corrective action for any program violation, whether identified by the ICDS plan or by ODM.

b. Monitoring Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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:
(2) The number and percent of ICDS Waiver participants reviewed whose waiver service plans have strategies to address and mitigate their identified health and welfare risk factors. Numerator: Number of participant records reviewed whose service plans have strategies to address and mitigate their health and safety risks factors. Denominator: Total number of participant records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
EQRO

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 = 95% w/MOE of +/-5%
☒ **Other** Specify: EQRO	☐ **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**

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

Performance Measure:
(3) The number and percent of waiver service plans reviewed that address individuals' personal goals. Numerator: The number of waiver service plans reviewed that address individuals' personal goals. Denominator: Total number of waiver service plans reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
EQRO

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 = 95% w/MOE of +/-5%
☒ **Other** Specify: EQRO	☐ **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:
(1) The number and percent of ICDS Waiver participants reviewed whose waiver service plans adequately address their assessed needs. Numerator: Number of participant records reviewed whose service plans adequately address their assessed needs. Denominator: Total number of participant records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
EQRO

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 = 95% w/MOE of +/-5%
☒ **Other** Specify: EQRO	☐ **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:

b. ***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.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

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:
(5) The number and percent of sampled ICDS Waiver participants whose service plans were revised, as needed, to address changing needs. Numerator: Number of sampled ICDS waiver participant records whose service plans were revised, as needed, to address changing needs. Denominator: Total number of participant records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
EQRO

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 =

		95% w/MOE of +/-5%
☒ **Other** Specify: EQRO	☐ **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:

(4) The number and percent of ICDS Waiver participants reviewed whose waiver service plans were updated at least once in the past 12 months. Numerator: Number of participant records reviewed whose service plans were updated at least once in the

past twelve months. Denominator: Total number of participant records reviewed.

Data Source (Select one):
Reports to State Medicaid Agency on delegated
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: ICDS Plans	☐ **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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***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:
(6) The number and percent of ICDS Waiver participants reviewed who received services in the type, scope, amount and frequency specified in their service plan. Numerator: Number of participant records reviewed who received services in the type, scope, amount and frequency specified in the service plan. Denominator: Total number of participant records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
EQRO

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 = 95% w/MOE of +/-5%
☒ **Other** Specify: EQRO	☐ **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:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

e. ***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:
(7) The number and percent of ICDS Waiver participants reviewed whose records contained a document signed by the participant to indicate their choice to receive waiver services instead of institutional care. Numerator:Number of records containing document signed by participant to indicate their choice to receive waiver services instead of institutional care. Denominator:Number of records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
EQRO

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 = 95% w/MOE of +/-5%
☒ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

EQRO		
	☐ **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.

The State will rely on an external quality review organization (EQRO) to gather information for several performance measures. The EQRO will be required to use a team of reviewers that minimally consists of a registered nurse and social worker. This will be critical given that the waiver service plan reviews will be included as part of a broader review of the plan's comprehensive care management model. The EQRO will be required to designate a project lead/director with at least five years of experience with Medicaid long term services and supports. State staff will provide orientation to the EQRO related to waiver service planning and will ensure that the EQRO has access to any operational, regulatory, and program documents related to waiver service planning. State staff will also make themselves available to serve as an ongoing resource to the EQRO. As part of the evaluation design, the State will closely work with the EQRO to ensure it understands and correctly interprets the intent of the QIS measures and will participate in mock reviews with the EQRO until there is a confidence by State staff that the EQRO is able to make appropriate assessments of plan's compliance with each of the areas under evaluation.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Oversight of the concurrent waivers is performed by ODM. ODM's Office of Managed Care maintains a Compliance Assessment System that assures compliance with Medicaid program requirements for both the 1915(b) and (c) waivers. ODM will compile, trend and review analyzed data gathered through the QIS processes detailed in this waiver application.

ODM relies on reports submitted by the State's EQRO contractor to identify deficiencies related to service planning. ODM maintains a system for reporting and tracking to resolution findings related to service planning issues. When such findings are reported on a care planning issue, ODM notifies the ICDS plan and requires the ICDS plan to address the identified problem and report completion to the State.

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 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. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

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. The nature of the opportunities afforded to participant:

The nature of the employment authority opportunities afforded to individuals enables them to act as the employers of record with the authority to hire, train, direct, and dismiss their self-directed caregivers. Self-directed caregivers may include friends, neighbors, and some relatives. Individuals exercising this authority may have multiple self-directed caregivers.

Individuals can also exercise budget authority when developing their person-centered services plans in conjunction with their case managers and determining the budget amount for self-directed services, including Choices home care attendant, personal care aide, home care attendant, waiver nursing, alternative meals, home maintenance and chores, home modification, and home medical equipment and supplies, and supplemental adaptive and assistive devices.

Individuals identify self-directed caregivers for program enrollment. Individuals evaluate their current person-centered services plans to determine what services they need to safely maintain themselves at home and share these determinations with their case managers.
In this waiver, for self-directed services paid through the FMS, the FMS is responsible for these activities. The FMS contractor “tracks and reports participant funds, disbursements and the balance of individual waiver funds.
In addition, the ICDS plans through the care manager, their designee, or the FMS will be responsible for verifying that a caregiver selected to furnish HCBS meet the necessary qualification established by the state and have the appropriate agreements in place to furnish Medicaid services.

The State (with collaboration from the ICDS plan) will monitor FMS performance against the FMS entity’s contract with the State. The FMS Contractor will be the caregiver enrollment entity for self-directed services specified in appendix C and will conduct eligibility verifications, including criminal record and screening. The FMS contractor will maintain records of all individual employers and self-directed caregiver associations and will provide ODM access to all data necessary to conduct provider oversight and other administrative activities.

The FMS Contractor shall collect, process, and verify timesheets of each individual employer’s workers for the authorized services as outlined in the individual's service plan and individual budget. The FMS Contractor shall verify that the service billed and hours worked are in the approved service plan prior to making payment. The FMS Contractor shall produce twice monthly statements for each individual employer and provide a report accounting for all payments made to individual caregiver. The FMS Contractor shall include in these statements and the report the name and identification number of the employer, the employer’s caregiver's name and identification number, wages, taxes, and insurances paid for the current period and year-to-date compared to the amount authorized for the current period and year-to-date.

B. How the individuals take advantage of these opportunities:
At each initial assessment and annual reassessment, case managers give individuals an overview of the waiver program that includes a description of the self-direction options available. This includes a discussion of the purpose of self-direction, the differences between provider-managed and self-directed services, and the additional responsibilities of individuals who choose this option. Individuals may choose a representative to support their use of self-direction, but some individuals may need a representative. Individuals and their representatives must be willing and able to direct the services to use the self-directed service delivery method.
Information about the self-directed service option is also available on OMD's and ODA's website and on request.

C. The entities that support individuals who direct their service and the supports that they provide:
Waiver service coordinators, including case managers, provide information and assistance, help individuals gain knowledge of employer responsibilities, and assist with the development and management of their person-centered services plans. When individuals express an interest in using the self-directed option, Waiver service coordinators provide them with information and guidance on the qualifications of a self-directed caregiver, recruitment, hiring, and training of a qualified provider, and employer-related tasks, including working with the FMS. Case managers also work with individuals on budget authority for identified services. If individuals identify representatives to assist with directing their service, the representatives work with the individuals and the Waiver service coordinators to understand the self-directed option. Case managers work with individuals who need representatives, but have not identified any, to identify their representatives.

The FMS is a vendor that holds a contract with Ohio Department of Administrative Services to provide individuals with

administrative functions.
The FMS assists with individual education on becoming an employer by providing individuals with an employer packet. On behalf of individuals, the FMS vendor furnishes self-directed caregiver employee packets that include an enrollment form, the individual employer/employee agreement, sample reports, and the necessary Federal and State employment and tax forms, including for the Ohio Bureau of Workers' Compensation.

The FMS assists individuals by reviewing time sheets and processing the self-directed caregiver's payroll. The FMS reports payroll processing issues to individuals, self-directed caregivers, and case managers (when appropriate), and works with them to resolve problems.

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

When individuals express interest in becoming employers through self-direction, waiver service coordinators work with them to develop person-centered services plans that include any support needed to assist individuals with the responsibilities of an employer. Waiver service coordinators provide these individuals with information that explains all of the following employer expectations:

1. Understanding methods for selecting, managing, and dismissing employees.
2. Understanding what service activities are covered.
3. Participating in the development, monitoring, and revision of the person-centered services plan and reliable back-up plans.
4. Understanding corresponding provider requirements, including criminal records checks.
5. Working with the FMS for timely payroll processing, including written approval of provider time sheets.

Waiver case managers also provide individuals who express interest in budget authority through self-direction the following information:
1. Determining wages and establishing billable rates for self-directed caregivers; and
2. Deciding spending for eligible self-directed services

The ICDS plan will arrange for additional skills development in specific areas as requested by the individual or as deemed necessary by the ICDS plan to assist the individual in the role of the employer. Individuals who cannot meet any of the expectations as employers may elect to use self-direction if case managers determine that their representatives are able to meet those expectations. Individuals who elect to exercise budget authority will receive training from their waiver service coordinator on selecting caregivers and budgeting to ensure their assessed needs are met.

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.

At each initial assessment and annual reassessments, care managers and/or waiver service coordinators give individuals an overview of the waiver program that includes the role of the care manager, waiver service coordinator, the person-centered planning process, available services, and a description of the self-direction option. This description includes a discussion of the purpose of self-direction, the differences between the provided-managed and self-directed services, and the additional responsibilities of individuals who choose the self-directed option.

Information about self-directed option is also available on OMD's and ODA's website and on request. Waiver service coordinators will assist individuals with accessing this additional information.

When individuals express interest in self-directed services, waiver service coordinators provide detailed information about self-direction, including the requirements for hiring, taxes, insurance, and working with the FMS.

When individuals elect to proceed with participant direction, waiver service coordinators provide more information on several components of participant direction, including:

- Identification of the elements of the service to be provided by the self-directed caregiver.
- Qualifications of participant-directed provider.
- Recruitment, hiring, and training of a qualified provider.
- Employer-related tasks, including working with the FMS.
- Service planning, including development of a back-up plan.
- Budget development, including wage setting and determining billable rates.

The FMS also assists individuals with onboarding their self-directed caregivers. The FMS provides support from the time individuals identify their self-directed caregivers and ongoing as individuals change or add caregivers. The FMS assigns enrollment specialists to work with individuals, self-directed caregivers, and case managers. The enrollment specialists conduct orientation and assist with onboarding and paperwork through the providers' first paychecks.

Any materials issued by the ICDS plans and FMS will be subject to ODM approval or utilize an ODM-supplied template. ODM will provide guidance to the ICDS plans and the FMS on the requirements for these materials to ensure individuals receive the same information on self-direction regardless of which plan the individual selects to manage their services and supports.

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:

A representative identified to assist an individual with employer or budget authority can be a legally responsible person such as an individual's legal guardian or any other person identified by the individual. If the case manager or individual identifies that the individual would benefit from a representative, the case manager will identify options including other family members, neighbors, community members, etc. This information must be documented within the individual's record and communicated to the FMS.

A representative that is not the individual's legal representative carries out decisions made by the individual but cannot make decisions without the individual's consent.

A representative must:

1. Demonstrate a strong personal commitment to the participant and show knowledge about the individual's preferences.

2. Be willing and able to fulfill all the employer responsibilities on behalf of the waiver individual when they are using employer authority.

3. Agree to meet with the individual, case manager, and FMS as identified on the service plan.

A representative may not be paid for this function or be hired by the individual as a self-directed caregiver. As reflected in the care plan, the case manager must assess the individual's satisfaction with the representative's actions. Additional actions taken by the case manager to ensure health and safety include a review of claims, submitted incidents, FMS communications and any other individual concerns during the regularly scheduled contacts. If concerns arise, the case manager must increase the frequency face to face visits and other contacts.

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
Alternative Meals Service	☐	☒
Waiver Nursing	☒	☒
Personal Care	☒	☒
Choices - Home Care Attendant Service	☒	☒
Self-directed goods and services	☐	☒
Home Modification	☐	☒
Home Medical Equipment and Supplemental Adaptive and Assistive Device Services	☐	☒
Home Maintenance and Chore	☐	☒
Home Care Attendant	☒	☒

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:

Entities specializing in FMS for self- directed programs and payroll services that are consistent with the applicable regulations of 45 CFR §74 may provide this function. The ICDS plan will contract with a state approved FMS entity. Waiver service dollars and the FMS contractual amount will flow through the ICDS plan.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The amount of the fee is set by an administrative contract with the ICDS plan.

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:

The FMS enrolls and maintains timekeeping records for the self-directed caregivers. They will also serve as the enrollment broker for all self-directed caregivers identified in Appendix C. They will complete the criminal records and other validations to ensure self-directed caregivers who are not also enrolled with ODM as Medicaid providers are eligible to render Medicaid services.

Provides self-directed caregivers information and/or training in the following areas:

Applicable Ohio Administrative Code requirements;
Accurate time reporting;
Correct completion of timesheets;
Incident reporting; and
Medicaid fraud detection and reporting.

The FMS is responsible for payment for goods and services and to obtain receipts or other documentation of purchases to verify that the goods and services were delivered in accordance with the standards specified in the waiver. Reimbursement maybe made directly to the individual when an authorized goods and service purchase from a point-of-sale vendor, such as an on-line store. The individual may not be the vendor for any goods and service purchase.

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.

ODM monitors that the ICDS plans contract with the ODM-approved FMS. The monitoring and assessment of the FMS performance will be conducted by the ICDS plans. As described in performance measures in Appendix I, ODM receives reports from the ICDS plans to verify the integrity of financial transactions through a review of provider documentation on a semi-annual frequency.

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
Alternative Meals Service	☐
Waiver Nursing	☐
Nutritional Consultation	☐
Personal Care	☐
Social Work Counseling	☐
Waiver Transportation	☐
Out-of-Home Respite	☐
Community Transition Service	☐
Choices - Home Care Attendant Service	☐
Personal Emergency Response System	☐
Structured Family Caregiving Services	☐
Home Delivered Meals	☐
Self-directed goods and services	☐
Adult Day Health	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Community Integration Service	☐
Home Modification	☐
Homemaker	☐
Home Medical Equipment and Supplemental Adaptive and Assistive Device Services	☐
Enhanced Community Living Service	☐
Home Maintenance and Chore	☐
Assisted Living Service	☐
Home Care Attendant	☐

☒ **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:

A. Waiver service coordinators and the FMS support individuals in exercising their employer and/or budget authority.

B. The information and assistance support are an administrative function of the ICDS and/or waiver service coordinator and the State contracts with a vendor to furnish the FMS statewide. The FMS contractor is established through a competitive bidding process that meets the requirements of 45 CFR §74. Additionally, AAAs serve in an information and assistance role however, as established under 173-2-02, are eligible to receive the subaward for this work.

C. Before and throughout enrollment, waiver service coordinators inform individuals of their employer responsibilities including hiring, training, dismissing, and tracking the time sheets of their self-directed caregivers and developing person-centered services plans and associated budgets. Regular in-person home visits are conducted by the waiver service coordinator with the individual and any other individuals of their choice to review responsibilities and mitigate risk on-going.

The FMS provides payroll functions for participants including completing federal and state employment and tax forms and tracking time sheets.

D. The waiver service coordinators conduct self-directed caregiver record reviews. Any issues are reported to the individual, ODA as the certifying entity or the FMS and ODM. ODA and ODM review the findings, and directs the remediation, when indicated.

E. The oversight of the self-directed service delivery method is the shared responsibility of ODA as the certifying entity and the State Medicaid agency.

The individual may designate a representative of their choice to assist with some, or all, their employer and/or budget authority responsibilities. This representative cannot be the self-directed caregiver.

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:

The Office of the State Long-Term Care Ombudsman program (ombudsman) is responsible for addressing complaints regarding the health, safety, welfare, and civil rights of long-term care participants in MyCare, as well as the rights of nursing homes and residential care facility residents found in Chapter 3721.10 - 3721.17 of the Ohio Revised Code. Further, the ombudsman investigates allegations of the action or inaction of providers of long-term care or representatives of providers of long-term care, government entities, or private social service agencies whose actions may adversely affect the health, safety, welfare, or rights of participants.

Participants receive ombudsman information from the case manager, including contact information for the state and local programs at enrollment, annually at reassessment, and as needed.
Ohio Administrative Code rule 173-14-16 addresses timeframes for responding to inquiries and resolution. Contact with the ombudsman does not have an effect on the timeframes for appeal rights.

The Department of Jobs and Family Services Adult Protective Services (APS) is responsible for investigating and evaluating all reports of suspected abuse, neglect, and exploitation of adults aged 60 and over. Care managers, waiver service providers, and all service providers are mandated reporters and mandated to report suspicion of abuse, neglect, and exploitation of a participant to APS. Individuals and their caregivers (if appropriate) receive APS information from the care manager/assessor, including contact information for the state and local programs, at enrollment, annually at reassessment, and as needed.

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:

When individuals voluntarily terminate self-direction, waiver service coordinators, in partnership with the care manager, must do all of the following:

1. Identify the contributing factors which led to the voluntary termination.

2. Reassess the individual's current needs to identify alternative services.

3. Authorize provider-managed services.

4. Assist the individual with the provider selection.

5. Coordinate the last day of self-directed services with the first day of provider-managed service or the backup plan if there is a gap between the last day of self-directed services and the first day of provider-managed service.

6. Ensure that the individual, self-directed caregiver, and the FMS take all necessary actions to terminate the employer-employee relationship.

As with all individual care transitions, care managers and waiver service coordinators are responsible to ensure individual’s care needs are met during the transition period. This includes developing a transition of care plan with the individual and onboarding providers as needed. Additionally, back-up plans may be used during any periods of time not covered by the self-directed caregiver or other provider types.

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.

Involuntary termination of self-direction may be necessary under any of the following situations:

1. The individual no longer has an assessed need for the self-directed service.

2. The individual or their representatives are unable to perform their responsibilities as employers.

3. Self-direction cannot assure the individual’s health and welfare.

Waiver service coordinators, in collaboration with the care manager, will develop plans with individuals to ensure that they receive appropriate services and supports to transition safely to provider-managed services that meet their assessed needs. As with all individual care transitions, care managers and waiver service coordinators are responsible to ensure individual’s care needs are met during the transition period. This includes developing a transition of care plan with the individual and onboarding providers as needed. Additionally, back-up plans may be used during any periods of time not covered by the self-directed caregiver or other provider types.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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		151
Year 2		152
Year 3		153
Year 4		154
Year 5		155

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:

☒ **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:

The ODA-certified self-directed caregiver is responsible for the cost of obtaining a criminal records check. When the FMS is the enrolling entity for a self-directed caregiver, the FMS is responsible for the cost of obtaining a criminal records check. Individuals can request the FMS supply any criminal history investigation.

☒ **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:

Individuals may require specific skill training to ensure tasks will be performed in a manner that is responsive to their individual preferences. The individual specific required skill training doesn't change the State's method for conducting background checks. The FMS will conduct screening and criminal record checks for all self-directed caregivers for whom they conduct enrollment activities. This includes criminal record and registry verifications using their contracted background check vendor. ODM will also allow conditional employment for self-directed caregivers to begin employment while the criminal record check is conducted. The conditional employment will only be effective with a signed affidavit from the self-directed caregiver indicating no prohibited offenses are on their record and will be valid for up to 60 calendar days. the prohibited offenses outlined in OAC 5160-1-17.8 will be verified and, if identified during the criminal record check, the self-directed caregiver will be terminated.

☒ **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.

At the time of enrollment in the ICDS waiver, the individual's ICDS plan will review the individual's assessed needs and work with the individual to develop a self-directed service package that will safely maintain the individual at home. The individual and their ICDS plan will set their initial budget for services as if all services will be provider managed. The amount of money that is allocated for the individual to direct the delivery of his or her services is based on the estimated cost of comparable provider managed services. Budgets are calculated based on the current non-agency fee-for-service rate approved in the Ohio Administrative Code. Based on that budgeted amount, the individual, in consultation with the care manager or their designee, which may include the waiver service coordinator, will determine how much of the budget will be used to purchase self-directed services, the number of hours that will be purchased and the number of self-directed caregivers that will be hired to provide the service. Individuals may use any self-directed waiver service funds remaining in the annual budget to cover home modifications above the current service limit described in C-4.

The care manager or their designee must adhere to the service planning requirements set forth in Appendix D-1-a of the waiver application when developing the self-directed service package. Individuals may also exercise budget authority over the self-directed goods and services; alternative meals; home modification; home maintenance and chore and the home medical equipment and supplemental adaptive and assisted devices services by designing their service plan and prioritizing services according to their preferences. The amount spent may vary by individual, however, the care manager or their designee, who may include the waiver service coordinator, will be responsible for monitoring the implementation of the person-centered service plan to ensure the needs of the individual enrolled on the waiver are consistently being met.

The individual, as the employer, will also establish the pay wage for each self-directed caregiver and any pay differentials (early morning/late night) that will be offered. The individual must pay each self-directed caregiver no less than the current state minimum wage. The average pay for direct care agency and non-agency staff are shared with the individual to assist them with determining self-directed caregiver wages. The individual is educated about the correlation between wages and the amount of service hours available for purchase based on those wages, including employer related expenses and billable rates.

The content of the individual self-directed budget is supplied in a format prescribed by ODM. The format, along with methodology, will be available through the ODM website. The budget amount available for goods and services are established in appendix C of this waiver and rule 5160-45-03.5 of the Ohio Administrative Code. The budget amount available for home modifications is as established in appendix C of this waiver and rule 5160-44-13 of the Ohio Administrative Code, except that excess funds in an individual's self-directed budget may be used in addition to the established service limit.

According to the proposed transition requirements in the waiver, individuals will retain their waiver providers for up to one year and they will receive services in the same amount, scope, and duration during that time. In addition, providers will continue to be reimbursed at the rate paid prior to the individual's enrollment in the ICDS. The maximum rates for these services are specified in the Ohio Administrative Code. Once the transition period ends, the individual will also transition to providers on the plan's provider panel (there may not be a need to change providers unless there is an identified performance issue or at the request of the individual). The reimbursement rates paid may differ from the fee-for-service waivers as the ICDS plans are given the latitude to negotiate rates with providers as is typical for all providers in a managed care arrangement.

During the orientation process, individuals who elect to direct their services are given wage information in order to assist them with negotiating a payment rate with their employee. They are also informed of the differences between wages and billable rates to assist them with establishing their budget.

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 care manager, along with the waiver service coordinator, works with individuals, informing them of the available budget for services, then working with them to develop the self-directed services budget. Budgets are communicated using an ODM-approved budget worksheet that the individual can use to determine wages and amounts available for services. Individuals may request a reassessment if their current person-centered services plan needs change. A reassessment of need will be conducted and, if appropriate, individuals' person-centered services plans and budgets will be revised. Available budgets are to be updated and made available as the individual's needs change and/or caregiver wages or billable rates, cost of comparable provider managed services, and service authorizations are updated. individual budgets will be shared at least annually or as updated.

The ICDS plan will inform individuals of their rights to a state hearing and the method of obtaining a state hearing when a change to the person-centered services plan results in a denial, reduction, or termination of services, including available self-directed budget amounts. The ICDS plan informs individuals of the circumstances under which a timely hearing request will result in continued benefits up to the time a decision is rendered on the administrative appeal.

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:

Individuals who self-direct may adjust the provider type and make caregiver schedule changes to meet their individual needs without updates to the person-centered services plan. Adjustments must be within the allotted monthly budget amount and caregivers identified within the person-centered services plan and enrolled with the FMS.

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 ICDS plan will, in conjunction with the FMS, monitor the individual's monthly use of the of the Choices home care attendant service; alternative meals; personal care aide; home care attendant; waiver nursing; self-directed goods and services; home modification; home maintenance and chore and the home medical equipment and supplemental adaptive and assisted devices service.

The individual will submit timesheets for consumer-directed individual providers per pay period. If the individual is in a position to overspend the service budget, the ICDS plan will contact the individual to discuss the service use and, if necessary, reassess the individual's service needs and the waiver service plan.

If the individual is under utilizing the budget the ICDS plan will ensure that the individual has adequate access to all services stated in waiver service plan. If under utilization continues for a quarter, reassessment of the individual's service needs will be conducted and the waiver service plan and individual budget may be revised. The individual will be given fair hearing rights.

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.

The ICDS waiver operates concurrently with a 1915(b) waiver through an ICDS plan, which is a capitated managed care delivery system. All waiver applicants/individuals are notified of their right to request a fair hearing by the ICDS plan in accordance with 42 CFR 431 Subpart E and 42 CFR 438 Subpart F.
Upon enrollment in the ICDS plan, the ICDS plan provides information about Medicaid appeal rights. Individuals with limited literacy will receive a verbal explanation of their appeal rights during the initial home visit. In addition, per 42 CFR 438.406(a), the ICDS plan will be required to give individuals any reasonable assistance in completing forms and taking other procedural steps. This includes but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. Individuals enrolled will receive information, guidance and support from the ICDS plan and their waiver service coordinator regarding how to freely exercise their rights and accept personal responsibility.

Final approvals and denials for waiver participation are issued by the State. Individuals are notified of their appeal rights whenever an adverse action benefit determination is proposed. Adverse actions benefit determination includes denial or limited authorization of a requested service, including determination based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit; reduction, suspension or termination of previously authorized services; denial in whole or in part, of payment as not coveredfor a service; failure to provide or authorize services in a timely manner; and failure to act within the required appeal/grievance response times.

The ICDS plan sends a written notice to the individual explaining the reason for the adverse benefit determination, instructions on how to access an appeal and a state fair hearing (and if applicable, the Medicare hearing process for Medicare covered services), the time frame for making the request, information on continuation of services during the appeal process (if applicable) and contact information for questions and concerns. The notice also contains information on the state level hearing processes as set forth in OAC Division 5101:6, and toll free numbers for the Medicaid agency and for requesting free legal assistance.

Notices of termination, suspension or reduction are mailed to the individual a minimum of 15 days before the authorized service is actually reduced, terminated or suspended, or as outlined in 42 CFR 431.211, 431.213 and 431.214 and include reasons and process for benefit to continue while under appeal. The plan must provide all reasonable assistance in filing a grievance, appeal or state hearing. Individuals must exhaust their ICDS plan’s internal appeal process before requesting a hearing with the State (and if applicable, the Medicare hearing process for Medicare covered services) in accordance with 42 CFR 438.402.

An individual or AR can appeal any decision to the ICDS plan. An authorized representative must have the member’s written consent to file an appeal on the member’s behalf.
If an ICDS plan appeal was requested, the ICDS plan sends a written notice of the reconsideration decision to the individual, along with detailed instructions on requesting a State fair hearing after plan appeal process is exhausted (or with Medicare, if applicable).

The ICDS plan gathers information on the case and schedules the appeal with an independent reviewer who had no prior involvement in making the adverse decision in accordance with 42 CFR 438.406.Appeals must be resolved as expeditiously as the individual’s health condition requires, but always within prescribed timeframes, including any expedited appeals conducted by the ICDS plans.

The individual must be notified in writing of the decision.
Notices of all adverse benefit determination, documentation of appeal decisions and the opportunity to request a fair hearing will be kept at the ICDS plan and in the individual’s case record in accordance with 42 CFR 438.3(h)

When the plan appeal process is exhausted and a state hearing is requested, the ICDS plan must provide the individual or AR with a copy of all appropriate state hearing forms, and the state hearing process will be followed in accordance with OAC Division 5101:6. Individuals must be provided with a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing, must be allowed to examine the case file before and during the appeals process.

Each ICDS plan must develop and implement a system that includes a grievance process, an appeals process, and a process to inform individuals about accessing the state hearings system. These processes must be described in the ICDS plan’s member handbook/EOC, and must allow individuals to pursue resolution of their concerns either through the ICDS plan, the state hearing process, or both.

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**

b. 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.

The ICDS plan has an internal dispute resolution system as required by 42 CFR 438 Subpart F. The internal system encompasses both an appeal process, as described in Appendix F-1, for addressing an action and a grievance process for addressing grievances (complaints). Actions include the denial or limited authorization of a requested service, reduction, suspension or termination of a previously authorized service and failure to take action within the timeframes specified in the contract for resolving grievances and appeals.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

Grievances

An individual or AR can file a grievance orally or in writing at any time in accordance with 42 CFR 438.402. The ICDS plan must acknowledge receipt of the grievance and review grievances as expeditiously as the individual's health condition requires, but no less than within prescribed timeframes. At a minimum, the ICDS plan must provide oral notification of a grievance resolution to the individual; however, the plan must issue confirmation in writing if it is unable to speak directly to the individual or if the resolution includes information that must be confirmed in writing. The individual must be informed of his or her hearing rights when grievances are not resolved according to prescribed timeframes.

Additionally, ODM maintains a Medicaid Hot Line which is a toll-free number available to anyone to lodge a complaint regarding a Medicaid-funded program or provider. The SLTCOP is responsible for addressing complaints regarding the health, safety, welfare, and civil rights of long-term care individuals, as well as violations of rights of residents of nursing homes and residential care facilities found in Chapter 3721.10 - 3721.17 of the Ohio Revised Code. Further, the SLTCOP investigates allegations of the action or inaction of a provider of long term care or a representative of a provider of long term care, government entities or private social service agencies whose actions may adversely affect the health, safety, welfare or rights of an individual.

c. 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 ICDS plan is responsible for receiving, reporting, and responding to grievances received for individuals enrolled in that ICDS plan, including those supported through the ICDS waiver. Grievances are defined as any expression of dissatisfaction other than actions per 42 CFR 438 Subpart F.

ODM requires each ICDS plan to report all grievances under 42 CFR 438 Subpart F made to the ODM not less than quarterly. The submission of the ICDS plan grievance and appeal report is included in the contract between the ICDS plan and ODM.

Information is recorded on the customer service form and recorded in the ICDS plan grievance and appeal database for analysis. Action taken by the ICDS plan is recorded to include a summary of all issues, investigations and actions taken and the final disposition resolution. Guidelines define the resolution for types of grievances that may be made. The total number of calendar and working days from receipt to completion are also recorded.

The ICDS plan must accept and dispose of all grievances consistent with the policies and procedures and timelines in 42 CFR 438 Subpart F and approved by CMS in the ICDS contract. The ICDS plan must dispose of each grievance and provide notice, as expeditiously as the individual's health condition requires, within State-established timeframes not to exceed 90 days from the day the ICDS plan receives the grievance.

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.

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, responding to, investigation and remediation of all critical incidents. The State has identified and established case management 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. All investigative entities are required to submit incident data to ODM in a format and frequency determined by ODM.

Types of Critical incidents that must be reported

-Abuse
-Neglect
-Exploitation
-Misappropriation
-Unexplained Death
-Health & Welfare of the individual or others are placed at risk to due any of the following: activities that involve law enforcement intervention; individual's health and welfare is in immediate and serious jeopardy; unexpected crisis in the individual's family or environment that results in inability to ensure health and safety in the individual's primary residence; or the individual cannot be located.
-Any of the following prescribed medication issues: Provider error; individual's misuse resulting in EMS response, emergency room visit, or hospitalization; individual's repeated refusal to take prescribed medications resulting in EMS response, emergency room visit, or hospitalization.

The following reportable events must be addressed as determined appropriate by the case management entity and shall be entered into the State's incident management system for the purpose of tracking and trending:

-Death, other than unexplained
-Individual or family behavior/actions resulting in the creation of or adjustment to a Health and Safety Action Plan.
-Health and Welfare of the individual or others at risk due to the loss of the individual's caregiver.
-Any of the following prescribed medication issues: individual's misuse not resulting in EMS response, emergency room visit, or hospitalization; individual's repeated refusal to take prescribed medications not resulting in EMS response, emergency room visit, or hospitalization.
-Hospitalization that results in an adjustment to the person-centered services plan
-Eviction from place of residence.

Individuals/entities that must report critical incidents and reportable events.
ODM or it's designee and all waiver service providers are required to report all critical incidents.

Time frames within which critical incidents must be reported
Critical incidents must be reported to the case management entity upon discovery but no later than 24 hours unless bound by federal, state or local law or professional licensure or certification requirements to report sooner.

Method of Reporting
Critical incidents may be reported by phone, in written form (email/fax), or through a web-based reporting system. The case management entity must enter the critical incident into the State's incident management system within one business day of discovery

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.

Training/Information Furnished to participants and informal caregivers
Information regarding how to prevent, identify, and report abuse, neglect and exploitation is provided to individuals and/or their informal caregivers.

Entities Responsible for providing the training/information
The case management entity is primarily responsible for providing the training/ information.

Frequency the Training/Information is Provided
At a minimum, the training/information is required to be provided at initial enrollment and at the annual re-assessment. Information will be provided during the course of the waiver enrollment in response to participant specific circumstances.

Individuals receive a member handbook and evidence of coverage (EOC) from their selected MCOP at the time of enrollment. The handbook/EOC includes information about individuals' rights, protections against and how to report alleged incidents. It also contains information about the advocacy agencies that can educate and assist individuals. Individuals also receive a copy of similar information at the time of reassessment. The MCOP care manager or waiver service coordinator verbally reviews the content of the handbook/EOC with individuals/family members/caregivers. The individual or authorized representative sign a form that documents receipt of this information and the form is maintained in the individual's file at the MCOP. The MCOP will provide individual instruction to individuals, caregivers, and authorized representatives about how to notify the authorities in the event health and welfare may be in jeopardy. The MCOP will reinforce the training on incidents during each contact and/or in person visit and will assist individuals and/or their informal caregivers with any formal notification necessary. The MCOP operates toll-free care management lines where individuals can receive additional information or assistance, if needed. These lines will have the capacity to assist LEP members and/or who are hearing impaired.

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.

Entities that Receive Critical Incident Reports
The case management entity receives the initial report of each type of critical incident listed in G-1-B and notifies ODM within one business day of discovery of the critical incidents. The case management entity is also required to notify ODM within one business day any significant public media event involving an individual enrolled on the waiver or a provider serving an individual enrolled on the waiver or when an employee of the case management entity or the investigative entity is the alleged violator.

Entities Responsible for evaluating reports and how reports are evaluated
The initial evaluation of a critical incident report is completed by the case management entity.
The evaluation includes: ensuring immediate action is taken, as applicable to the nature of the incident, to protect the health and welfare of the individual and any other individuals who may be at risk; issuing notification to any appropriate investigative, protective authority or regulatory, oversight or advocacy entities and notify ODM within twenty-four hours of discovery.

Entity Responsible for conducting investigations and how investigation are conducted
Within one business day of receipt of the critical incident, the investigative entity is required to take the following action:

- Verify the immediate action taken, as applicable to the nature of the incident, resulted in protecting the health and welfare of the individual and any other individuals who may be at risk. If such actions were not taken, the investigative entity must do so immediately and no later than 24 hours after discovering the need for action to protect those at risk.

- Verify the appropriate entities have been notified. If such action was not taken, the investigative entity must make the appropriate notifications.

No later than two business days after being notified of a critical incident, the investigative entity must initiate the investigation. The investigation will include the following:
- Conduct a review of all relevant documents as appropriate to the reported incident
- Conduct and document interviews, as appropriate to the reported incident, with anyone who may have information relevant to the incident investigation.
- Identify, to the extent possible, any causes and contributing factors
- Determine whether or not the incident report is substantiated.
- Document all investigative activities in the State's incident management system established by ODM.

Timeframes for conducting and completing an investigation
Unless a longer timeframe has been prior-approved by ODM, the investigative entity must conclude the investigation no later than forty-five days after the investigative entity's initial receipt of the incident report.

Process and timeframes for informing the participant and other relevant parties of the investigation results
The investigative entity shall provide to the individual and/or their authorized representative or legal guardian, a summary of the investigative findings, unless such action could jeopardize the health and welfare of the individual. The summary shall include: summary of the investigation, and identify whether or not the incident was substantiated.

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.

State Entity Responsible for overseeing the operation of the incident management system
ODM/ODA is responsible for overseeing the operation of the incident management system.

Methods for overseeing the operation of the incident management system
Oversight of the incident management system includes regular monitoring of reports generated by the system, as well as any ad hoc pulling or review of data to track and trend incidents and reportable events to predict and prevent future occurrences.

Frequency of Oversight Activities
At least quarterly or more often as necessary.

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).

Restraints are measures of last resort that may be used to assist in keeping an individual safe when he or she presents behaviors that are a danger to self or others. Allowable restraints include:

- Physical restraint, i.e., the use of any hands-on or physical method that to restrict the movement or function of the individual's head, neck, torso, one or more limbs or the entire body; or
- Chemical restraint, i.e., the use of any sedative psychotropic drug exclusively to manage or control behavior; or
- Mechanical restraint, i.e., the use of any device to restrict an individual's movement or function for any purpose other than positioning and/or alignment.

Less restrictive measures such as verbal redirection/prompting and positive reinforcement are alternative strategies to avoid or reduce the use of restraints. They will always be explored and encouraged by the ICDS plan and the individual's trans-disciplinary care team.

Restraints may not be used as a routine programmatic intervention, for punitive purposes or for staff convenience. The only restraint that may be used in an emergency is a protective hold which is the application of body pressure to an individual for the purpose of restricting or suppressing the person's movement.

If it is determined through the assessment and care planning processes that restraint is being considered by the individual's trans-disciplinary care team, the ICDS plan will work with the team to promote the least restrictive/intrusive, most positive intervention culture needed to keep the individual safe. Restraints must be authorized pursuant to a behavior support plan developed by a physician, licensed psychologist, or another behavioral health treatment professional, in conjunction with the ICDS plan and the individual's trans-disciplinary team. The behavior support plan is an addendum to the service plan. The development and implementation of this plan are covered State plan services through rehabilitation and other services and the plan will be coordinated to ensure an integrated approach to support individuals with complex behavioral challenges. Staff who are implementing restraints will be trained via a variety of methods including, but not limited to, training directly from the entity that is writing the plan.

When a plan for restraint is being developed, the ICDS plan must assure that the following elements are addressed:

- Agreement from the individual's trans-disciplinary team that the use of restraint is appropriate.
- Promotion of the least restrictive/intrusive intervention, and the most positive intervention culture needed to keep the individual safe.
- Inclusion and requirement of the use of preventive and/or alternative and non-aversive measures to assure the safety and well-being of the individual.
- Verification of authorization of the use of restraint by the authorizing entity.
- Identification of an oversight entity responsible for ensuring that staff are appropriately trained regarding implementation of the behavior plan, including use of the restraint, as well as for ongoing monitoring of the use of restraint. The oversight entity can include a parent/guardian or authorized representative or a behavioral health provider. However, the person implementing the restraint cannot be the person responsible for monitoring the use of the restraint.
- Existence of a plan to assure, and identification of the party responsible for, training the staff who implement restraint.
- Documentation of the planned use of restraint in the individual's waiver service plan and communication record.
- Development and plan for submission of tracking logs related to the use of restraint.

If a protective hold, or unauthorized restraint is utilized, direct care staff must report the incident and follow appropriate reporting procedures. The provider must contact the ICDS plan and the ICDS plan must contact the individual and his/her legal representative within 24 hours of receiving the incident report. Changes to the service plan or living situation may be considered to support the person's safety and well-being. Follow-up visits in response to the incident report and to complaints by the individual and his/her legal representative will be conducted and include questions about any actions taken by the service provider that may qualify as unauthorized use or misapplication of physical restraints.

Individuals who are also receiving services through a county board of developmental disabilities are eligible to access services through a behavior support plan. This includes the county board's oversight committees and processes. ICDS plans are expected to collaborate with county board staff to access this service on behalf of the individual. ICDS plans should request to be added specifically to the list of those who receive status reports for individuals with an aversive plan, which would include those plans with restraint.

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 ICDS plan reports data to ODM on a quarterly basis regarding such things as the number of individuals for whom restraints are used; and authorizing entity.

The ICDS plan will identify any unauthorized or inappropriate use of restraints and report case-specific information through the incident management system operated by the investigative entity contractor. The investigative entity contractor will report this data to ODM.

Data is analyzed by both the ICDS plan and ODM, with appropriate follow-up as needed regarding identified trends and patterns to support improvement strategies. Follow-up includes, but is not limited to: additional ODM or ICDS plan training of ICDS plan or provider staff, and/or changes in protocols and/or rules. Through this analysis and the incident management system, if case-specific concerns are noted, follow-up will occur with the authorizing entity and the individual's team.

Any significant injuries which result from employment of a restraint must be carefully analyzed and immediately reported to ODM and the ICDS plan in accordance with critical incident reporting requirements.

In addition, the ICDS Plan and an oversight entity (e.g., a parent/guardian or authorized representative or a behavioral health provider) will help to ensure that staff is appropriately trained and that restraint is used safely and appropriately. The waiver service coordinator must communicate with the ICDS care manager and verify documentation of the use of restraints in the comprehensive care plan, waiver service plan, and communication record.

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.

Restrictive interventions are measures of last resort that may be used to assist in keeping an individual safe when he or she presents behaviors that are a danger to self or others. Less restrictive measures such as verbal redirection/prompting and positive reinforcement are alternative strategies to avoid or reduce the use of restrictive interventions. They will always be explored and encouraged by the ICDS plan and the individual's trans-disciplinary care team.

Restrictive interventions may be appropriate to address issues such as wandering in unsafe environments, risk of ingesting unsafe or unhealthy items or failing to complete necessary medical/personal care tasks. Interventions may include, but are not limited to manipulation of the environment or denying access to a wanted item or activity until completion of a certain task. Restrictive intervention may not be used as a routine programmatic intervention, for punitive purposes or for staff convenience.

Time away is a restrictive intervention during which the individual is directed away from a location or an activity using verbal prompting, only to address a specific behavior. The individual is able to return to the location or activity at his/her choosing. Time away shall never include the use of a physical prompt or an escort. Time away is considered a restrictive intervention as long as the intervention does not meet the definition of seclusion/time-out. The use of any physical prompt or required timeline for re-engaging in an activity shall elevate the restrictive intervention to "seclusion."

If it is determined through the assessment and care planning processes that restrictive intervention is being considered by the individual's trans-disciplinary care team, the ICDS plan will work with the team to promote the least restrictive/intrusive, most positive intervention culture needed to keep the individual safe. Restrictive interventions must be authorized pursuant to a behavior support plan developed by a physician, licensed psychologist, or another behavioral health treatment professional, in conjunction with the ICDS plan and the individual's trans-disciplinary team. Staff who are implementing restrictive intervention will be trained via a variety of methods including, but not limited to, training directly from the entity that is writing the plan.

When a plan for restrictive intervention is being developed, the ICDS plan must assure that the following elements are addressed:

• Agreement from the individual's trans-disciplinary team that the use of restrictive interventions is appropriate.
• Promotion of the least restrictive/intrusive intervention, and the most positive intervention culture needed to keep the individual safe.
• Inclusion and requirement of the use of preventive and/or alternative measures to assure the safety and well-being of the individual.
• Verification of authorization of the use of restrictive interventions by the authorizing entity.
• Identification of an oversight entity responsible for ensuring that staff are appropriately trained regarding implementation of the behavior plan, including use of the restrictive interventions, as well as for ongoing monitoring of the use of the restrictive interventions. The oversight entity can include a parent/guardian or authorized representative or a behavioral health provider. However, the person implementing the restrictive interventions cannot be the person responsible for monitoring the use of the restrictive interventions.
• Existence of a plan to assure, and identification of the party responsible for, training the staff who implement the restrictive interventions.
• Documentation of the planned use of restrictive interventions in the individual's waiver service plan and communication record.
• Development and plan for submission of tracking logs related to the use of restrictive interventions.

Use of restrictive intervention in accordance with an approved plan is documented using a tracking log. ICDS care managers must assure the providers have access to and understand the use and submission expectations of the tracking log. All restrictive interventions must be documented on the log, except in cases where the restrictive intervention lasts for the entire day. Environmental controls such as door alarms, locked cabinets or other access limitations within a residence do not require notation in a tracking log.

If an unauthorized restrictive intervention must be utilized, direct care staff must write a report the incident and follow appropriate reporting procedures. The provider must contact the ICDS plan. The ICDS plan must

contact the individual and his/her legal representatives within 24 hours of receiving the incident report. Changes to the service plan or living situation may be considered to support the person's safety and well-being. Follow-up visits in response to the incident report and to complaints by the individual and his/her legal representatives will be conducted and include questions about any actions taken by the service provider that may qualify as unauthorized use or misapplication of a restrictive intervention.

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 ICDS plan reports data to ODM on a quarterly basis regarding such things as the number of individuals for whom restrictive interventions are used; types of restrictive interventions being used; and authorizing entity.

The ICDS plan will identify any unauthorized or inappropriate use of restrictive intervention and report case-specific information through the incident management system operated by the investigative entity contractor. The investigative entity contractor will report this data to ODM.

Data is analyzed by both the ICDS plan and ODM, with appropriate follow-up as needed regarding identified trends and patterns to support improvement strategies. Follow-up includes, but is not limited to: additional ODM or ICDS plan training of ICDS plan or provider staff, and/or changes in protocols and/or rules. Through this analysis and the incident management system, if case-specific concerns are noted, follow-up will occur with the authorizing entity and the individual's team.

Any significant injuries which result from employment of a restrictive intervention must be carefully analyzed and immediately reported to ODM and the ICDS plan in accordance with critical incident reporting requirements.

In addition, the ICDS Plan and an oversight entity (e.g., a parent/guardian or authorized representative or a behavioral health provider) will help to ensure that staff is appropriately trained and that restrictive intervention is used safely and appropriately. The waiver service coordinator must communicate with the ICDS care manager and verify documentation of the use of restrictive intervention in the comprehensive care plan, waiver service plan, and communication record.

The ICDS plan must develop an individual-specific annual report that will be sent to the physician who certified the plan if the physician is the authorizing entity. The report must include identification of the restrictive interventions used, frequency of use per month, and information regarding the outcome or response to the use of the restrictive interventions. The ICDS plan must assure the physician reauthorizes the use of the restrictive interventions at least annually.

The ICDS plan must review tracking logs and status reports for approved plans at least monthly. This must include addressing any implementation concerns and assuring unauthorized restrictive interventions have been reported appropriately. The ICDS plan must review and discuss the use of restrictive interventions with the individual's trans-disciplinary team on an ongoing basis, and at least every 90 days. Additionally, the ICDS plan must review all incidents related to the use of restrictive interventions. They must also review the use of all restrictive interventions to ensure the use was appropriate and within prescribed guidelines.

Use of any unauthorized restrictive interventions is reported to the ICDS plans as an incident. Additionally, the use of any prohibited restrictive interventions is reported as an incident. ICDS Care Managers are required to review these expectations with all persons authorizing and implementing a restrictive intervention.

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).

Seclusions are measures of last resort that may be used to assist in keeping an individual safe when he or she presents behaviors that are a danger to self or others. Less restrictive measures such as verbal redirection/prompting and positive reinforcement are alternative strategies to avoid or reduce the use of seclusion. They will always be explored and encouraged by the ICDS plan and the individual's trans-disciplinary care team.

Seclusion or Time-Out is used to address a specified behavior that prevents the individual from leaving a location for any period of time. Seclusion may include preventing the individual from leaving an area until he or she is calm. Seclusion shall never include the use of locked doors and must always include constant visual supervision of the individual. It must only be used for behaviors that are physically harmful to the individual or other persons.

Seclusion may not be used as a routine programmatic intervention, for punitive purposes or for staff convenience. Seclusion will only be permitted if approved as a part of a behavior support plan.

If it is determined through the assessment and care planning processes that seclusion is being considered by the individual's trans-disciplinary care team, the ICDS plan will work with the team to promote the least restrictive/intrusive, most positive intervention culture needed to keep the individual safe. Seclusion must be authorized pursuant to a behavior support plan developed by a physician, licensed psychologist, or another behavioral health treatment professional, in conjunction with the ICDS plan and the individual's trans-disciplinary team. The behavior support plan is an addendum to the service plan. The development and implementation of this plan are covered State plan services through rehabilitation and other services and the plan will be coordinated to ensure an integrated approach to support individuals with complex behavioral challenges. Staff who are implementing seclusion will be trained via a variety of methods including, but not limited to, training directly from the entity that is writing the plan.

When a plan for seclusion is being developed, the ICDS plan must assure that the following elements are addressed:

- Agreement from the individual's trans-disciplinary team that the use of seclusion is appropriate.
- Promotion of the least restrictive/intrusive intervention, and the most positive intervention culture needed to keep the individual safe.
- Inclusion and requirement of the use of preventive and/or alternative and non-aversive measures to assure the safety and well-being of the individual.
- Verification of authorization of the use of seclusion by the authorizing entity.
- Identification of an oversight entity responsible for ensuring that staff are appropriately trained regarding implementation of the behavior plan, including use of the seclusion, as well as for ongoing monitoring of the use of seclusion. The oversight entity can include a parent/guardian or authorized representative or a behavioral health provider. However, the person implementing the seclusion cannot be the person responsible for monitoring the use of the seclusion.
- Existence of a plan to assure, and identification of the party responsible for, training the staff who implement seclusion.
- Documentation of the planned use of seclusion in the individual's waiver service plan and communication record.
- Development and plan for submission of tracking logs related to the use of seclusion.

If unauthorized seclusion is utilized, direct care staff must report the incident and follow appropriate reporting procedures. The provider must contact the ICDS plan and the ICDS plan must contact the individual and his/her legal representative within 24 hours of receiving the incident report. Changes to the service plan or living situation may be considered to support the person's safety and well-being. Follow-up visits in response to the incident report and to complaints by the individual and his/her legal representative will be conducted and include questions about any actions taken by the service provider that may qualify as unauthorized use of seclusion.

Individuals who are also receiving services through a county board of developmental disabilities are eligible to access services through a behavior support plan. This includes the county board's oversight committees and processes. ICDS plans are expected to collaborate with county board staff to access this service on

behalf of the individual. ICDS plans should request to be added specifically to the list of those who receive status reports for individuals with an aversive plan, which would include those plans with seclusion.

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 ICDS plan reports data to ODM on a quarterly basis regarding such things as the number of individuals for whom seclusion are used; and authorizing entity.

The ICDS plan will identify any unauthorized or inappropriate use of seclusions and report case-specific information through the incident management system operated by the investigative entity contractor. The investigative entity contractor will report this data to ODM.

Data is analyzed by both the ICDS plan and ODM, with appropriate follow-up as needed regarding identified trends and patterns to support improvement strategies. Follow-up includes, but is not limited to: additional ODM or ICDS plan training of ICDS plan or provider staff, and/or changes in protocols and/or rules. Through this analysis and the incident management system, if case-specific concerns are noted, follow-up will occur with the authorizing entity and the individual's team.

Any significant injuries which result from employment of seclusion must be carefully analyzed and immediately reported to ODM and the ICDS plan in accordance with critical incident reporting requirements.

In addition, the ICDS Plan and an oversight entity (e.g., a parent/guardian or authorized representative or a behavioral health provider) will help to ensure that staff is appropriately trained and that seclusion is used safely and appropriately. The waiver service coordinator must communicate with the ICDS care manager and verify documentation of the use of seclusion in the comprehensive care plan, waiver service plan, and communication record.

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)*

b. 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.

The safe, effective and appropriate use of medications is an essential component to the ICDS Waiver, and to the assurance of the individual's ongoing health and welfare.

Each ICDS plan will complete a review of the individual's medications and utilization during the assessment/reassessment process. This includes all prescription, over-the-counter medications, nutritional supplements and herbal remedies. The person(s) responsible for administering medications will be identified and documented in the comprehensive assessment and on the care plan.

Administration of medication will be limited to medical personnel who are professionally licensed to do so in accordance with the Revised Code (e.g., a physician licensed to practice in the State of Ohio, and a nurse licensed to practice in Ohio in accordance with Section 4723. of the Revised Code, etc.). Providers who are responsible for medication administration will be required to record and report medication administration errors to the ICDS plan for appropriate follow-up and referral (see incident reporting above). Medication errors will be included in the data management system. When errors are substantiated, referrals will be made to the physician, and when appropriate, the applicable state licensing authority.

Medical professionals who prescribe medication will have "first-line" responsibility for monitoring medication regimens. Ongoing monitoring of medication management will also take place during regular contacts and visits with the ICDS care manager and the waiver service coordinator as outlined in Appendix D.

In addition, each ICDS plan will be required to make available a medication therapy management program for all individuals participating in the ICDS demonstration. This person-centered approach will empower individuals to take an active role in their medication management, improve collaboration among pharmacists, physicians and other healthcare providers, enhance communication between individuals and their trans-disciplinary care team, and improve health outcomes. It will also pay specific attention to the use of narcotics, poly-pharmacy and providers with outlier prescribing patterns.

Upon request by the individual or upon referral by a provider or the trans-disciplinary care team, medication therapy management program pharmacists will meet face-to-face and/or consult by phone with individuals to:

- Ensure individuals receive the correct medications in the proper dosage and for the appropriate length of time;
- Ensure that individuals can access all of their medications, including filling prescriptions in a timely manner;
- Monitor prescription use to ensure the best possible health outcomes and to avoid or decrease the likelihood of adverse events;
- Provide individuals with education and counseling about their medications, including such things as why the medications are necessary, when they should be taken, risks and side effects, etc.; and
- Identify and alert prescribing physicians of any medication contraindications, and any other medication therapies that may be appropriate.

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.

Direct oversight of medication management is conducted by the ICDS plans; however, the State has methods to detect systemic issues. State rules and regulations outline the requirements for policies and procedural precautions that must be implemented for medication management, including prohibited practices. Case-specific situations where harmful practices are discovered receive remediation. Additionally, medication errors are reported and remediated through the incident management system. Data is reviewed and analyzed with trends and patterns noted, and follow-up as needed. Follow-up includes, but is not limited to requirements for additional staff training, and changes in protocol and rules. The ICDS plans must report any corrective action taken or technical assistance offered to staff.

Licensed provider agencies shall comply with appropriate licensing requirements governing medication management. Unlicensed provider agencies are required to have a pharmacist or physician complete quarterly medication/drug reviews for participants taking medications with potentially serious side effects. Individuals or their authorized representatives who are employers of record are required to train or arrange for training of their employees in medication administration, if applicable.

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)*

ii. 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).

Administration of medication is limited to medical personnel who are professionally licensed to do so in accordance with the Ohio Revised Code (e.g., a physician licensed to practice in the State of Ohio, and a nurse licensed to practice in the State of Ohio in accordance with Section 4723 of the Ohio Revised Code, etc.).

Personal care aides are not permitted to administer prescribed or over-the-counter medications to the individual, but may, unless otherwise prohibited by the provider's certification or accreditation status, pursuant to rule 4723-13-02 of the Administrative Code, help the individual self-administer medications by:

- Reminding the individual when to take the medication, and observing to ensure the individual follows the directions on the container;
- Assisting the individual by taking the medication in its container from where it is stored and handing the container to the individual;
- Opening the container for the individual who is physically unable to open the container;
- Assisting the individual who is physically-impaired, but mentally alert, in removing oral or topical medication from the container and in taking or applying the medication; and
- Assisting the individual who is physically unable to place a dose of medication in his or her mouth without spilling or dropping it by placing the dose in another container and placing that container to the mouth of the consumer.

Additionally, pursuant to Sections 5111.88- 5111.8811 of the Ohio Revised Code, certain unlicensed providers are permitted to assist individuals with self-administration of medications as part of the home care attendant service.

iii. 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:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

◉ **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:

Providers are required to record the medication error and report to the ICDS plan through the non-critical event reporting process.

The specific types of medication error that providers must record are:

- Administering the wrong drug, strength, or dose of medication;
- Missed dosage;
- Unauthorized dosage;
- Wrong time of administration (more than 1 hour);
- Incorrect route of administration;
- Medication refusals
- Wrong patient
- Adverse drug reactions
- Medication diversions

iv. 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.

ODM is responsible for the oversight of medication administration. The monitoring functions have been delegated to ICDS plans in accordance with Appendix A. Providers who are responsible for medication administration will be required to record and report medication administration errors to the ICDS plan for appropriate follow-up and referral through the non-critical incident reporting process. When errors are substantiated, referrals will be made to the physician, and when appropriate, the applicable state licensing authority.

The ICDS plan is responsible for reporting all medication errors to the investigative entity vendor. The ICDS Plan and ODM will ensure that all applicable state requirements have been followed regarding medication errors as part of the critical incident report review process. Aggregate data reports will be used through the continuous quality improvement process to identify recurrent problems with providers and prevent reoccurrence.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

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:
(1) Number and percent of Abuse, Neglect, Exploitation, and Misappropriation Incidents (over $500) reported into the ODM approved incident management system(s) within the required timeframe. N:Total number of Abuse Neglect, Exploitation, Misappropriation (ANEM) incidents reported into the ODM approved incident management system within the required timeframe D:Total number of ANEM incidents.

Data Source (Select one):
Critical events and incident reports
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**

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

Performance Measure:
(2) The number and percent of unexplained or suspicious deaths with a required need for investigation for which an investigation was completed according to Ohio Administrative Code (OAC) requirements. Numerator: Number of unexplained or suspicious death investigations completed according to OAC requirements. Denominator: Number of unexplained or suspicious deaths requiring an investigation.

Data Source (Select one):
Critical events and incident reports
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:

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:
(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. Numerator: Total number of ANEM investigations completed according to the OAC requirements Denominator: Total number of ANEM investigations.

Data Source (Select one):
Critical events and incident reports
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:

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:
(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):
Critical events and incident reports
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:

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:
(6) Number and percent of incidents investigated for Abuse (physical, verbal, emotional, sexual), Neglect, Exploitation, and all Misappropriation (over $500) that involved paid caregivers. Numerator: Total number of ANEM incidents involving a paid caregiver that were investigated. Denominator: Total number of ANEM incidents that involved a paid caregiver.

Data Source (Select one):
Critical events and incident reports
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:
(7) Number and percent of substantiated Provider Medication Error incidents with a prevention plan developed as a result of the incident. Numerator: Total number of Provider Medication Error incident with prevention plans completed. Denominator: Total number of Provider Medication Error incidents needing a prevention plan.

Data Source (Select one):
Critical events and incident reports
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:

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 States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Oversight of the concurrent waivers is performed by ODM. ODM's Office of Managed Care maintains a Compliance Assessment System that assures compliance with Medicaid program requirements for both the 1915(b) and (c) waivers. ODM will compile, trend and review analyzed data gathered through the QIS processes detailed in this waiver application.

ODM relies on reports submitted by the State's EQRO contractor, investigative entity vendor, and through information gathered via the State's ongoing review to identify deficiencies affecting individual health and safety and to monitor incident reporting and investigation.

ODM, through the investigative entity vendor, maintains a system for reporting and tracking to resolution critical incidents. ODM monitors activities performed by the investigative entity vendor and the ICDS plans to assure that all prevention, investigation and resolution protocols are followed through and to completion. Individual remediation and any subsequent corrective action as required by OMA will be monitored by OMA and ICDS plans will be required to demonstrate compliance as appropriate.

The ICDS Plans will continue to enter incidents directly into the ODM-approved incident management system(s). Until ODM establishes a single incident management system in which all incidents will be entered among all Ohio NF-based LOC waivers, the Plans will continue to provide monthly incident reports to ODM. ODM will continue to aggregate and analyze the data at least quarterly and annually as indicated in section b.ii Remediation Data Aggregation.

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:

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

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 §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 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 Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may

provide a work plan to fully develop its Quality Improvement Strategy, 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 Quality Improvement Strategy 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 Quality Improvement Strategy. 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.

ODM will utilize the information gathered during the discovery and remediation efforts identified throughout this waiver application in conjunction with the information garnered through the 1915(b) waiver to ensure a seamless approach to system improvement for the ICDS waiver. In support of these activities ODM will convene a quality team led by ODM and comprised of representatives from ODA, each ICDS Plan, the provider oversight contractor and others as appropriate. This team will assist ODM in identifying areas requiring system improvements through the review of information gathered through the discovery and remediation processes. Systems improvement strategies used by ODM will be tailored to address the specific issues identified through discovery and remediation data, and can include targeted technical assistance and training with the ICDS plans (and, as needed with their provider panels), data system improvements, or contract clarifications or adjustments to ensure that the issues identified through discovery and remediation are ameliorated. ODM will carefully monitor the implementation and subsequent data to ensure that the designed system improvement has the intended results.

The 1915(c) waiver data sources identified throughout the appendices in this application will form the basis of information upon which systems improvement will be undertaken. In addition to the data and information related to the measures specifically identified in this waiver, ODM will utilize Information from the following sources to achieve a coordinated, effective system improvement strategy. The additional information sources will include: information from accreditation and Medicare reviews, consumer satisfaction surveys, Care Management surveys, ICDS consumer advisory groups, quarterly reports, systematic review of hearing and grievance data, EQRO reviews, on-site reviews, Performance Improvement Projects and performance measures. These sources (described in greater detail below) will be used together with the ICDS Waiver discovery and remediation data to determine appropriate design changes and system improvements throughout the life of the waiver.

Accreditation and Medicare Reviews - ODM will use information from private accreditation and Medicare reviews in conjunction with other compliance monitoring activities in order to evaluate the quality and timeliness of, and access to, care and services, and to identify, implement and monitor interventions to improve quality, timeliness and accessibility of services.

Consumer Satisfaction and Care Management Surveys - ODM and the ICDS Plans will utilize a variety of surveys in order to assess participant satisfaction with the ICDS Plans, services and care management.

Consumer Advisory Groups - ICDS plans will be required to obtain beneficiary and community input on issues of program management through the establishment of ICDS plan specific regional consumer advisory groups that will meet at least quarterly. State staff and representatives from consumer advocacy groups will also participate. Feedback from the groups will help the State to inform and refine processes related to the administration of the program.

Quarterly Reporting - The ICDS plans, the level of care vendor and the provider oversight contractor are required to submit a set of quarterly reports to ODM that include operational output and quality performance data. ODM reviews this information and follows up with each entity as needed.

Systematic Review of Hearing and Grievance Data - ICDS plans will be required to submit data files to the State that document grievances and appeals received during the prior month in all regions for which the ICDS plans have a provider agreement. State staff will review a representative sample of appeals and grievances on a monthly basis to verify accurate categorization and adequate resolution, and to identify patterns. Audits may occur to evaluate appropriate identification and submission of grievances in response to any observation in reported appeals or grievance to assure compliance with program requirements. Compliance action is taken by ODM following the review of grievances or appeals if it is determined that the issues were not resolved or the ICDS Plan is in violation of a program requirement.

EQRO Findings - Ohio’s External Quality Review Organization will conduct independent assessments of the program’s impact on access, quality and cost effectiveness during the first two waiver periods. The EQRO will integrate CMS’s duals demonstration evaluation into the design of the waiver review. Additionally the EQRO will be a primary data source for many of the quality measures contained within the ICDS Waiver.

Onsite Reviews - Onsite reviews are primarily conducted with the comprehensive administrative reviews that are completed every three years to comply with 42 CFR 438.358; however, focused reviews may be conducted on an annual basis at OMA’s discretion. Reviews may focus on a variety of domains including, but not limited to,

coordination and continuity of care, subcontracting and delegation, health information systems, coverage and authorization of services, etc.

Performance Improvement Projects - Performance Improvement Projects are an integral part of improving the overall quality of care. Each ICDS plan will be required to conduct PIPs on clinical and non-clinical areas. ODM expects PIPs to be multi-year, structured quality improvement projects that yield favorable health outcomes and improved experiences of care for individuals.

Performance Measures - ICDS Plans will be held accountable for comprehensive performance measures that focus on most aspects of the program from improved health outcomes to access to care, as well as the 1915(c) waiver assurances. When negative findings are identified related to the QIS measures, individual remediation will be required in accordance with the ICDS Waiver.

Data from these sources will be aggregated by ODM and reviewed as a whole to create a broad picture of the program and inform timely and ongoing systems improvement. Quality assessment and systems improvement will be continuous as plans will be required to complete evaluations of the impact and effectiveness that their care management model has on individuals' health outcomes and participant satisfaction. The results of these evaluations will be integrated into the ICDS plans' continuous quality improvement programs. Quality will be further assured through the utilization of a core set of measures used by all demonstration projects. Ohio-specific measures focused on transition, diversion and balance will also be used, in addition to QIS measures traditionally associated with home and community-based services. The findings from these measures will further inform areas requiring systems improvement, contributing to a fully integrated approach to systems improvement that assures adherence to the statutory assurances of the 1915(c) waiver and beyond. These efforts will be further informed by a CMS-State Contract Management team which shall conduct ICDS Plan contract management activities related to ensuring access, quality, program integrity, program compliance, and financial solvency. For the ICDS demonstration, CMS and the State shall conduct a joint comprehensive performance and quality monitoring process that is at least as rigorous as Medicare Advantage, Medicare Prescription Drug, and Medicaid managed care requirements.

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: National accreditation bodies and Medicare certification reviewers	☒ **Other** Specify: As required by NCQA and Medicare

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.

ODM is committed to making sound, data driven design changes based upon information gathered from discovery and remediation, from the 1915(b) waiver monitoring activities and the evaluation component of the ICDS program. The State will use this data to inform future QIS considerations. The State will utilize formalized processes, including solicitation of input from CMS, to monitor the efficacy of the intervention to ensure that the areas targeted for improvement are positively impacted. ODM will carefully monitor design changes from two vantage points. First, we will monitor to ensure that the systems improvement intervention is implemented as intended. Recognizing that a well targeted but flawed implementation of a systems improvement intervention may yield negative results, ODM will work with all partners to ensure that the strategy for improvement is carried out with fidelity to design. Second, ODM will monitor interventions to make sure that they were, indeed, the right strategy to achieve the desired system improvement. Information from all of the review processes is used to determine compliance with state and federal regulations, evaluate the quality and timeliness of, and access to care and services, and to identify interventions needed to improve outcomes for individuals and the overall performance of the system. Areas of non-compliance are addressed through a progressive sanctioning process that may include corrective action plans developed by the ICDS Plans or by the level of care or provider monitoring contractor, as appropriate, and such interventions will further inform overall system design changes to prevent future issues.

Within Ohio, ODM will work seamlessly in the review of discovery, remediation and related data to determine system improvement strategies. While a formalized trending and prioritization of data will happen quarterly, communication regarding oversight and quality improvement will be ongoing and continuous. Similarly, OMA will work collaboratively with the ICDS plans, the level of care vendor, and the provider oversight contractor to ensure that systems improvements are well-tailored, implemented as intended and achieve desired outcomes. ODM will further work with CMS in joint oversight of the plans for the ICDS demonstration to ensure a fully integrated approach to quality improvement on aspects of system design and implementation.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

ODM has engaged with stakeholders and advocates throughout the design and development phases of ICDS demonstration. In order to ensure success and maintain a truly collaborative process, we will continue reaching out to providers, advocates, and individuals throughout the implementation and operational phases of the demonstration. To that end, Ohio commits to an ongoing review of the quality improvement process to ensure that it is effectively identifying issues, remediating problems and ensuring effective systems improvements. In addition to the ongoing incorporation of a continuous quality improvement process for the quality and oversight process as a whole, ODM will, at least once during the initial term of the waiver engage in a critical assessment of the performance of both the system improvement and the QIS and revise it as necessary and appropriate.

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).*

Ohio's ICDS 1915(c) waiver will operate concurrently with a 1915(b) waiver and all services are provided through an ICDS plan. In accordance with the three-way Agreement and Medicaid Provider Agreement, the ODM makes a capitated payment monthly to each ICDS plan for each individual and the contracting ICDS plan provides all needed Medicaid State Plan and HCBS services through their provider networks. The contract requires each ICDS plan to implement a compliance plan to guard against fraud and abuse, to conduct provider audits to verify that services authorized and paid for by each ICDS plan are actually provided and to make referrals to ODM for review in cases of suspected fraud or abuse.

ODM staff meet periodically with each ICDS plan to discuss financial integrity and accountability. The ODM routinely conducts audits of state held contracts and reviews data and information relative to the concurrent (b)(c) waiver.

The ICDS plans are required to promptly report all instances of provider fraud and abuse to ODM and member fraud to the appropriate county department of job and family services (CDJFS). The ICDS plan, at a minimum, must report on cases where the ICDS plan's investigation has revealed that an incident of fraud and/or abuse has occurred. This requirement requires reporting (by provider type) all fraud and abuse findings promptly through an organized Managed Care Program Integrity Group (MCPIG), as well as annually in a summary report. Provider agencies are monitored at a frequency set by the State. Each ICDS plan must comply with all applicable program integrity requirements, including those specified in 42 CFR 455 and 42 CFR 438 Subpart H.

The Auditor of the State of Ohio is the entity responsible for conducting an annual Single Audit 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).

ODM also contracts with the Auditor of State to conduct post payment reviews of professional service providers and contracts with Permedion to conduct post payment reviews of inpatient hospital claims. ODM performs post payment reviews onsite and virtually of certain provider types.

As outlined in the MyCare Ohio provider agreement, in accordance with 42 CFR 438.608, the MCOP shall create, implement, and maintain a fraud, waste, and abuse program that includes several items including a description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, such as:
a. A list of automated pre-payment claims edits;
b. A list of automated post payment claims edits;
c. A list of desk audits on post payment review of claims;
d. A list of reports of provider profiling and credentialing used to aid program and payment reviews; and/or
e. A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

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 in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

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:
(2) The number and percent of claims sampled in performance measure #1 that were found to be unsupported claims for waiver services for which payment was recouped. N: Number of paid claims reviewed for which provider documentation did not support payment of the claim, and payment was recouped. D: Number of paid claims reviewed for which provider documentation did not support payment of the claim.

Data Source *(Select one):*
Financial audits
If 'Other' is selected, specify:
ICDS plans

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 =* *95% within MOE of +/- 5%*
☒ ***Other*** *Specify:* *ICDS plans*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*

	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☒ ***Other*** *Specify:* *Semi-annually*	

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:
(1) The number and percent of claims verified through a review of provider documentation to have been paid in accordance with individuals' waiver service plans. Numerator: The number of claims reviewed for which provider documentation supported that the claim was appropriately paid in accordance with the individuals' waiver service plan. Denominator: The number of paid claims reviewed.

Data Source *(Select one):*
Financial audits
If 'Other' is selected, specify:
ICDS plans

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 =* *95% within MOE of +/- 5%*
☒ ***Other*** *Specify:* *ICDS plans*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☒ ***Other*** *Specify:* *Semi-annually*	

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:*

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*

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.

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.*

Medicaid capitated payments to the ICDS plans are developed and certified by an actuarial contractor in accordance with managed care requirements for contracts and rate development in 42 CFR Part 438. The actuaries use Medicaid data to set the rates and take into consideration any program or policy changes that might impact the waiver program.

The Managed Care Program Integrity Group (McPIG), is comprised of representatives of ODM's Office of Managed Care (OMC) and representatives of each of Ohio's ICDS plans and the Attorney General's Medicaid Fraud Control Unit. This group meets quarterly to share information about fraud trends, fraud schemes, and ongoing compliance investigations.

Additionally, ICDS plans are required to routinely monitor the federal exclusion list for providers that have been excluded from Medicaid.

"Unsupported claims" are determined by comparing documentation obtained from the provider to the waiver services they authorized. The MCOP reviews the documentation to ensure the claim was correctly paid: To the authorized provider; For the authorized service; For the authorized amount of service; and Evidence supports that the service was delivered as authorized. The Plans report their findings to ODM, including whether unsupported claims payments were recouped. The Plan is responsible for the processes to recoup payment from the provider.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

The 1915(b) permits selective contracting of providers and the ICDS plans are responsible for assuring the quality and adequacy of their provider network. Also, the ICDS plans have the authority to terminate their contracts with providers and recoup payments when finding that services are provided inappropriately, i.e., services are not provided in accordance with program requirements. When significant problems are detected that may impact the health and safety of individuals, the ICDS plan reports to the State immediately. The State initiates remediation as appropriate and may require corrective action by the ICDS plans.

When MFCU prosecutes a provider for defrauding the Medicaid program, it will always ask that as part of the defendant's sentence, the court order restitution to the entity that paid the claim. If the false claims were paid directly by OMA, MFCU will ask that the court order restitution to ODM. If, in the alternative, the false claims were paid by an ICDS plan, MFCU will ask that the court order restitution to the ICDS plan. In the event that both ODM and an ICDS plan paid the false claim, MFCU will ask that the court order restitution to both based on the value of the false claims paid by each.

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 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).

The State employs an actuary to calculate an actuarially sound payment rate per 42 CFR 438.4 and 42 CFR 438.5 on at least an annual basis.

The ICDS plans are responsible for negotiating rates with providers for waiver services (except for those rates for services included in the capitation payment that remain at the FFS level during transition periods as noted above). The ICDS plans negotiate provider payment based on demand for services, availability of qualified providers, clinical priority or best clinical practices and estimated provider service cost.

Under the ICDS demonstration program, there are no Medicaid services that are paid on a fee-for-service basis outside of the capitation payments. Per CMS instructions, the following information should be included under this section in the waiver application in conjunction with information that has already been included. The State's capitation payments made to the ICDS plans are in accordance with the managed care contracts and the §1915(b) waiver. ICDS health plans submit encounter data to the MMIS system based upon bills paid to providers for traditionally arranged services according to the requirements of the managed care contracts and the §1915(b) waiver.

FFS provider rates are established either through Ohio's legislative budget process or Ohio's administrative rule making process and serve as a basis for rates established between the plans and contracted providers. The legislative budget process allows public input from any interested member of the public including general members of the public, waiver participants, provider associations and any other stakeholders. There are several public hearings held throughout the budget process with notices posted on the Ohio General Assembly website with additional information about hearings in many of Ohio's major newspapers. The public is also encouraged to write or telephone their state legislators to express their views. Any Ohioan, advocate, service provider, or member of the general public is encouraged to contact ODM any time that a change is proposed in the area of administrative law regarding HCBS waiver services. Proposed rules are posted on ODM's website and public hearings are advertised and held at both the agency level and at the legislative Joint Committee on Agency Rule Review (JCARR) prior to adopting new rules regarding provider rate changes.

ODM regularly informs waiver participants, providers and stakeholders of administrative policy changes including FFS rate changes through its internal and external department clearance process. They are afforded opportunities to discuss their concerns prior to and during public hearings. Notices for the public hearings for all rate-related policy or rate changes are made in accordance with 42 CFR 447.205 and as outlined in the Main Module 6-I of this application.

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:*

The 1915(c) waiver operates concurrently with a 1915(b) waiver. Capitated payments for each individual enrolled on the ICDS Waiver are made to each ICDS plan monthly through the State's Medicaid Information Technology System (MITS) which is Ohio's MMIS, in accordance with the risk contract between the state Medicaid agency and each ICDS plan. The capitated payments are considered payment in full for all services covered under the 1915(b)/1915(c) concurrent waivers.

Individual providers bill the contracting ICDS plan according to the terms of the contract between the contracting ICDS plan and its providers. The risk contract between the state Medicaid agency and each ICDS plan outline requirements for subcontracting and timeliness of payment to providers by the contracting ICDS plan.

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.)

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 State determines eligibility for capitated payments by identifying individuals through MITS who are eligible for Medicaid, reside in one of the counties covered by the waiver and have been determined by the State to participate in the ICDS. MITS generates a capitated payment to each ICDS plan at the beginning of the following month for each waiver individual identified through this process.

The ICDS plans have mechanisms in place to ensure that payment for waiver services occurs according to the service plan. Through the comprehensive care management process, authorization for waiver services is entered into each ICDS plan's claims payment system. These claims payment systems then edit claims against authorized service plans to prevent payment for unauthorized services.

Pursuant to 42 CFR 455.20, ICDS plans must have a method for verifying with individuals whether services billed by providers were received. Therefore, the ICDS plan is required to conduct a mailing of Explanation of Benefits (EOB) to a 95% confidence level (plus or minus 5 percent margin of error) sample of the ICDS plan's enrollees once a year. The EOB mailing must only include those members that have received health care services within the last six months, comply with all state and federal regulations regarding the release of personal health information, outline the recent medical services identified as having been provided to the enrollee, and request that the enrollee report any discrepancies to the ICDS plan. ICDS plans must inform their Contract Administrator of the date of the EOB mailing and provide results of the mailing 60 to 90 days after the mailing (i.e., number mailed, number of enrollees reporting discrepancies). This annual EOB mailing (which would include waiver services) is a tool for the state to gather information from consumers to verify/report if services are not received.

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:

Eligibility for waiver participation is entered into the State's eligibility system by the CDJFS in the participating counties once the determination has been made that an individual is Medicaid eligible and is eligible to participate in the waiver. The eligibility system transmits eligibility information into MITS, which pays a monthly capitated payment to each ICDS plan for each individual. Capitated payments continue until one of the following occurs: the individual loses Medicaid eligibility, the individual moves to a county outside of the managed care service areas, or eligibility for ICDS is not met. Waiver service providers do not have an option to receive direct payments.

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:

☒ ***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.

Not applicable – all services are in the State's contract with ICDS plans.

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.

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:

Types of public providers that receive payment for waiver services include city and county health departments with HHA, services and senior centers providing personal care, homemaker, and transportation services as well as public ICFs-MR providing Out-of-Home Respite Services. Additionally, public hospitals that may provide personal care or home delivered meals. Public providers furnish the same services that private providers furnish.

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.

Each ICDS plan retains the monthly capitated payment. A quality withhold may be instituted pursuant to the MOU negotiated between CMS and the State to implement the ICDS demonstration.

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.

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 §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 §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 §1915(b)/§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 §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 ?1115/?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 ?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 textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §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 §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:

☐ ***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:

☐ ***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:

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 capitated payments to each ICDS plan were initially based on expenditures for similar services in the FFS 1915(c) waivers that serve the rest of the State. FFS payment rates are based on the cost of providing the service exclusive of room and board. Subsequent capitated payments to each ICDS plan have been developed utilizing a combination of ICDS plan submitted cost report information and available encounter data.

For the Assisted Living service offered through the ICDS waiver, providers receive two separate payments: the monthly room and board payment and the service payment. These payments come from two different sources. The authorized service payments are paid to the provider by the ICDS plans. The room and board payment is made by the individual directly to the waiver service provider. The State does not play any role in collecting or paying the room and board payment.

The State's role in the cost of room and board furnished in a residential setting to an individual enrolled on the waiver is limited to establishing the maximum monthly room and board amount paid by an individual. The provider may not charge the individual a security deposit or an additional fee above the maximum monthly room and board rate to hold the living unit during a temporary absence (ie: hospital or short term nursing facility stay).

The room and board rate is the current Supplemental Security Income (SSI) federal benefit minus a $50.00 personal needs allowance. The room and board rate increases annually when the SSI benefit cost of living adjustment is applied. The room and board rate may not exceed the rate established by the state.

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***
- [ ] ***Coinsurance***
- [ ] ***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:

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: Hospital, Nursing Facility

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	19818.55	6014.82	25833.37	40133.34	2568.61	42701.95	16868.58
2	23425.00	6148.57	29573.57	40936.01	2619.98	43555.99	13982.42
3	23587.00	6286.54	29873.54	41754.73	2672.38	44427.11	14553.57
4	23834.05	6450.40	30284.45	42589.82	2725.83	45315.65	15031.20
5	24080.51	6619.83	30700.34	43441.62	2780.35	46221.97	15521.63

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:	Level of Care:
		Hospital	Nursing Facility

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: Hospital	Level of Care: Nursing Facility
Year 1	40921	818	40103
Year 2	40921	818	40103
Year 3	40921	818	40103
Year 4	40921	818	40103
Year 5	40921	818	40103

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.*

The average length of stay has been projected based on actual experience in the current waiver cycle through December 31, 2022 and reflects year-over-year increases during the new 5-year waiver period based on projected phase-in and phase-out assumptions. The actual ALOS for CY22 (January 1, 2022 through December 31, 2022) was approximately 301 days. The ALOS is not anticipated to change materially during the 5-year waiver period based on recent experience and maintaining the level of unduplicated participants counts across the 5 years of the renewal period.

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:*

The number of projected users were adjusted based on total projected slots. The total number of unduplicated participants is held at the level listed in WY 5 of the current waiver (40,921) to adhere to CMS's MOE requirements.

Development of the Factor D costs for the MyCare Ohio program is based on an allocation process of the managed care capitation rates paid to MyCare Ohio health plans. We applied an allocation to the actual payments made to the MyCare Ohio health plans based on the development of the capitation rates specific to the waiver services provided to MyCare Ohio waiver enrollees. The following provides a summary of the methodology utilized to allocate historical expenditures for purposes of a starting point:

• Step 1 – Summarize encounter data
o Utilizing files, we summarized unduplicated participants and days of waiver enrollment for the historical time periods.
o Total expenditures from the vendor files were summarized for each waiver service category for the identified MyCare members.
o Costs reported in the files were divided between the waiver services (Factor D) and state plan services (Factor D').
• Step 2 – Allocate capitation expenditures
o Total waiver expenditures were summarized from the portion of monthly capitation rates attributed to waiver services.
o Factor D costs were calculated as the ratio of total waiver expenditures divided by the unduplicated participants. o Waiver expenses by waiver service distribute the total waiver expenses from the monthly capitation rates according to the distribution of expenses by waiver service summarized from the encounter claims in the files. Factor D for the new 5-year waiver period for the renewal (January 1, 2024 through December 31, 2028) was projected from waiver year 5 of the current renewal data in the following manner:
• Base number of users was calculated by determining the allocated number of users from the historical experience as described in the process above. The percentage of members identified as using a service from the historical unduplicated participant count was applied to future projected unduplicated participant counts to determine the number of users across the 5-year renewal period. Therefore, a projected number of users for WY 1 represents projected experience for current WY 5 multiplied by the change in unduplicated participant count from WY 5 to WY 1. Growth from WY 1 to WY 5 of the renewal period applied the same methodology
• Baseline average units per user was calculated by adjusting the historical experience of average units per user through WY 4 (CY 2022) by projected growth in the ALOS. Therefore, a projected average units per user was developed for WY 5 by taking actual experience and multiplying by the change in ALOS from WY 4 to projected WY 5. Subsequently the State developed average units per user for WY 1 of the renewal period utilizing a similar methodology of projected WY 5 experience multiplied by the change in ALOS from WY 5 to WY 1. Growth from WY 1 to WY 5 of the renewal period applied the same methodology. The change reflected in WY 1 of the renewal period for average units per user was calculated from the projected WY 5 average units per user multiplied by the estimated change in ALOS to 299.
• Baseline average cost per unit values were calculated by adjusting the historical experience of unit cost through WY 5 (CY 2023) and developed from the allocated capitation expenditure calculation methodology discussed above. Using the total expenditures by waiver service developed from the allocation process and dividing by the total number of units, the cost per unit was established for most of the services in the MyCare Ohio program.

*** As a result of proposed budgetary changes to be effective January 1, 2024 the average cost per unit for Waiver Nursing Service, Personal Care, Choices Home Care Attendant, Homemaker, Home Care Attendant, Adult Day Health, Home Delivered Meals, Assisted Living Service, Enhanced Community Living Service, and Home Modifications, Maintenance and Repair reflect additional funding specific for SFY 2024 and SFY 2025 which cover the renewal period for WY 1 and WY 2. We have held the average cost per unit constant for WY 3-5 for the identified services. Remaining services are also held at the same cost per unit across the 5-year waiver period.*

**** As the MyCare waiver submission reflects a renewal, the cost per unit increases are not reflective of changes from a previously approved submission, but rather reflect the impact the budgetary changes had on the cost per unit values included in Appendix J-2-d. The noted percentages represent the impact on the waiver submission had budgetary changes not been implemented:*
- *Adult Day Health – 13.4% for WY 1, 6.9% for WY 2*
- *Homemaker – 78.2% for WY 1, 15.3% for WY 2*

- *Personal Care – 50.4% for WY 1, 18.2% for WY 2*
- *Assisted Living – 73.2% for WY 1, 20.5% for WY 2*
- *Choices - Home Care Attendant – 48.1% for WY 1, 18.3% for WY 2*
- *Enhanced Community Living – 26.7% for WY 1, 13.2% for WY 2*
- *Home Care Attendant – 58.1% for WY 1, 17.3% for WY 2*
- *Home Delivered Meals – 4.7% for WY 1, 8.6% for WY 2*
- *Home Modifications, Maintenance and Repair – 25.7% for WY 1, 13.0% for WY 2*
- *Waiver Nursing Service– 45.6% for WY 1, 15.5% for WY 2*

These increases were based on legislative changes under Ohio House Bill 33 targeting the nursing services crisis and the ability to provide quality home and community based services. These noted increases were part of a planned provider rate increase of approximately 40% across the HCBS program with a noted increase of 80% for Assisted Living. The percentages vary by service due to the budgetary appropriations made for the different services. The total projected impact of these changes reflected an approximate $259 million increase for CY 2024 and an additional increase of approximately $147 million for CY 2025. As the changes will take effect January 1, 2024, the impact is reflected in WY 1 with additional budgetary changes reflected in WY 2 and forward.

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 for Factor D' was developed based on the state plan services identified in the capitation payment allocation methodology discussed above. The Factor D` values for future time periods were developed based on anticipated changes to acute care services for future MyCare Ohio capitation rates. Estimates of Factor D' for each waiver year are illustrated in the cost neutrality summary in Table 1.

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 currently filed Factor G costs for WY 5 of the current waiver: January 1, 2019 through December 31, 2023. Factor G was trended at a rate of 2.0% per year based on historical experience and budget forecast trends to assess future MyCare capitation rates. Estimates of Factor G for each waiver year are illustrated in the cost neutrality summary in Table 1.

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 currently filed Factor G costs for WY 5 of the current waiver: January 1, 2019 through December 31, 2023. Factor G' was trended at a rate of 2.0% per year based on historical experience and budget forecast trends to assess future MyCare capitation rates. Estimates of Factor G' for each waiver year are illustrated in the cost neutrality summary in Table 1.

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	
Adult Day Health	
Homemaker	
Personal Care	
Alternative Meals Service	
Assisted Living Service	
Choices - Home Care Attendant Service	

Waiver Services	
Community Integration Service	
Community Transition Service	
Enhanced Community Living Service	
Home Care Attendant	
Home Delivered Meals	
Home Maintenance and Chore	
Home Medical Equipment and Supplemental Adaptive and Assistive Device Services	
Home Modification	
Nutritional Consultation	
Out-of-Home Respite	
Personal Emergency Response System	
Self-directed goods and services	
Social Work Counseling	
Structured Family Caregiving Services	
Waiver Nursing	
Waiver Transportation	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**5132348.00**
Adult Day Health	☒	Day	862	104.00	57.25	**5132348.00**	
Homemaker Total:							**2350857.60**
Homemaker	☒	15 minute	338	720.00	9.66	**2350857.60**	
Personal Care Total:							**589959609.10**
Personal Care	☒	15 minute	24790	3203.00	7.43	**589959609.10**	
Alternative Meals Service Total:							**145181.12**

GRAND TOTAL:	**810995051.20**
Total: Services included in capitation:	810995051.20
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	**40921**
Factor D (Divide total by number of participants):	**19818.55**
Services included in capitation:	19818.55
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	299

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Alternative Meals Service	☒	Meal	56	788.00	3.29	145181.12	
Assisted Living Service Total:							114639432.18
Assisted Living Service	☒	Day	4701	182.00	133.99	114639432.18	
Choices - Home Care Attendant Service Total:							3172624.76
Choices - Home Care Attendant Service	☒	15 minute	151	3314.00	6.34	3172624.76	
Community Integration Service Total:							3720.00
Community Integration Service	☒	15 minute	5	465.00	1.60	3720.00	
Community Transition Service Total:							345960.00
Community Transition Service	☒	Job	240	1.00	1441.50	345960.00	
Enhanced Community Living Service Total:							18808.48
Enhanced Community Living Service	☒	15 minute	46	1076.00	0.38	18808.48	
Home Care Attendant Total:							773950.00
Home Care Attendant	☒	15 minute	20	230.00	168.25	773950.00	
Home Delivered Meals Total:							49272656.25
Home Delivered Meals	☒	Meal	21023	375.00	6.25	49272656.25	
Home Maintenance and Chore Total:							1271405.52
Home Maintenance and Chore	☒	Job	969	1.00	1312.08	1271405.52	
Home Medical Equipment and Supplemental Adaptive and Assistive Device Services Total:							4807957.17

GRAND TOTAL:	810995051.20
Total: Services included in capitation:	810995051.20
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	40921
Factor D (Divide total by number of participants):	19818.55
Services included in capitation:	19818.55
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	299

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Medical Equipment and Supplemental Adaptive and Assistive Device Services	☒	Item	9091	51.00	10.37	**4807957.17**	
Home Modification Total:							**11003867.48**
Home Modification	☒	Job	1786	1.00	6161.18	**11003867.48**	
Nutritional Consultation Total:							**674.24**
Nutritional Consultation	☒	15 minute	2	28.00	12.04	**674.24**	
Out-of-Home Respite Total:							**250065.84**
Out-of-Home Respite	☒	Day	62	29.00	139.08	**250065.84**	
Personal Emergency Response System Total:							**6720638.73**
Personal Emergency Response System Monthly Rental	☒	Month	26312	12.00	21.19	**6690615.36**	
Personal Emergency Response System Installation	☒	Item	1149	3.00	8.71	**30023.37**	
Self-directed goods and services Total:							**0.00**
Self-directed goods and services	☐		0	0.00	0.01	**0.00**	
Social Work Counseling Total:							**233144.01**
Social Work Counseling	☒	15 minute	271	121.00	7.11	**233144.01**	
Structured Family Caregiving Services Total:							**0.00**
Structured Family Caregiving Services	☐		0	0.00	0.01	**0.00**	

GRAND TOTAL:	**810995051.20**
Total: Services included in capitation:	810995051.20
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	**40921**
Factor D (Divide total by number of participants):	**19818.55**
Services included in capitation:	19818.55
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	299

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Waiver Nursing Total:							**19827400.32**
Waiver Nursing	☒	15 minute	2106	672.00	14.01	**19827400.32**	
Waiver Transportation Total:							**1064750.40**
Waiver Transportation	☒	Mile	1568	1509.00	0.45	**1064750.40**	

GRAND TOTAL:	**810995051.20**
Total: Services included in capitation:	810995051.20
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	**40921**
Factor D (Divide total by number of participants):	**19818.55**
Services included in capitation:	19818.55
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	299

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**5526451.84**
Adult Day Health	☒	Day	868	104.00	61.22	**5526451.84**	
Homemaker Total:							**2727072.00**
Homemaker	☒	15 minute	340	720.00	11.14	**2727072.00**	
Personal Care Total:							**698511171.18**
Personal Care	☒	15 minute	24963	3187.00	8.78	**698511171.18**	
Alternative Meals Service Total:							**145181.12**
Alternative Meals Service	☒					**145181.12**	

GRAND TOTAL:	**958574426.31**
Total: Services included in capitation:	958574426.31
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**40921**
Factor D (Divide total by number of participants):	**23425.00**
Services included in capitation:	23425.00
Services not included in capitation:	
Average Length of Stay on the Waiver:	299

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		Meal	56	788.00	3.29		
Assisted Living Service Total:							**139030928.40**
Assisted Living Service	☒	Day	4733	182.00	161.40	**139030928.40**	
Choices - Home Care Attendant Service Total:							**3777960.00**
Choices - Home Care Attendant Service	☒	15 minute	152	3314.00	7.50	**3777960.00**	
Community Integration Service Total:							**3720.00**
Community Integration Service	☒	15 minute	5	465.00	1.60	**3720.00**	
Community Transition Service Total:							**348843.00**
Community Transition Service	☒	Job	242	1.00	1441.50	**348843.00**	
Enhanced Community Living Service Total:							**21283.28**
Enhanced Community Living Service	☒	15 minute	46	1076.00	0.43	**21283.28**	
Home Care Attendant Total:							**908178.00**
Home Care Attendant	☒	15 minute	20	230.00	197.43	**908178.00**	
Home Delivered Meals Total:							**53904112.50**
Home Delivered Meals	☒	Meal	21170	375.00	6.79	**53904112.50**	
Home Maintenance and Chore Total:							**1280590.08**
Home Maintenance and Chore	☒	Job	976	1.00	1312.08	**1280590.08**	
Home Medical Equipment and Supplemental Adaptive and Assistive Device Services Total:							**4841275.98**
Home Medical	☒					**4841275.98**	

GRAND TOTAL:	**958574426.31**
Total: Services included in capitation:	958574426.31
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**40921**
Factor D (Divide total by number of participants):	**23425.00**
Services included in capitation:	23425.00
Services not included in capitation:	
Average Length of Stay on the Waiver:	299

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Equipment and Supplemental Adaptive and Assistive Device Services		Item	9154	51.00	10.37		
Home Modification Total:							**12516615.18**
Home Modification	☒	Job	1798	1.00	6961.41	**12516615.18**	
Nutritional Consultation Total:							**674.24**
Nutritional Consultation	☒	15 minute	2	28.00	12.04	**674.24**	
Out-of-Home Respite Total:							**254099.16**
Out-of-Home Respite	☒	Day	63	29.00	139.08	**254099.16**	
Personal Emergency Response System Total:							**6767635.29**
Personal Emergency Response System Monthly Rental	☒	Month	26496	12.00	21.19	**6737402.88**	
Personal Emergency Response System Installation	☒	Item	1157	3.00	8.71	**30232.41**	
Self-directed goods and services Total:							**133110.00**
Self-directed goods and services	☒	Item	51	6.00	435.00	**133110.00**	
Social Work Counseling Total:							**234864.63**
Social Work Counseling	☒	15 minute	273	121.00	7.11	**234864.63**	
Structured Family Caregiving Services Total:							**3506892.32**
Structured Family Caregiving Services	☒	Day	152	233.00	99.02	**3506892.32**	

GRAND TOTAL:		**958574426.31**
Total: Services included in capitation:		958574426.31
Total: Services not included in capitation:		
Total Estimated Unduplicated Participants:		**40921**
Factor D (Divide total by number of participants):		**23425.00**
Services included in capitation:		23425.00
Services not included in capitation:		
Average Length of Stay on the Waiver:	299	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Waiver Nursing Total:							**23061548.16**
Waiver Nursing	☒	15 minute	2121	672.00	16.18	**23061548.16**	
Waiver Transportation Total:							**1072219.95**
Waiver Transportation	☒	Mile	1579	1509.00	0.45	**1072219.95**	

GRAND TOTAL:	**958574426.31**
Total: Services included in capitation:	958574426.31
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**40921**
Factor D (Divide total by number of participants):	**23425.00**
Services included in capitation:	23425.00
Services not included in capitation:	
Average Length of Stay on the Waiver:	299

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**5564653.12**
Adult Day Health	☒	Day	874	104.00	61.22	**5564653.12**	
Homemaker Total:							**2751134.40**
Homemaker	☒	15 minute	343	720.00	11.14	**2751134.40**	
Personal Care Total:							**702552297.88**
Personal Care	☒	15 minute	24982	3203.00	8.78	**702552297.88**	
Alternative Meals Service Total:							**145181.12**
Alternative Meals Service	☒					**145181.12**	

GRAND TOTAL:	**965203455.92**
Total: Services included in capitation:	965203455.92
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**40921**
Factor D (Divide total by number of participants):	**23587.00**
Services included in capitation:	23587.00
Services not included in capitation:	
Average Length of Stay on the Waiver:	299

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		Meal	56	788.00	3.29		
Assisted Living Service Total:							**140000296.80**
Assisted Living Service	☒	Day	4766	182.00	161.40	**140000296.80**	
Choices - Home Care Attendant Service Total:							**3802815.00**
Choices - Home Care Attendant Service	☒	15 minute	153	3314.00	7.50	**3802815.00**	
Community Integration Service Total:							**3720.00**
Community Integration Service	☒	15 minute	5	465.00	1.60	**3720.00**	
Community Transition Service Total:							**351726.00**
Community Transition Service	☒	Job	244	1.00	1441.50	**351726.00**	
Enhanced Community Living Service Total:							**21283.28**
Enhanced Community Living Service	☒	15 minute	46	1076.00	0.43	**21283.28**	
Home Care Attendant Total:							**908178.00**
Home Care Attendant	☒	15 minute	20	230.00	197.43	**908178.00**	
Home Delivered Meals Total:							**54275865.00**
Home Delivered Meals	☒	Meal	21316	375.00	6.79	**54275865.00**	
Home Maintenance and Chore Total:							**1289774.64**
Home Maintenance and Chore	☒	Job	983	1.00	1312.08	**1289774.64**	
Home Medical Equipment and Supplemental Adaptive and Assistive Device Services Total:							**4875123.66**
Home Medical	☒					**4875123.66**	

GRAND TOTAL:	**965203455.92**
Total: Services included in capitation:	965203455.92
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**40921**
Factor D (Divide total by number of participants):	**23587.00**
Services included in capitation:	23587.00
Services not included in capitation:	
Average Length of Stay on the Waiver:	299

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Equipment and Supplemental Adaptive and Assistive Device Services		Item	9218	51.00	10.37		
Home Modification Total:							**12600152.10**
Home Modification	☒	Job	1810	1.00	6961.41	**12600152.10**	
Nutritional Consultation Total:							**674.24**
Nutritional Consultation	☒	15 minute	2	28.00	12.04	**674.24**	
Out-of-Home Respite Total:							**254099.16**
Out-of-Home Respite	☒	Day	63	29.00	139.08	**254099.16**	
Personal Emergency Response System Total:							**6814377.57**
Personal Emergency Response System Monthly Rental	☒	Month	26679	12.00	21.19	**6783936.12**	
Personal Emergency Response System Installation	☒	Item	1165	3.00	8.71	**30441.45**	
Self-directed goods and services Total:							**159210.00**
Self-directed goods and services	☒	Item	61	6.00	435.00	**159210.00**	
Social Work Counseling Total:							**236585.25**
Social Work Counseling	☒	15 minute	275	121.00	7.11	**236585.25**	
Structured Family Caregiving Services Total:							**4302849.60**
Structured Family Caregiving Services	☒	Day	153	280.00	100.44	**4302849.60**	

GRAND TOTAL:	**965203455.92**
Total: Services included in capitation:	965203455.92
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**40921**
Factor D (Divide total by number of participants):	**23587.00**
Services included in capitation:	23587.00
Services not included in capitation:	
Average Length of Stay on the Waiver:	299

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Waiver Nursing Total:							**23213769.60**
Waiver Nursing	☒	15 minute	2135	672.00	16.18	**23213769.60**	
Waiver Transportation Total:							**1079689.50**
Waiver Transportation	☒	Mile	1590	1509.00	0.45	**1079689.50**	

GRAND TOTAL:	**965203455.92**
Total: Services included in capitation:	965203455.92
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**40921**
Factor D (Divide total by number of participants):	**23587.00**
Services included in capitation:	23587.00
Services not included in capitation:	
Average Length of Stay on the Waiver:	299

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**5602854.40**
Adult Day Health	☒	Day	880	104.00	61.22	**5602854.40**	
Homemaker Total:							**2774862.60**
Homemaker	☒	15 minute	345	722.00	11.14	**2774862.60**	
Personal Care Total:							**709818713.68**
Personal Care	☒	15 minute	25154	3214.00	8.78	**709818713.68**	
Alternative Meals Service Total:							**145733.84**
Alternative Meals Service	☒					**145733.84**	

GRAND TOTAL:	**975313143.10**
Total: Services included in capitation:	975313143.10
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**40921**
Factor D (Divide total by number of participants):	**23834.05**
Services included in capitation:	23834.05
Services not included in capitation:	
Average Length of Stay on the Waiver:	300

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		Meal	56	791.00	3.29		
Assisted Living Service Total:							**141744223.80**
Assisted Living Service	☒	Day	4799	183.00	161.40	**141744223.80**	
Choices - Home Care Attendant Service Total:							**3840375.00**
Choices - Home Care Attendant Service	☒	15 minute	154	3325.00	7.50	**3840375.00**	
Community Integration Service Total:							**3736.00**
Community Integration Service	☒	15 minute	5	467.00	1.60	**3736.00**	
Community Transition Service Total:							**353167.50**
Community Transition Service	☒	Job	245	1.00	1441.50	**353167.50**	
Enhanced Community Living Service Total:							**21826.80**
Enhanced Community Living Service	☒	15 minute	47	1080.00	0.43	**21826.80**	
Home Care Attendant Total:							**912126.60**
Home Care Attendant	☒	15 minute	20	231.00	197.43	**912126.60**	
Home Delivered Meals Total:							**54795897.52**
Home Delivered Meals	☒	Meal	21463	376.00	6.79	**54795897.52**	
Home Maintenance and Chore Total:							**1297647.12**
Home Maintenance and Chore	☒	Job	989	1.00	1312.08	**1297647.12**	
Home Medical Equipment and Supplemental Adaptive and Assistive Device Services Total:							**4908442.47**
Home Medical	☒					**4908442.47**	

GRAND TOTAL:	**975313143.10**
Total: Services included in capitation:	975313143.10
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**40921**
Factor D (Divide total by number of participants):	**23834.05**
Services included in capitation:	23834.05
Services not included in capitation:	
Average Length of Stay on the Waiver:	300

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Equipment and Supplemental Adaptive and Assistive Device Services		Item	9281	51.00	10.37		
Home Modification Total:							**12690650.43**
Home Modification	☒	Job	1823	1.00	6961.41	**12690650.43**	
Nutritional Consultation Total:							**674.24**
Nutritional Consultation	☒	15 minute	2	28.00	12.04	**674.24**	
Out-of-Home Respite Total:							**258132.48**
Out-of-Home Respite	☒	Day	64	29.00	139.08	**258132.48**	
Personal Emergency Response System Total:							**6861119.85**
Personal Emergency Response System Monthly Rental	☒	Month	26862	12.00	21.19	**6830469.36**	
Personal Emergency Response System Installation	☒	Item	1173	3.00	8.71	**30650.49**	
Self-directed goods and services Total:							**161820.00**
Self-directed goods and services	☒	Item	62	6.00	435.00	**161820.00**	
Social Work Counseling Total:							**238305.87**
Social Work Counseling	☒	15 minute	277	121.00	7.11	**238305.87**	
Structured Family Caregiving Services Total:							**4345633.60**
Structured Family Caregiving Services	☒	Day	154	280.00	100.78	**4345633.60**	

GRAND TOTAL:	**975313143.10**
Total: Services included in capitation:	975313143.10
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**40921**
Factor D (Divide total by number of participants):	**23834.05**
Services included in capitation:	23834.05
Services not included in capitation:	
Average Length of Stay on the Waiver:	300

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Waiver Nursing Total:							**23446438.00**
Waiver Nursing	☒	15 minute	2150	674.00	16.18	**23446438.00**	
Waiver Transportation Total:							**1090761.30**
Waiver Transportation	☒	Mile	1601	1514.00	0.45	**1090761.30**	

GRAND TOTAL:	**975313143.10**
Total: Services included in capitation:	975313143.10
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**40921**
Factor D (Divide total by number of participants):	**23834.05**
Services included in capitation:	23834.05
Services not included in capitation:	
Average Length of Stay on the Waiver:	300

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**5641055.68**
Adult Day Health	☒	Day	886	104.00	61.22	**5641055.68**	
Homemaker Total:							**2798679.92**
Homemaker	☒	15 minute	347	724.00	11.14	**2798679.92**	
Personal Care Total:							**717090037.50**
Personal Care	☒	15 minute	25325	3225.00	8.78	**717090037.50**	
Alternative Meals Service Total:							**146286.56**
Alternative Meals Service	☒					**146286.56**	

GRAND TOTAL:	**985398714.52**
Total: Services included in capitation:	985398714.52
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**40921**
Factor D (Divide total by number of participants):	**24080.51**
Services included in capitation:	24080.51
Services not included in capitation:	
Average Length of Stay on the Waiver:	301

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		Meal	56	794.00	3.29		
Assisted Living Service Total:							**143469105.60**
Assisted Living Service	☒	Day	4831	184.00	161.40	**143469105.60**	
Choices - Home Care Attendant Service Total:							**3878100.00**
Choices - Home Care Attendant Service	☒	15 minute	155	3336.00	7.50	**3878100.00**	
Community Integration Service Total:							**3752.00**
Community Integration Service	☒	15 minute	5	469.00	1.60	**3752.00**	
Community Transition Service Total:							**356050.50**
Community Transition Service	☒	Job	247	1.00	1441.50	**356050.50**	
Enhanced Community Living Service Total:							**21907.64**
Enhanced Community Living Service	☒	15 minute	47	1084.00	0.43	**21907.64**	
Home Care Attendant Total:							**916075.20**
Home Care Attendant	☒	15 minute	20	232.00	197.43	**916075.20**	
Home Delivered Meals Total:							**55315366.47**
Home Delivered Meals	☒	Meal	21609	377.00	6.79	**55315366.47**	
Home Maintenance and Chore Total:							**1306831.68**
Home Maintenance and Chore	☒	Job	996	1.00	1312.08	**1306831.68**	
Home Medical Equipment and Supplemental Adaptive and Assistive Device Services Total:							**4941761.28**
Home Medical	☒					**4941761.28**	

GRAND TOTAL:	**985398714.52**
Total: Services included in capitation:	985398714.52
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**40921**
Factor D (Divide total by number of participants):	**24080.51**
Services included in capitation:	24080.51
Services not included in capitation:	
Average Length of Stay on the Waiver:	301

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Equipment and Supplemental Adaptive and Assistive Device Services		Item	9344	51.00	10.37		
Home Modification Total:							**12774187.35**
Home Modification	☒	Job	1835	1.00	6961.41	**12774187.35**	
Nutritional Consultation Total:							**674.24**
Nutritional Consultation	☒	15 minute	2	28.00	12.04	**674.24**	
Out-of-Home Respite Total:							**258132.48**
Out-of-Home Respite	☒	Day	64	29.00	139.08	**258132.48**	
Personal Emergency Response System Total:							**6907862.13**
Personal Emergency Response System Monthly Rental	☒	Month	27045	12.00	21.19	**6877002.60**	
Personal Emergency Response System Installation	☒	Item	1181	3.00	8.71	**30859.53**	
Self-directed goods and services Total:							**161820.00**
Self-directed goods and services	☒	Item	62	6.00	435.00	**161820.00**	
Social Work Counseling Total:							**240026.49**
Social Work Counseling	☒	15 minute	279	121.00	7.11	**240026.49**	
Structured Family Caregiving Services Total:							**4389042.00**
Structured Family Caregiving Services	☒	Day	155	280.00	101.13	**4389042.00**	

GRAND TOTAL:	**985398714.52**
Total: Services included in capitation:	985398714.52
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**40921**
Factor D (Divide total by number of participants):	**24080.51**
Services included in capitation:	24080.51
Services not included in capitation:	
Average Length of Stay on the Waiver:	301

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Waiver Nursing Total:							**23680077.20**
Waiver Nursing	☒	15 minute	2165	676.00	16.18	**23680077.20**	
Waiver Transportation Total:							**1101882.60**
Waiver Transportation	☒	Mile	1612	1519.00	0.45	**1101882.60**	

GRAND TOTAL:	**985398714.52**
Total: Services included in capitation:	985398714.52
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**40921**
Factor D (Divide total by number of participants):	**24080.51**
Services included in capitation:	24080.51
Services not included in capitation:	
Average Length of Stay on the Waiver:	301