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:**
IO Waiver Amendment January 1, 2025
C. **Waiver Number:OH.0231**
Original Base Waiver Number: OH.0231.
D. **Amendment Number:**
E. **Proposed Effective Date:** (mm/dd/yy)

01/01/25

Approved Effective Date of Waiver being Amended: 07/01/24

2. Purpose(s) of Amendment

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

As part of the waiver amendment process and in partnership with DODD and HCBS stakeholders, Ohio has included the following changes in the Individual Options waiver program January 1, 2025 amendment:

Appendix B
Updated Medicaid eligibility groups to include Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in Section 1902 (a)(10)(A)(ii)(XIII) of the Act)

Appendix C
Updated service definitions/specifications:

Environmental Accessibility Adaptations:
Added language to align with Ohio Administrative Code rule 5123-9-23 for the service limit of 10K per project. This update reflects service limits established and operated in Ohio Administrative rules in 2019.

Non-medical Transportation (NMT):
Added specifications for special per-trip payment rates when an agency provider or an independent provider transports an individual to or from competitive integrated employment. The special per-trip payment rates are established on a per-person basis, depending on the length of the trip and whether the service is provided in a modified vehicle or a non-modified vehicle.

Updated certification standards to include reference to Ohio Administrative Code Chapter 2.
Added Health Care Assessment as a new subscription service.

Appendix I
Rate Methodology I-2-a. Has been updated to include methods for NMT and Health Care Assessment. See Main B for information.

I-3-c Supplemental or Enhanced Payments.
Updated to include non-medical transportation to competitive integrated employment rates.

Appendix J

Cost neutrality and estimates have been adjusted to include new service and rates. Updates made in:

J-2-c Derivation of Estimates for Each Factor
J-2-d Cost neutrality tables for WY 1, 2, 3, 4, 5

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
Waiver Application	Main B
Appendix A Waiver Administration and Operation	
Appendix B Participant Access and Eligibility	B-4-b
Appendix C Participant Services	C-1-a, C-3

Component of the Approved Waiver	Subsection(s)
Appendix D Participant Centered Service Planning and Delivery	
Appendix E Participant Direction of Services	
Appendix F Participant Rights	
Appendix G Participant Safeguards	
Appendix H	
Appendix I Financial Accountability	I-2-a, I-3-c
Appendix J Cost-Neutrality Demonstration	J-2-c, J-2-d

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

Modify target group(s)

Modify Medicaid eligibility

Add/delete services

Revise service specifications

Revise provider qualifications

Increase/decrease number of participants

Revise cost neutrality demonstration

Add participant-direction of services

Other
Specify:

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

1. Request Information (1 of 3)

A. The **State** of **Ohio** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §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*):

IO Waiver Amendment January 1, 2025

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**

Original Base Waiver Number: OH.0231
Draft ID: OH.007.06.01

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/24
Approved Effective Date of Waiver being Amended: 07/01/24

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:

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:

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:

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.

The purpose of the Individual Options waiver is to offer home and community-based services (HCBS) to eligible individuals, as an alternative to receiving medicaid services in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

The goals and objectives of the waiver include:

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

2. Increasing choice and control of HCBS through:
•Identifying and addressing unique needs through the person-centered services planning process.
•Recruitment, enrollment and oversight of waiver service providers.
•Providing education and assistance on all waiver service options, including self-directed service options.

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

Traditional and self-directed methods of service delivery are used. Providers include for profit and not-for-profit agency and independent providers, and county boards when no other providers are available in accordance with the corrective action plan agreed upon by CMS.

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:

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:

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

• Electronic: Ohio posts a public notice, summary of the draft waiver, the draft waiver itself on the ODM website. DODD posts public notices on their websites, which link to the ODM website. The public has the ability to submit electronic comments via email to a mailbox designated by the state. The public may also submit written comments to the state at a mailing address designated to receive written comments.

• The local county boards post a copy of the Public Notice and Request for Comment announcement, which includes information about how to obtain a non-electronic copy of the waiver and the proposed renewals from DODD and local county boards. Individuals are able to obtain the waiver application which is available in both hard copies and online and requests may be through mail or phone.
• Stakeholders, advisory groups, and working committees. Announcements are issued to DODD stakeholders regarding the formal public comment period with a request to disseminate the information to their respective colleagues and distribution lists, which link to the electronic documents.

• Ohio offers four methods for the public to provide input on the proposed waiver renewal and/or request a non-electronic copy:

1) E-mail: waiverfeedback@dodd.ohio.gov
2) Written comments sent to: DODD 30 E. Broad Street, 13th Floor, Columbus, OH 43215
3) Phone: Call to leave a voicemail message at: (614) 466-5990
4) Courier or in-person submission to: Attn: DODD 30 E. Broad Street, 13th Floor, Columbus, OH 43215

Active links used to post entire waiver applications: Ohio Department of Medicaid link: https://medicaid.ohio.gov/about-us/notices/individual-options-waiver-amendment- Public Notices | Medicaid (ohio.gov) https://medicaid.ohio.gov/about-us/notices/public-notices Ohio Department of Developmental Disabilities link: https://dodd.ohio.gov/waivers-and- services/waivers/Waiver_Amendments_

Public Comment Summary for the public comment period: August 30, 2024 to September 29, 2024.
Active link used to post the entire application: https://medicaid.ohio.gov/about-us/notices/public-notices I Public Notices (ohio.gov)

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

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

7. Contact Person(s)

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

Last Name: Sly

First Name: ShaRhonda

Title: Section Chief, Home and Community Based Policy

Agency: Ohio Department of Medicaid

Address: 50 West Town Street, 5th floor, Columbus, OH 43215

Address 2: P.O. Box 182709

City: Columbus

State: **Ohio**

Zip: 43215

Phone: (380) 215-2063 **Ext:** **TTY**

Fax: (614) 644-6945

E-mail: sharhonda.sly@medicaid.ohio.gov

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

Last Name: Showalter

First Name: Allan

Title: Deputy Director, Medicaid Development and Administration

Agency: Ohio Department of Developmental Disabilities

Address: 30 E. Broad St., 13th Floor

Address 2:

City: Columbus

State: **Ohio**

Zip: 43215

Phone:

(614) 387-0375 **Ext:** **TTY**

Fax:

(614) 644-6945

E-mail:

allan.showalter@dodd.ohio.gov

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:

N/A

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.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

January 2025 Additional Information
Health Care Assessment.
Based on positive feedback from stakeholders who participated in a telemedicine pilot program funded by DODD in the calendar years 2022 and 2023, the Department determined to pursue creating the new Health Care Assessment service. DODD convened a workgroup to develop the new Health Care Assessment service and rule. The workgroup reviewed data compiled by The Ohio State University Nisonger Center, a University Center for Excellence in Developmental Disabilities, regarding a telemedicine pilot program funded by the Department in calendar years 2022 and 2023. The workgroup also reviewed similar Medicaid services implemented in Missouri and Pennsylvania. The data and information assisted in the development of the new Health Care Assessment service. Proposed new rule 5123-9-27 has been shared and discussed with partners in January and February of 2024. The rule defines Health Care Assessment and sets forth provider qualifications, requirements for service delivery and documentation of services, and payment standards for the service. Health Care Assessment is a unique subscription service different from telehealth as in-person visits are not required. The service uses technology to facilitate real-time consultation and support provided by a physician, a physician assistant, or an advanced practice nurse to assist an individual and/or the individual's caregivers to understand the individual's presenting health symptoms and identify appropriate next steps. Providers are expected to have in-depth knowledge of health care for persons with developmental disabilities. The intent of the service is to provide right-on-time health assessment to determine the best clinical course of action, often avoiding unnecessary emergency room visits and decreasing the need for inpatient admissions. The service does not replace state plan services.

Rate Methodology I-2-a

Non-medical transportation to competitive integrated employment rates were developed in consultation with a stakeholder group and use an independent rate model; a provider survey was used to capture costs and service delivery experience. The rates are organized into the following mileage bands, each with four rates under each band (non-modified vehicles for agency providers, non-modified vehicles for independent providers, modified vehicles for agency providers, modified vehicles for independent providers): 0-15 miles, 16-30 miles, 31+ miles.

Health Care Assessment waiver rate was based on a pilot project that ran from 2022 and ended 6/30/2024 and then increased by the biennial budget rate increases. The rate for the pilot project was based on the fair market value of the service to be provided.

July 2024
Below is additional information about the new service specifications including outcome-based payments for Career Planning and Individual Employment Supports.
Outcome based payments.
In addition to gathering public comment through the waiver application process, the Department of Developmental Disabilities convenes on-going focus groups for waiver service improvements.
In January 2020, DODD chartered a representative group of stakeholders to help implement strategies to improve adult day, employment, and transportation services. This group is called the Blueprint Group. Members represent all sectors of the developmental disabilities field, including individuals served and their families, providers of services, county boards of developmental disabilities, and other support systems in Ohio. The Blueprint Group generated several sub-groups: Rule and Waiver Implementation Team, Communication Implementation Team and the Training and Technical Assistance Implementation Team. The focus is on adult day employment, and transportation services resulting in employment quality initiatives. The current initiative for outcome-based payments is for Career Planning-Job Development and Individual Employment Support. Development of the program was discussed and developed throughout 2023. Presentations and discussions were held with DD advocacy groups, providers, the Ohio Association of County Boards of Developmental Disabilities, Service and Support Administration Directors of county boards of developmental disabilities and other work groups. Additional groups that were pivotal in the development of the program include the Waiver Workgroup and Employment First Taskforce.
The goal of the program is to increase opportunities for waiver recipients to become employed in the community. DODD updated Ohio Administrative Code to include the process resulting in further public engagement.
Additional Information from 1-2-a

The statewide rates for agency providers and non-agency providers reflect differences in administrative overhead, supervisory-related expenses, and non-billable work time. The rates are adjusted upward based on the number of individuals sharing services, up to four individuals per setting. The rates may be adjusted using "add-ons" for services rendered to individuals who meet certain medical, behavioral, and/or complex care criteria, for routine HPC services rendered by direct support professionals.
An add on for DSPs who have at least 2 yrs. experience and 60 hours accredited competency-based training for HPC services is termed a "competency-based" add-on.

The add-on of $0.39/unit was developed with stakeholder input in response to the existing workforce shortage. The intent was to promote retention of direct support professionals by making available an additional $1.00/hour. Upon increasing the wage component of the homemaker/personal care rate to reflect the additional $0.25/unit, the employee-related expenses, productivity assumptions, and administrative assumptions that are part of the rate methodology were increased accordingly. A one-year term limited add-on for HPC when the individuals formerly resided in intermediate care facilities for individuals with intellectual disabilities (ICFs-IID termed a “community integration” add on.)
Rates are paid in fifteen-minute units for services to individuals who do not share services with others (e.g., live alone or live with others who do not receive HPC services from the same provider). A Daily Billing Unit (DBU) is paid for services to individuals who share the same provider in the same site. The DBU for homemaker/personal care was developed using the HPC rates for individuals who share services in a consistent and predictable pattern. The estimated DBU includes the base fifteen-minute unit rates currently approved by CMS as well as any applicable rate add-ons to determine the total expected amount of payment and service hours for the site and for each individual during their waiver span. After services are rendered, the provider will report the hours of service rendered by a provider in a given month to determine the amount of the total month's reimbursement claim that is attributable to each individual during that month.

The provider will then submit an individual-specific claim, the DBU, for the service period. The Shared Living rate was calculated using the costs of HPC services delivered to adults identified as living with family and utilizing a provider and the cost of providing adult foster care. There are four daily rates which apply to the Ohio Developmental Disabilities Profile (ODDP) groups.

Participant Direction - PD-HPC rates are based on the independent rate model discussed above. The Appendix to OAC 5123-9-32 details information concerning common law employee and agency with choice rates. For both common law and agency with choice on-site/on-call PD-HPC, these rates are synchronous with minimum wage in Ohio. These rates adjust based on changes to Ohio’s minimum wage, with an addition of 13% to cover employer-related expenses. For further information regarding PD-HPC, reference Appendix E.
Since the adoption of the independent rate model, the Ohio General Assembly provided funding for the following rate increases: in 2013, 6% in 2016, 13.27% in 2020, 2.82% in 2021, 4% in 2022, 30.81% in 2024 and 5.56% in 2025.
Independent Model Services: Non-HPC.
The independent rate model was developed for Non-Medical Transportation (NMT), which may be billed either per trip or per mile. Trip rates originally calculated using 1/1/2005-6/30/2005 county board cost report data. From the cost report data, the total reported transportation costs for adults are divided by the total number of reported trips to derive a cost per trip by county. This cost is then adjusted for inflation and eight cost of doing business categories. Originally, mile rates combine the hourly rate of the vehicle driver with the mileage rate based on the 2 minutes of service at HPC cost for each mile driven.

The NMT per mile rate was adjusted in January 2020 as a result of stakeholder discussions and legislative appropriations. The per mile rate no longer included staff time as a component of the rate. The rate equaled the federal transportation reimbursement rate as of 2019. A vehicle modification rate was added in 2020. The vehicle modification rate is equal to $1.00 per mile. This is not in addition to the regular $.58 per mile rate. The independent rate model was modified for the Remote Support waiver service. The model includes BLS information specific to Ohio’s job market and incorporated reimbursement for employee related expenses, administrative overhead, productivity assumptions and a responder/on call component. The independent rate model was modified for adult day support, vocational habilitation, and supported employment-enclave services. Data from 1/1/2005-6/30/2005 county board cost reports were used to calculate a series of additional wage cost components. Those rates were adjusted for the cost of doing business and for acuity requirements. The rates may be adjusted using "add-ons" for services rendered to individuals who meet certain medical and/or behavioral criteria, or for ADS and VH services when provided in integrated settings in groups of four or fewer individuals by staff of who have completed a DODD approved community integration program; this is the community integration add-on.

In 2023, the biennial budget incorporated maximum rate increases Ohio’s HCBS programs. The increase in funding allotted results in an increase to anticipated expenditures for the Individual Options program. The purpose of this amendment is to incorporate the appropriated service reimbursement increase, impacting adult day support, career planning, group employment support, homemaker/personal care, home-delivered meals, individual employment support, money management, participant-directed homemaker/personal care, remote supports, respite (residential and community), shared living, transportation, vocational habilitation, waiver nursing delegation, and waiver nursing.
The following service categories will receive an estimated average (rounded to the nearest whole number) rate increase of 31% above current rates, effective 1/1/2024 through 6/30/24 and an additional rate increase of 38% above current rates, effective 7/1/2024.

- Add-Ons (Behavior, Competency, Complex Care, & Medical);
- Adult Day Services (Adult Day Support, Voc. Hab, Group, Career Planning, & Individual);
- Competency-Based Homemaker/Personal Care; *Homemaker/Personal Care (Including On-Site, On-Call); Participant

Directed Homemaker/Personal Care;
- Participant Directed Transportation;
- Remote Support;
- Respite;
- Shared Living;
- Transportation;
- Non-Medical Transportation;
- Home Delivered Meals will receive an estimated average (rounded to the nearest whole number) rate increase of 22% above current rates current rates, effective 7/1/2024.
- Waiver Nursing will receive an estimated average (rounded to the nearest whole number) rate increase of 24% above current rates current rates, effective 7/1/2024.
- Delegated Nursing will receive an estimated average (rounded to the nearest whole number) rate increase of 24% above current rates current rates, effective 7/1/2024.
- Money Management Services will receive an estimated average (rounded to the nearest whole number) rate increase of 62% above current rates, effective 1/1/2024 through 6/30/24 and an additional rate increase of 71% above current rates, effective 7/1/2024.

Information for 7/1/2022 Amendment
Home Delivered Meal Service: Effective July 1, 2022, the State will modify the home delivered meal service available through Level 1 and I/O waiver programs. Service changes will include aligning with home delivered meal rates and types available through the Ohio's 1915(c) nursing-based facility based waiver programs, as in effect on November 1, 2021. This includes the addition of kosher and therapeutic meal types. The State will also add the service, as described to the SELF waiver program.

To establish nursing-facility based waiver service rates in 2019, the State reviewed the methodology to ensure economy, efficiency, quality of care and found it to be sufficient to meet these requirements and ensure sufficient provider capacity. The rate methodology was based on assumptions for three categories of cost: meal preparation, transportation and delivery, and administration and overhead. The methodology was developed as the sum of the following cost components: wages (based upon the Bureau of Labor Statistics data), employment related expenses, transportation costs, supplies, administration, and other overhead expenses. The methodology included a review of Ohio Medicaid claims and enrollment data, research of public resources, and a comparison to similar waiver service offerings in other state Medicaid programs. Initial rates established were effective July 1, 2019 and later increased on November 1, 2021 as a result of Ohio's House Bill 110. Home delivered meal types and associated Medicaid maximum rates are standard meal at $7.20 and therapeutic and kosher meals at $8.68.

ODM engaged an actuary to study factors such as labor market data, education, licensure status and length of service visit in the development of the waiver nursing and nursing delegation rates. The model begins with BLS information specific to Ohio's job market and incorporates reimbursement for employee related expenses, administrative overhead, and non-billable work time.

The social worker, nutritionist and interpreter waiver services were all developed on a per service basis. The models include BLS information specific to Ohio's job market and incorporated reimbursement for employee related expenses, administrative overhead, and productivity assumptions for agency and independent providers. All associated rates for these three services are proposed for an increase in July 1, 2022 to align with industry standards the State's five year rule review process. Rates will increase between 33-40%, depending on the type of provider and service. No changes to the rate methodologies are proposed at this time.
Waiver Nursing Delegation rates were developed to align with Ohio Department of Medicaid's (ODM) rates. The rates are being increased and updated to align with ODM's most recent rate increase.

In July 2019, the Ohio General Assembly passed a total 20% increase, and a 40% increase to direct service providers of routine Homemaker/Personal Care (HPC) and Onsite/Oncall HPC, respectively. The rates for these affected services are set to take effect on January 1, 2020 and January 1, 2021 (for routine HPC only). In July 2021, the Ohio General Assembly passed House Bill (HB) 110, which is the State's biennium budget for State Fiscal Years 2022 and 2023. A 4% increase to both residential and non-residential services approved under the IO waiver was included in HB 110. Information relative to this rate increase is also included in Appendix J-2. Services affected by the biennium budget increase include: ADS, Career Planning, Group Employment Support, Individual Employment Support, HPC (including PD-HPC and Onsite/Oncall), NMT, VH, Community and Residential Respite, Shared Living, and Transportation.

Appendix A: Waiver Administration and Operation

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

one):

The waiver is operated by the state Medicaid agency.

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

The Medical Assistance Unit.

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

The Ohio Department of Developmental Disabilities (DODD)

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

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

The Ohio Department of Medicaid (ODM), as the single State Medicaid Agency, assures compliance and maintains administrative oversight of operational and policy development at the Ohio Department of Developmental Disabilities (DODD), the operating agency, through an interagency agreement between ODM and DODD. This agreement provides for ODM oversight and review of programmatic compliance with federal and state laws and regulations and in addition to auditing and fiscal compliance.
ODM's oversight of DODD's performance and assurance of compliance occurs through a continuous review process that includes reviews of performance data, quality briefings and meetings, on-going communication and collaboration, resolving individual issues and systemic remediation and fiscal reviews as described below and in further detail in Appendix H.

ODM monitors DODD's compliance and performance by:

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

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

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

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

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

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

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

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

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

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

Appendix A: Waiver Administration and Operation

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

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.
Check each that applies:

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

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

County boards of developmental disabilities (county boards) conduct waiver operational and administrative functions at the local level, as prescribed in Ohio Revised Code 5126.055.

These responsibilities include performing assessments and evaluations, recommending to DODD if the person needs the level of care provided in an ICF/IID, assisting in the preparation and submission of prior authorization requests for waiver services, assisting individuals in exercising free choice of provider, monitoring services, investigating allegations of abuse, neglect and major incidents, case management (known as service and support administration) and managing waiting lists in accordance with Section 5123.042 of the Ohio Revised Code.

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

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

Appendix A: Waiver Administration and Operation

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

In accordance with Section 5126.054 of the Ohio Revised Code, each county board of developmental disabilities (county board) develops a plan for Medicaid waiver administration.

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

Department of Developmental Disabilities (DODD) oversight activities:

1. Reviews and approves the county board requests for waiver allocation;
2. Reviews county board recommendations regarding whether an individual's application for home and community-based waiver services (HCBS) should be approved or denied, including whether the individual meets an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) level of care;
3. Retains the authority to review any Individual Service Plan (ISP) recommended by the county board for waiver services; and
4. Provides communication, technical assistance and training to county boards regarding their role as local operators for waivers.

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

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

Appendix A: Waiver Administration and Operation

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

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

1. Accredits each county board of developmental disabilities (county board) for a period of one to three years, with better performing boards granted the longer accreditation terms;
2. Conducts annual reviews of each county board to evaluate participant Prevention from Harm systems; and
3. On an ongoing basis, investigates complaints and individual incidents of abuse, neglect, or exploitation, especially when the alleged problem potentially resulted from a local system failure. The tools used for accreditation contain questions, probes, and requests evidence that tie directly to federal assurances, including assurances for: service planning & consumer free choice of provider; level of care determination; health and welfare; and hearing rights. The health and welfare sections of the accreditation tool are used for the annual Protection from Harm evaluations. The Operating Agency produces regular reports on participant-specific Major Unusual Incidents, including county-specific data, and monitors to detect trends and patterns.

On a quarterly basis, DODD will review the timeliness of processing payroll and payment of other invoices by the FMS.

Periodically, DODD will randomly select a number of provider files maintained by the FMS to verify qualifications of these providers. At the end of the first year, DODD will review all systems and practices to confirm compliance with the contract and Medicaid regulations. An independent outside audit group will conduct internal audits in accordance with a Compliance Plan which must be approved by DODD.

Appendix 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	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment				
Waiver enrollment managed against approved limits				
Waiver expenditures managed against approved levels				
Level of care 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:
A-4: Number and percent of County Board of Developmental Disabilities (CBDD) accreditations completed timely by Ohio Department of Developmental Disabilities. Numerator: Number of accreditation reviews completed timely. Denominator: Total number of CBDDs due for accreditation review.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD's Accreditation Reviews/Office of Provider Standards and Review

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

	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

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

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

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
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:
A-2: Number and percent of quarterly performance measure reports that were submitted to Ohio Department of Medicaid (ODM) by Ohio Department of Developmental Disabilities on time and in the correct format. Numerator: Number of quarterly performance measure reports submitted on time and in the correct format. Denominator: Total number of quarterly performance measure reports required by ODM.

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

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

Data Aggregation and Analysis:

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

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

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence

		Interval =
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify: As required by ODM	

Data Aggregation and Analysis:

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

Performance Measure:
A-5 Number and percent of reviewed Medicaid provider agreements executed by the contracted FMS entity that meet Ohio Department of Medicaid and Federal requirements. Denominator: Number of DODD reviewed Medicaid provider agreements executed. Numerator: Number of those agreements that meet ODM and Federal requirements.

Data Source (Select one):
Other
If 'Other' is selected, specify:
FMS provider enrollment reports

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

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:

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

Oversight Activities by ODM:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.

Methods for Remediation/Fixing Individual Problems

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

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

The Department of Developmental Disabilities (DODD) receives and acts upon complaints/compliance issues in a variety of ways. DODD's Major Unusual Incident (MUI)/Registry Unit receives complaints through a toll-free number for reporting abuse/neglect and other MUIs. Complaints are also received via email and U.S. mail. Each complaint received is logged and acted upon the same or next day and followed up until the issue is resolved. Some calls result in MUIs while other calls are assorted complaints which are referred to other department staff, county boards, or outside entities such as the Department of Health. These include medical, behavior, environmental and other miscellaneous subjects. Complaints are resolved by MUI/Registry unit managers when a MUI has occurred, other complaints are resolved by the appropriate DODD unit managers.
DODD employs a Family Outreach & Education Coordinator who works with families to provide technical assistance, including addressing complaints.

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

ii. Remediation Data Aggregation

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

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

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	Continuously and Ongoing
	Other Specify: semi-annually

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 ï¿½441.301(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			
		Disabled (Physical)			
		Disabled (Other)			
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury			
		HIV/AIDS			
		Medically Fragile			
		Technology Dependent			
Intellectual Disability or Developmental Disability, or Both					
		Autism			
		Developmental Disability	0		
		Intellectual Disability	0		
Mental Illness					
		Mental Illness			

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Serious Emotional Disturbance			

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

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

Not applicable. There is no maximum age limit

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

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

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

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

The 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	30500
Year 2	30500
Year 3	30500
Year 4	30500
Year 5	30500

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	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
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	
Community Alternative	
HB 287 Provisions	
Emergencies and Hearing Decisions	

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):*

Community Alternative

Purpose *(describe):*

Community option for individuals seeking placement, or currently residing in, a public or private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).

Describe how the amount of reserved capacity was determined:

The projection for this reserved capacity was derived as a result of meetings with stakeholders on how to advance Ohio's support of the Olmstead Initiative in terms of individual's seeking placement in an ICF-IID and for moving individuals out of institutional settings.

Three percent (3%) of the unduplicated number of participants (listed in Table B-3-a) is reserved each waiver year to accommodate reserved capacity. The 3% is then distributed among specified categories. This reserved capacity will apply to Waiver Years 1-5 during this waiver cycle. Percentages are based on previous waiver year categories and unduplicated counts.

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

Waiver Year	Capacity Reserved
Year 1	400
Year 2	400
Year 3	400
Year 4	400
Year 5	400

Appendix B: Participant Access and Eligibility

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

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

HB 287 Provisions

Purpose *(describe):*

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

Describe how the amount of reserved capacity was determined:

Three percent (3%) of the unduplicated number of participants (listed in Table B-3-a) is reserved each waiver year to accommodate reserved capacity. The 3% is then distributed among specified categories. This reserved capacity will apply to Waiver Years 1-5 during this waiver cycle. Percentages are based on previous waiver year categories and unduplicated counts. 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	77
Year 2	77
Year 3	77
Year 4	77
Year 5	77

Appendix B: Participant Access and Eligibility

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

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

Emergencies and Hearing Decisions

Purpose *(describe):*

a. Emergencies: Individuals who require waiver resources to address immediate needs due to circumstances specified in Ohio Administrative Code (OAC) 5123-9-04.

b. Hearing Decisions: An order for a county board to enroll an individual on the waiver as the result of a Medicaid state hearing decision made in accordance with 5101.35 of the Revised Code

Describe how the amount of reserved capacity was determined:

Three percent (3%) of the unduplicated number of participants (listed in Table B-3-a) is reserved each waiver year to accommodate reserved capacity. The 3% is then distributed among specified categories. This reserved capacity will apply to Waiver Years 1-5 during this waiver cycle. Percentages are based on previous waiver year categories and unduplicated counts.

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

Waiver Year	Capacity Reserved
Year 1	438
Year 2	438
Year 3	438
Year 4	438
Year 5	438

Appendix B: Participant Access and Eligibility

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

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

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

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

e. Allocation of Waiver Capacity.

Select one:

Waiver capacity is allocated/managed on a statewide basis.

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

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

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

Reviews of allocations requested and granted, as well as waiver enrollments, can occur in real-time. Ohio Department of Medicaid (ODM) staff members have direct access to the data contained in the WES and can also request reports at any time. Real-time reporting compares the unduplicated number of individuals enrolled and the number of waiver applications in process. DODD reports to quarterly to ODM waiver allocation data. Once the unduplicated count approaches the approved count, the actual enrollments are monitored closely, as are the number of applications in process to assure that the unduplicated count is not exceeded.

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

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

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

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

Section 5126.042 of the Ohio Revised Code (ORC) requires the state to work with stakeholders to establish a process for a home and community-based services waiting list. ORC 5126.042 was amended in September 2017 to remove the existing priority groups.

Ohio Administrative Code (OAC) 5123-9-04 specifies how individuals are selected for entrance to the waiver.

The OAC specifies the one statewide process for how individuals are selected for entrance to a Department of Developmental Disabilities (DODD)-operated waiver, defines criteria for immediate need, and establishes the order in which individuals on a waiting list will be offered home and community-based services according to criteria that defines an individual’s current need for home and community-based services.

In accordance with OAC 5123-9-04, individuals assessed to have immediate needs who require waiver enrollment to address those needs are enrolled without being placed on the waiting list. When selecting individuals from the waiting list for enrollment, individuals determined to have the greatest need are enrolled ahead of others with fewer needs. Urgency of need is determined by the number of criteria met for placement on the waiting list. Individuals who meet multiple criteria are enrolled ahead of those who meet only one criterion. When two or more individuals meet the same number of criteria, order of enrollment is determined by the earliest waiting list placement date.

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

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)

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

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)

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 435.110: Parents and other Caretaker Relatives Section 1925: Transitional Medical Assistance
42 CFR 435.115: Extended Medicaid due to Spousal Support Collections 42 CFR 435.116: Pregnant Women
42 CFR 435.117: Deemed Newborns
42 CFR 435.118: Infants and Children under Age 19
42 CFR 435.145: Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care 42 CFR 435.150: Former Foster Care Children
42 CFR 435.130: Individuals Receiving Mandatory State Supplements 42 CFR 435.131: Individuals Who Are Essential Spouses
42 CFR 435.131: Individuals Who Are Essential Spouses
42 CFR 435.132: Institutionalized Individuals Continuously Eligible Since 1973 42 CFR 435.133: Blind or Disabled Individuals Eligible in 1973
42 CFR 435.134: Individuals Who Lost Eligibility for SSI/SSP Due to an Increase in OASDI Benefits in 1972
42 CFR 435.135: Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA increases since April 1977
42 CFR 435.137: Disabled Widows and Widowers Ineligible for SSI due to Increase in OASDI
42 CFR 435.138: Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security Section 1619(b): Working Disabled under 1619(b)
1634(c): Disabled Adult Children
42 CFR 435.222: Reasonable Classifications of Individuals under Age 21 42 CFR 435.227: Children with Non-IV-E Adoption Assistance
42 CFR 435.226: Independent Foster Care Adolescents
42 CFR 435.229: Optional Targeted Low Income Children
42 CFR 435.213: Certain Individuals Needing Treatment for Breast or Cervical Cancer
42 CFR 435.210: Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash Assistance
42 CFR 435.119: Adult Group - Individuals at or below 133% FPL Age 19 through 64 - newly eligible for all states

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

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

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

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

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

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

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 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:

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

Other

Specify:

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

Not Applicable

The state provides an allowance for a spouse who does not meet the definition of a community spouse in §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:

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

Other

Specify:

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

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

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

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:

If an individual is anticipated to need waiver services less frequently than every thirty calendar days, Service and Support Administrators (SSAs) are to indicate in the ISP the method of monitoring they will employ to assure that the individual's health and welfare is not in jeopardy. Completion of this monitoring activity and the outcomes of the reviews are to be documented, and the documentation is to be maintained in the individual’s file. Otherwise, Ohio Administrative Code (OAC) 5123-4-02 requires monitoring to occur at the frequency specified in the person’s plan. Consistent with ODM authorizing rules, when an individual does not use any waiver service every thirty consecutive days, the county board shall assess the individual’s current need for waiver services, monitor the individual to verify the individual’s ongoing need for waiver enrollment, and discuss these needs with the individual and their representative, if applicable. As a result of the assessment and discussion, if no waiver services are needed, the individual shall be recommended for disenrollment.

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:

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

Initial Levels of Care are determined by Qualified Intellectual Disabilities Professional staff, as defined in 42 CFR 483.430(a):
(a) Qualified intellectual disability professional:
(1) Has at least one year of experience working directly with persons with intellectual disability or other developmental disabilities; and
(2) Is one of the following:
(i) A doctor of medicine or osteopathy.
(ii) A registered nurse.
(iii) An individual who holds at least a bachelor's degree in a human services field (including, but not limited to: sociology, special education, rehabilitation counseling, and psychology).

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

As a condition of waiver eligibility, applicants must meet an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) (also known in Ohio as the Developmental Disabilities (DD)) Level of Care as defined in OAC rule 5123-8-01.
Criteria for ICF-IID level of care:

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

(a) The individual has a substantial developmental delay or specific congenital or acquired condition other than an impairment caused solely by mental illness; and

(b) In the absence of individually planned supports, the individual has a high probability of having substantial functional limitations in at least three areas of major life activities set forth in OAC 5123-8-01 later in life:
(i) Self-care;
(ii) Receptive and expressive communication;
(iii) Learning;
(iv) Mobility;
(v) Self- direction;
(vi) Capacity for independent living; and
(vii) Economic self-sufficiency.

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

(a) The individual has been diagnosed with a severe, chronic disability that:

(i) Is attributable to a mental or physical impairment or combination of mental and physical impairments, other than an impairment caused solely by mental illness;
(ii) Is manifested before the individual is age twenty-two; and
(iii) Is likely to continue indefinitely.

(b) The condition described in paragraph (C)(2)(a) of OAC rule 5123-8-01 results in substantial functional limitations in three or more of the following areas of major life activities, as determined through use of the standardized level of care assessment instrument approved by the Ohio Department of Medicaid:

(c) The condition described in paragraph (C)(2)(a) of this rule reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance of lifelong or extended duration that are individually planned and coordinated.

DODD uses a standardized functional assessment, which is part of the department's web-based application to ensure all required information has been submitted.

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

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

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

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

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

The details information for this section can also be found in Appendix B-6-d. The requirements and processes for ICF-IID Level of Care determinations and redetermination is prescribed in OAC rule 5123-8-01. The level of care initial evaluation and annual reevaluation is completed using the standardize assessment maintained in the DODD's Level of Care application. In order for the ICF-IID LOC request to be approved, each initial LOC recommendation must include:
a) current diagnoses, including an indication of whether the individual has been diagnosed with a severe, chronic disability as described in paragraph (C)(2)(a) of in OAC rule 5123-8-01.
b) Review of current functional capacity. This review shall be documented using a standardized functional assessment that is approved by the Ohio Department of Medicaid.
c) The assessment documentation shall be maintained in the individual's record and made available for state and federal quality assurance and audit purposes.
Initial level of care recommendations for individuals seeking enrollment in a Medicaid home and community-based services waiver must be approved by the DODD prior to enrollment in the waiver. Level of care recommendations may be submitted to the DODD up to ninety days in advance of the proposed enrollment date.

For reevaluations the County Board will submit an ICF-IID level of care redetermination to DODD within twelve months of the previous level of care determination and whenever the individual experiences a significant change of condition as described in paragraph (D) (5) (a-b) in OAC rule 5123-8-01. The county board evaluator is responsible to work with the individual/family to obtain all the necessary documents required for the level of care evaluation and/or re-evaluation.

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):*

DODD staff receive alerts from the level of care (LOC) system which gives the waiver participants names (by county), their LOC due date 90 days prior and 15 days prior to the redetermination due date. A Prior Notice letter (named such as it provides the individual their rights to a prior notice for a pending action) is issued to the individual and/or guardian and to the county board alerting them of the pending timelines and encourages collaboration with the county board to ensure all necessary documentation is submitted to DODD prior to the due date.

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

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD - Waiver Management System (WMS)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =

Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(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.

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD-Waiver Management System (WMS)

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

	Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD-Waiver Management System (WMS)

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

Data Aggregation and Analysis:

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

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

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

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

Performance Measures data reports are submitted to ODM by DODD on a quarterly basis.
The information is gathered from county board and DODD compliance activities. DODD is able to identify and address individual problems as they are discovered and provide technical assistance that may include plans of corrective action. When problems are discovered, the individual county board is notified and technical assistance is provided using e-mail, phone contact and/or letters to county board staff. When issues are noted that are systemic, DODD will provide statewide training and incorporate that corrective action into its monitoring during the next monitoring cycle.
Case Specific Resolution: During the course of any review conducted by ODM or DODD, when staff encounter a situation in which a waiver recipients health or welfare is at risk, or when case management deficiencies are identified, the staff follow a protocol to report these observations. Depending on the severity of the situation, the staff will take immediate action, coordinate intervention with providers or case managers, and report the finding to ODM managers. ODM communicates findings to DODD for further review and appropriate intervention, and with explicit variable timeframes within which a report back to ODM is expected. ODM logs and tracks all such findings and referrals to assure appropriate case-specific resolution.

b. Methods for Remediation/Fixing Individual Problems

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

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: Semi-annually

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

No

Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

At the time the individual requests home and community-based services (HCBS) waiver services, the county board of developmental disability (county board) in the county in which the individual resides is responsible for explaining the services available under the Individual Options (IO) waiver and the alternative of services delivered in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). Additionally, per Ohio Revised Code (ORC) prior to placement on the HCBS waitlist, the county board is responsible for:
a.) Informing the individual of the option to receive ICF-IID services;
b.) Providing the individual with the contact information for all ICFs/IID located in the county the board serves and contiguous counties;
c.) Directing the individual to the searchable database of vacancies in licensed residential facilities include on the Department of Developmental Disabilities' (DODD) website pursuant to section 5123.193 of the ORC.

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

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

The completed Freedom of Choice forms are maintained by the eighty-eight county boards of developmental disabilities.

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Community Respite**		
Statutory Service	**Habilitation - Adult Day Support**		
Statutory Service	**Homemaker/Personal Care**		
Extended State Plan Service	**Specialized Medical Equipment and Supplies**		
Other Service	**Assistive Technology**		

Service Type	Service		
Other Service	Career Planning		
Other Service	Community Transition Service		
Other Service	Environmental Accessibility Adaptations		
Other Service	Group Employment Support		
Other Service	Habilitation - Vocational Habilitation		
Other Service	Health Care Assessment		
Other Service	Home Delivered Meals		
Other Service	Homemaker/Personal Care - Daily Billing Unit		
Other Service	Individual Employment Support		
Other Service	Interpreter		
Other Service	Money Management		
Other Service	Non-Medical Transportation		
Other Service	Nutrition		
Other Service	Participant-Directed Homemaker/Personal Care		
Other Service	Remote Supports		
Other Service	Residential Respite		
Other Service	Shared Living		
Other Service	Social Work		
Other Service	Transportation		
Other Service	Waiver Nursing Delegation		
Other Service	Waiver Nursing		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Community Respite

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09011 respite, out-of-home

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

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

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

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

Community Respite shall not be provided in any residence and shall not be simultaneously provided at the same location where Adult Day Support or Vocational Habilitation is provided.

Payment for Community Respite does not include room and board.

Community Respite shall not be provided to an individual at the same time by the same provider as Homemaker/Personal Care or Shared Living. Only one provider of Residential Respite or Community Respite shall use a daily billing unit on any given day.

Community Respite is limited to 60 calendar days of service per waiver eligibility span.

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	Agency Community Respite Providers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community Respite

Provider Category:
Agency
Provider Type:

Agency Community Respite Providers

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Certification standards listed in Chapter 5123-2 and rule 5123-9-22 of the Ohio Administrative Code.

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

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:

Habilitation

Alternate Service Title (if any):

Habilitation - Adult Day Support

HCBS Taxonomy:

Category	Sub-Category
Category 1: 04 Day Services	**Sub-Category 1:** 04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:

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

(a) Supports to participate in community activities and build community membership consistent with the individual's interests, preferences, goals, and outcomes.

(b) Supports to develop and maintain a meaningful social life, including social skill development which offers opportunities for personal growth, independence, and natural supports through community involvement, participation, and relationships.

(c) Supports and opportunities that increase problem-solving skills to maximize an individual's ability to participate in integrated community activities independently or with natural supports.

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

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

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

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

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

Requirements for service delivery:

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

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

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

(4) ADS may be provided in a variety of settings in the community shall not be furnished in the individual's residence or other residential living arrangement except for virtual ADS support as described below.

(5) Adult Day Support may be provided through virtual support under the following conditions:
a) Virtual support does not have the effect of isolating an individual from the individual’s community or preventing the individual from interacting with people with or without disabilities.
b) The use of virtual support has been agreed to by an individual and the individual’s team and is specified in the individual service plan.

c) The provider ensures the use of virtual support complies with applicable laws governing an individual's right to privacy and the individual's protected health information.
d) Teams should consider that the provision of adult day support through virtual support does not include the following, therefore teams should assure that the person's needs are able to be met with this service:
e) Personal care including supports and supervision in the areas of personal hygiene, eating communication, mobility, toileting, and dressing to ensure an individual's ability to experience and participate in community living; or
f) Assisting an individual with self-medication or health-related activities or performing medication administration or health-related activities in accordance with Chapters 5123-6 and 5123:2-6 of the Administrative Code
g) Virtual support does not require an in-person visit but it does require the provision of services be by a direct support professional at a distant site who engages with an individual using interactive technology that has the capability for two-way, real-time audio and video communication. A person needs to be present through interactive technology and it must be live audio or video communication.
h) ADS shall be provided pursuant to a person-centered individual service plan that conforms to the requirements of rule 5123-4-02 of the Administrative Code and shall be coordinated with other services and supports set forth in the individual service plan. During this process, service and support administrators (SSAs) are responsible to complete an assessment of the individual, identify supports needed, and develop an individual service plan that includes services and supports that ensure health and welfare, assist the individual to engage in meaningful and productive activities; support community connections and networking, assist the individual to improve self-advocacy skills, ensure achievement of outcomes that are important to the individual and outcomes that are important for the individual, and identify risks and include supports to prevent minimize risks.
i) If technology or technology support is needed within the home to participate in remote virtual habilitation, the SSA could authorize one or more components of the assistive technology service. This service could provide assistive technology consultation, assistive technology equipment, or assistive technology support.
j) The Adult Day Support Rule, 5123-9-17, requires all employees and contractors who provide adult day support to comply with rule 5123-17-02 of the Administrative Code relating to incidents affecting health and safety.

(6) A provider of ADS shall comply with applicable laws, rules, and regulations of the federal, state, and local governments pertaining to the physical environment (building and grounds) where adult day support is provided. A provider of adult day support shall be informed of and comply with standards (e.g., Americans with Disabilities Act of 1990) applicable to the service setting.

(7) ADS includes both individual activities and group activities. The nature of group activities and the number of staff providing adult day support to a group of individuals shall be appropriate to meet the needs and achieve the outcomes identified in each group member's person-centered individual service plan.

(8) When meals are provided as part of adult day support, they shall not constitute a full nutritional regimen (i.e., three meals per day).

(9) A provider of ADS shall recognize changes in the individual's condition and behavior as well as safety and sanitation hazards, report to the service and support administrator, and record the changes in the individual's written record.

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

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

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

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	For profit and not-for-profit private providers of Adult Day Support

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Habilitation - Adult Day Support

Provider Category:

Agency

Provider Type:

For profit and not-for-profit private providers of Adult Day Support

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification standards listed in Chapter 5123-2 and rule 5123-9-17 of the Ohio Administrative Code.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

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):

Homemaker/Personal Care

HCBS Taxonomy:

Category	Sub-Category
Category 1: 08 Home-Based Services	**Sub-Category 1:** 08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:

Homemaker/personal care (HPC) means the coordinated provision of a variety of services, supports and supervision necessary for the health and welfare of an individual which enables the individual to live in the community. These are tasks directed at increasing the independence of the individual within his/her home or community. This service will help the individual meet daily living needs, and without this service, alone or in combination with other waiver services, the individual would require institutionalization.

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

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

i. The service is identified in the person-centered service plan.

ii. The homemaker/personal care is provided to meet the needs of the individual that are not met through the provision of acute care hospital services.

iii. Homemaker/personal care is necessary to ensure smooth transition between the acute care hospital and the individual's home ensuring the individual is able to return to their community home preserving the individual's functional abilities.

iv. The service is not duplicative nor a substitute for service the acute care hospital provides or is obligated to provide through its conditions of participation, federal law, state law, or other applicable requirement.

v. The person providing homemaker personal care is awake.

vi. A maximum of 16 hours per day of homemaker/personal care and a maximum total of no more than thirty days per waiver span may be provided to an individual in an acute care hospital.

vii. The cost of homemaker/personal care provided to an individual in an acute care hospital can be accommodated by the individual's authorized budget in the medicaid billing system.

Services included in the provision of HPC are as follows:

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

the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or other means of providing transportation.

The individual provider shall comply with the requirements of rule 5123-2-06 regarding behavior supports. If there is an individual behavior support strategy, the individual provider shall be trained in the components of the plan. The individual provider shall maintain documentation of such training in accordance with 5123-9-30 and present such documentation upon request by ODM, DODD, or the county board.

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

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

Due to the scope of services available, the HPC service may not be used at the same time as Career Planning, Vocational Habilitation, Individual Employment Support, Group Employment or Adult Day Support services. HPC services shall not be deemed to be services provided under Shared Living as defined in 5123-9-33. A person may receive shared HPC only on days when shared living is not provided. A provider of Homemaker/Personal Care cannot bill for both Homemaker/Personal Care and HPC - Daily Billing Unit on the same day. Billing for HPC services while an individual is in an acute care hospital will be at the same rate as other HPC.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Homemaker/Personal Care Providers
Agency	Agency Homemaker/Personal Care Providers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker/Personal Care

Provider Category:

Individual

Provider Type:

Independent Homemaker/Personal Care Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification standards listed in Chapter 5123-02 and rule 5123-9-30 of the Ohio Administrative Code.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker/Personal Care

Provider Category:

Agency

Provider Type:

Agency Homemaker/Personal Care Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification standards listed in Chapter 5123-02 and rule 5123-9-30 of the Ohio Administrative Code.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

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:

Extended State Plan Service

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category	Sub-Category
Category 1: 14 Equipment, Technology, and Modifications	**Sub-Category 1:** 14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Specialized medical equipment and supplies means adaptive and assistive devices, controls, or appliances, specified in the individual's individual services plan (ISP), which enable an individuals to increase their ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which the individual lives.

Specialized medical equipment and supplies includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid state plan. Specialized medical equipment and supplies includes repair or maintenance of a previously approved item which is within its useful life, as well as replacement of a previously approved item which is beyond its useful life. All items will meet applicable standards of manufacture, design, and installation. Specialized medical equipment and supplies does not include:

a) Repair or replacement of a previously approved item that has been damaged as a result of confirmed misuse, abuse, or negligence;
b) Items that are not of direct medical or remedial benefit to the individual;
c) Items otherwise available as assistive technology described in rule 5123-9-12 of the Administrative Code; or
d) For individuals less than twenty-one years of age, equipment and supplies that are available under the medicaid state plan or covered under the provisions of 1905 r of the Social Security Act, 42 U.S.C. 1396d, as in effect on the effective date of this rule.

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

Payment for specialized medical equipment and supplies will not exceed ten thousand dollars per item as established in 2018 in OAC rule 5123-9-25. When the cost of a needed item exceeds this limit, the department and the county board will collaborate with the individual and the individual's team to ensure the individual's health and welfare needs are met.
(a) Prior authorization may be requested in accordance with rule 5123-9-07 of the Administrative Code for an individual enrolled in the individual options waiver.

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	Independent Provider of Specialized Medical Equipment and Supplies
Agency	Agency Provider of Specialized Medical Equipment and Supplies

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Individual
Provider Type:

Independent Provider of Specialized Medical Equipment and Supplies

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

Medical equipment vendors who provide Specialized Medical Equipment and Supplies, including those agencies and individuals approved as adaptive/assistive equipment providers under the Medicaid State Plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Agency Provider of Specialized Medical Equipment and Supplies

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

Medical equipment vendors who provide Specialized Medical Equipment and Supplies, including those agencies and individuals approved as adaptive/assistive equipment providers under the Medicaid State Plan. Certification standards listed in OAC 5123-2 and 5123-9-25.

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Technology

HCBS Taxonomy:

Category	Sub-Category
Category 1: 14 Equipment, Technology, and Modifications	**Sub-Category 1:** 14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Assistive Technology means an interactive electronic item, device, product system, or engineered solution capable of internet connectivity, whether acquired commercially, modified, or customized that addresses an individuals' needs and outcomes identified in his or her individual service plan. The service is for the direct benefit of the individual in maintaining or improving independence, functional capabilities, vocational skills, community involvement or physical skills.

Assistive technology has three distinct components:
(a) "Assistive technology consultation" means an evaluation of the assistive technology needs of an individual, including a functional evaluation of technologies available to address the individual's assessed needs and support the individual to achieve outcomes identified in his or her individual service plan.

(b) "Assistive technology equipment" means the cost of equipment comprising the assistive technology and may include engineering, designing, fitting, customizing, or otherwise adapting the equipment to meet an individual's specific needs. Assistive technology equipment may include equipment used for remote support such as motion sensing system, radio frequency identification, live video feed, live audio feed, or web-based monitoring. Assistive technology equipment does not include non-technical, non-electronic equipment (e.g., grab bars or wheelchair ramps) or items otherwise available as environmental accessibility adaptations or specialized medical equipment and supplies.

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

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

Assistive technology support is limited to 40 hours per year.
The cost of all components of assistive technology equipment shall not exceed five thousand dollars per year.

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	Agency Provider of Assistive Technology

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Agency Provider of Assistive Technology

Provider Qualifications

License *(specify):*

License in occupational therapy or physical therapy issued in accordance with Chapter 4755. of the Ohio Revised Code; or speech-language pathology issued in accordance with Chapter 4753. of the Ohio Revised Code

Certificate *(specify):*

Assistive technology professional certification issued by the "Rehabilitation Engineering and Assistive Technology Society of North America"

Other Standard *(specify):*

Certified per standards listed in rule 5123-9-12 of the Ohio Administrative Code.

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD shall ensure that compliance reviews of certified providers are conducted so that each certified provider to reviewed within one year of initial billing for provision of services, and thereafter once during the term of their certification, which is every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Career Planning

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03030 career planning

Category 2:	Sub-Category 2:
03 Supported Employment	03010 job development

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

Service Definition *(Scope):*

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

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

(f) Job development. Job development is an individualized service to develop a strategy to attain competitive integrated employment. The job development strategy shall reflect best practices. The service may include analyzing a job site, identifying necessary accommodations, and negotiating with an employer for customized employment. This service is intended to result in achievement of a competitive integrated employment outcome consistent with the job seeker's or job holder's personal and career goals as identified in the individual service plan, as determined through career exploration, situational observation and assessment, career discovery, and/or the employment planning process. This service shall not be provided to an individual on place four of the path to community employment as described in rule 5123-2-05 of the Administrative Code.
(g) Self-employment launch. Self-employment launch is support to implement a self-employment business plan and launch a business. This service is intended to result in the achievement of an integrated employment outcome consistent with the job seeker's or job holder's personal and career goals as identified in the individual service plan, as determined through career exploration, situational observation and assessment, career discovery, and/or the employment planning process. This service shall not be provided to an individual on place four of the path to community employment as described in rule 5123-2-05 of the Administrative Code.(h) Worksite accessibility. Worksite accessibility includes:
(i) Time spent identifying the need for and ensuring the provision of reasonable worksite accommodations that allow the job seeker or job holder to gain, retain, and enhance employment or self-employment;
(ii) Time spent ensuring the provision of reasonable worksite accommodations through partnership efforts with the employer and, where appropriate, the opportunities for Ohioans with disabilities agency; and

(iii) Purchasing or modifying equipment that will be retained by the individual at the current employment site and/or in other settings, when documented that funding from the opportunities for Ohioans with disabilities agency or any other source is not available.
Requirements for service delivery:
The expected outcome of career planning is the individual's attainment of competitive integrated employment and/or career advancement in competitive integrated employment. 2) Career planning shall be provided pursuant to a person-centered individual service plan that conforms to the requirements of rules 5123-4-02 and 5123-2-05 of the Administrative Code and shall be coordinated with other services and supports set forth in the individual service plan.
3) Career planning may be provided in a variety of settings but shall not be furnished in the individual's residence or other living arrangement except for a home visit conducted as part of career discovery or when the individual is self- employed, and the residence is the site of self-employment.
4) Career planning shall be provided at a ratio of one staff to one individual.
5) Career planning services may extend to those times when the individual is not physically present while the provider is performing career planning activities on behalf of the individual.
6) A provider of career planning shall recognize changes in the individual's condition and behavior as well as safety and sanitation hazards

A provider of the job development component of career planning may be eligible for an outcome-based payment following an individual's achievement of competitive integrated employment.
a) A provider may obtain either or both of two possible outcome-based payments for each individual served:
i) One payment when the individual secures competitive integrated employment.
ii) One payment when the individual secures competitive integrated employment that: Pays at least twelve dollars per hour; and/or employs the individual for an average of at least thirty hours per week as determined over the course of at least four weeks.
b) To obtain an outcome-based payment, a provider will secure one or more pay stubs from the individual served sufficient to document the competitive integrated employment and/or hourly wage or average hours worked following provision of the job development component of career planning. The provider will submit the pay stub or pay stubs to the individual's service and support administrator, who will authorize the outcome-based payment in the individual service plan. When pay stubs cannot be secured, the provider will instead submit an attestation that the outcome has been achieved.
c) The amount of the outcome-based payment is determined by the nature of the competitive integrated employment and the acuity assessment group assignment of the individual at the time the individual secures competitive integrated employment.
d) No more than two outcome-based payments will be made during an individual's waiver eligibility span.
e) The service codes and payment rates for outcome-based payments are contained in the appendix to Ohio Administrative rule 5123-9-13.

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

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

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

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Career Planning

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification standards listed in Chapter 5123-2 and rule 5123-9-19 of the Ohio Administrative Code.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

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

Service Definition *(Scope):*

"Community transition" means reimbursement for non-recurring household start-up expenses for individuals who are transitioning for enrollment in the individual options waiver from an intermediate care facility for individuals with intellectual disabilities or a nursing facility in which they have resided for at least ninety days.
Community transition includes expenses that do not constitute room and board, necessary to enable an individual to establish a basic household. Community transition includes, but is not limited to:

- Security deposits and rental start-up expenses required to obtain a lease on an apartment or house;
- Essential household furnishings required to occupy and use a community domicile such as furniture, window coverings, food preparation items, and bed or bath linens;
- Start-up fees or deposits for utility or service access such as telephone, electricity, heating, and water;
- Moving expenses;
- Pre-transition transportation services necessary to secure housing and benefits; and
- Initial cleaning products and household supplies.

Community transition does not include room and board, grocery expenses, internet or cable expenses, ongoing monthly rent or mortgage expenses, ongoing utility or service charges, items intended for entertainment or recreational purposes, or tobacco products or alcohol.

Community Transition may be authorized for up to one hundred eighty calendar days prior to the date on which an individual enrolls in the individual options waiver and may be authorized for up to thirty calendar days after the date on which an individual enrolls in the individual options waiver.

The date of service for purposes of reimbursement shall be the date an individual enrolls in the individual options waiver upon discharge from the intermediate care facility for individuals with intellectual disabilities or the nursing facility. If for any unforeseen reason an individual does not enroll in the individual options waiver and transition to the community as planned (e.g., due to death or significant change in condition), the county board shall submit the individual's expenses to the department within one year. Expenses incurred in these circumstances are reimbursable to the county board by the department and to the department by the Ohio department of medicaid.

Pre-transition transportation expenses covered as community transition are limited to a maximum of five hundred dollars during the individual's pre-transition period, and for a maximum of thirty consecutive days after the individual leaves the intermediate care facility for individuals with intellectual disabilities or the nursing facility or until waiver enrollment, whichever comes first.

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

As outlined in Appendix D-1-b Service Planning Safeguards, county boards of developmental disabilities (county boards) providing targeted case management (TCM) will only be eligible to provide direct services when there is no other qualified and willing provider is available in the geographic area.

Community transition shall only be used one time per individual per waiver enrollment and shall not exceed two thousand dollars per individual.

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	Agency Provider of Community Transition Service
Agency	County Boards of DD Providers of Community Transition Service

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:

Agency Provider of Community Transition Service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification standards listed in Chapter 5123-2 and rule 5123-9-48 of the Ohio Administrative Code.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD shall ensure that compliance reviews of certified providers are conducted so that each certified provider to reviewed within one year of initial billing for provision of services, and thereafter once during the term of their certification.

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:

County Boards of DD Providers of Community Transition Service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification standards listed in Chapter 5123-2 and rule 5123-9-48 of the Ohio Administrative Code.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD shall ensure that compliance reviews of certified providers are conducted so that each certified provider to reviewed within one year of initial billing for provision of services, and thereafter once during the term of their certification.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Accessibility Adaptations

HCBS Taxonomy:

Category 1:	**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)*:

Environmental accessibility adaptations means those physical adaptations to the home, required by the individual's individual services plan (ISP), which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or 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. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes.

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

When an individual is moving from an institutional setting, environmental accessibility adaptations may be authorized for up to one hundred eighty calendar days prior to the date on which the individual enrolls in the individual options or level one waiver. Environmental accessibility adaptations begun while the individual is living in the institutional setting are not considered complete and the service may not be billed until the date the individual leaves the institution and enrolls in the waiver.

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

Payment will not exceed ten thousand dollars per item as established in OAC rule 5123-9-23. When the cost of a needed item exceeds this limit, the department and the county board will collaborate with the individual and the individual's team to ensure the individual's health and welfare needs are met.
Prior authorization may be requested in accordance with rule 5123-9-07 of the Administrative Code for an individual enrolled in the individual options waiver.

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	Independent Environmental Accessibility Providers
Agency	Agency Environmental Accessibility Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Independent Environmental Accessibility Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The provider has had prior experience completing the type of work involved in the modification, will comply with state and local building code requirements and will obtain a Medicaid provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Agency Environmental Accessibility Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The provider has had prior experience completing the type of work involved in the modification, will comply with state and local building code requirements and will obtain a Medicaid provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

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:

Group Employment Support

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
03 Supported Employment	03022 ongoing supported employment, group
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:

Group employment support means services and training activities provided in regular business, industry, and community settings for groups of two or more workers with disabilities such as mobile work crews and other business-based work groups engaging workers with disabilities in employment in the community.
(a) Activities that constitute group employment support include any combination of the following as necessary and appropriate to meet the community employment goals of the individual:
(i) Person-centered employment planning;
(ii) Work adjustment;
(iii) Job analysis;
(iv) Training and systematic instruction;
(v) Job coaching; and
(vi) Training in independent planning, arranging, and using transportation.

(b) Group employment support is provided in two distinct service arrangements:
(i) Dispersed enclaves in which individuals work in a self-contained unit within a company or service site in the community or perform multiple jobs in the company;
(ii) Mobile work crews comprised solely of individuals operating as distinct units and/or self-contained business working in several locations within the community.

c) Group employment support does not include services provided in facility-based work settings.

Requirements for service delivery:
(1) The expected outcome of group employment support is paid employment and work experience leading to further career development and competitive integrated employment.
(2) Group employment support shall be provided pursuant to a person-centered individual service plan that conforms to the requirements of rules 5123-4-02 and 5123-2-05 of the Administrative Code and shall be coordinated with other services and supports set forth in the individual service plan.
(3) The service and support administrator shall ensure that documentation is maintained to demonstrate that the service provided as group employment support to an individual enrolled in a waiver is not otherwise available as vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973, 29 U.S.C. 730, or as special education or related services as those terms are defined in section 602 of the Individuals with Disabilities Education Improvement Act of 2004, 20 U.S.C. 1401.
State response: The waiver application has been updated to reflect the following additions to the service definition:
Group employment support means services and training activities provided in regular business, industry, and community settings for groups of two or more workers with disabilities such as mobile work crews and other business-based work groups engaging workers with disabilities in employment in the community.
(a) Activities that constitute group employment support include any combination of the following as necessary and appropriate to meet the community employment goals of the individual:
(i) Person-centered employment planning;
(ii) Work adjustment;
(iii) Job analysis;
(iv) Training and systematic instruction;
(v) Job coaching; and
(vi) Training in independent planning, arranging, and using transportation.

(b) Group employment support is provided in two distinct service arrangements:
(i) Dispersed enclaves in which individuals work in a self-contained unit within a company or service site in the community or perform multiple jobs in the company;
(ii) Mobile work crews comprised solely of individuals operating as distinct units and/or self-contained business working in several locations within the community.

c) Group employment support does not include services provided in facility-based work settings.

Requirements for service delivery:
(1) The expected outcome of group employment support is paid employment and work experience leading to further career development and competitive integrated employment.
(2) Group employment support shall be provided pursuant to a person-centered individual service plan that conforms to the requirements of rules 5123-4-02 and 5123-2-05 of the Administrative Code and shall be coordinated with other services and supports set forth in the individual service plan.

(3) The service and support administrator shall ensure that documentation is maintained to demonstrate that the service provided as group employment support to an individual enrolled in a waiver is not otherwise available as vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973, 29 U.S.C. 730, or as special education or related services as those terms are defined in section 602 of the Individuals with Disabilities Education Improvement Act of 2004, 20 U.S.C. 1401.
(4) Group employment support shall be provided in a manner that promotes integration into the workplace and interaction between people with and without disabilities and individuals' access to the greater community, including opportunities to seek competitive, integrated employment, to engage in community life, and to have control over earned income.
(5) Group employment support may be provided in a variety of settings in the community but shall not be furnished in the individual's residence or other residential living arrangement.
(6) Individuals receiving group employment support shall be compensated in accordance with applicable federal and state laws and regulations. A determination that an individual receiving group employment support is eligible to be paid at special minimum wage rates in accordance with 29 C.F.R. Part 525, " Employment of Workers with Disabilities under Special Certificates," shall be based on documented evaluations and assessments.
(7) A provider of group employment support shall ensure the appropriate staff are knowledgeable about the Workforce Innovation and Opportunity Act, wage and hour laws, benefits, work incentives, and employer tax credits for individuals with developmental disabilities and ensure that individuals served receive this information.
(8) A provider of group employment support shall, in accordance with paragraph (F)(1) of rule 5123-2-05 of the Administrative Code, submit to each individual's team at least once every twelve months, or more frequently as decided upon by the individual's team, a written progress report. The written progress report shall outline the anticipated time-frame for each desired outcome of group employment support. If no progress is reported, the individual service plan shall be amended to identify the barriers toward achieving desired outcomes and the action steps to overcome the identified barriers.
(9) A provider of group employment support shall provide the service in a manner that presumes all participants can work in competitive, integrated employment. The provider shall encourage individuals receiving the service, on an ongoing basis, and as part of the annual person-centered planning process, to explore their interests, strengths, and abilities relating to community competitive integrated employment. The provider shall, as a component of this service, assist individuals to explore, identify, and pursue career advancement opportunities that advance them toward competitive, integrated employment with individual employment support as necessary.
(10) A provider of group employment support shall recognize changes in the individual's condition and behavior, report to the service and support administrator, and record the changes in the individual's written record.
(11) A provider of group employment support shall report identified safety and sanitation hazards that occur at the work site to employers having the responsibility to remedy the condition.

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

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

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent provider of group employment support

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Group Employment Support

Provider Category:
Individual
Provider Type:

Independent provider of group employment support

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Certification standards listed in Chapter 5123-2 and rule 5123-9-13 of the Ohio Administrative Code.

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Group Employment Support

Provider Category:
Agency
Provider Type:

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

Provider Qualifications
License *(specify):*

Certificate *(specify)*:

Certification standards listed in Chapter 5123-2 and rule 5123-9-13 of the Ohio Administrative Code.

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Habilitation - Vocational Habilitation

HCBS Taxonomy:

Category	Sub-Category
Category 1: 04 Day Services	**Sub-Category 1:** 04010 prevocational services
Category 2: 04 Day Services	**Sub-Category 2:** 04020 day habilitation
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

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

Vocational habilitation means services that provide learning and work experiences, including volunteer work, where the individual develops general skills that lead to competitive integrated employment such as ability to communicate effectively with supervisors, coworkers, and customers; generally-accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem-solving skills and strategies; and workplace safety and mobility training. Services are expected to occur over a defined period of time with specific outcomes to be achieved determined by the individual and his or her team.

Activities that constitute vocational habilitation include, but are not limited to:

(a) Ongoing support that may be provided in-person or through virtual support which includes direct supervision, telephone and/or in-person monitoring and/or counseling, and the provision of some or all of the following supports to promote the development of general work skills.

(i) Developing a systematic plan of instruction and support, including task analyses to prepare the individual for competitive integrated employment.

(ii) Assisting the individual to perform activities that result in increasing his or her social integration with other individuals and persons employed at the worksite.

(iii) Supporting and training the individual in the use of individualized or community-based transportation services.

(iv) Providing services and training that assist the individual with problem-solving and meeting job-related expectations.

(v) Assisting the individual to use natural supports and community resources.

(vi) Providing training to the individual to maintain current skills, enhance personal hygiene, learn new work skills, attain self-determination goals, and improve social skills.

(vii) Developing and implementing a plan to assist the individual to transition from his or her vocational habilitation setting to competitive integrated employment emphasizing the use of natural supports.

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

(b) Provision of information about or referral to career planning services, disability benefits services, or other appropriate consultative services.
Requirements for service delivery:

(1) The expected outcome of vocational habilitation is the advancement of an individual on his or her path to community employment and the individual's achievement of competitive integrated employment in a job well-matched to the individual's interests, strengths, priorities, and abilities whether the service is delivered in person or remotely.

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

(3) Vocational habilitation shall be provided pursuant to a person-centered individual service plan (ISP) that conforms to the requirements of rules 5123-4-02 and 5123-2-05 of the Administrative Code and shall be coordinated with other services and supports set forth in the individual service plan. Individuals receiving vocational habilitation shall have community employment outcomes in their ISP; vocational habilitation activities shall be designed to support the individual's community employment outcomes.

(4) Vocational habilitation may be provided in a variety of settings in the community but shall not be furnished in the individual's residence or other residential living arrangement except for virtual ADS support as described below.

(5) Vocational habilitation may be provided through virtual support under the following conditions:
a) Virtual support does not have the effect of isolating an individual from the individual's community or preventing the individual from interacting with people with or without disabilities.
b) The use of virtual support has been agreed to by an individual and the individual's team and is specified in the individual service plan.
c) The provider ensures the use of virtual support complies with applicable laws governing an individual's right to privacy and the individual's protected health information.
d) Teams should consider that the provision of vocational habilitation through virtual support does not include the following, therefore teams should assure that the person's needs are able to be met with this service:
e) Personal care including supports and supervision in the areas of personal hygiene, eating communication, mobility, toileting, and dressing to ensure an individual's ability to experience and participate in community living; or
f) Assisting an individual with self-medication or health-related activities or performing medication administration or health-related activities in accordance with Chapter 5123-6 of the Administrative Code
g) Virtual support does not require an in-person visit but it does require the provision of services be by a direct support professional at a distant site who engages with an individual using interactive technology that has the capability for two-way, real-time audio and video communication. A person needs to be present through interactive technology and it must be live audio or video communication.
h) Vocational habilitation shall be provided pursuant to a person-centered individual service plan that conforms to the requirements of rule 5123-4-02 of the Administrative Code and shall be coordinated with other services and supports set forth in the individual service plan. During this process, service and support administrators (SSAs) are responsible to complete an assessment of the individual, identify supports needed, and develop an individual service plan that includes services and supports that ensure health and welfare, assist the individual to engage in meaningful and productive activities; support community connections and networking, assist the individual to improve self-advocacy skills, ensure achievement of outcomes that are important to the individual and outcomes that are important for the individual, and identify risks and include supports to prevent minimize risks.
i) If technology or technology support is needed within the home to participate in remote virtual habilitation, the SSA could authorize one or more components of the assistive technology service. This service could provide assistive technology consultation, assistive technology equipment, or assistive technology support.
j) The Vocational Habilitation Rule, 5123-9-14, requires all employees and contractors who provide vocational habilitation to comply with rule 5123-17-02 of the Administrative Code relating to incidents affecting health and safety

(6) A provider of vocational habilitation shall, in accordance with paragraph (F)(1) of rule 5123-2-05 of the Administrative Code, submit to each individual's team at least once every twelve months, or more frequently as decided upon by the individual's team, a written progress report. The written progress report shall outline the anticipated time-frame for each desired outcome of vocational habilitation. If no progress is reported, the individual service plan shall be amended to identify the barriers toward achieving desired outcomes and the action steps to overcome the identified barriers.

(7) The service and support administrator shall ensure that documentation is maintained to demonstrate that the service provided as vocational habilitation to an individual enrolled in a waiver is not otherwise available as vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973, 29 U.S.C. 730, as in effect on the effective date of this rule.

(8) Individuals receiving vocational habilitation shall be compensated in accordance with applicable federal laws and state laws and regulations. A determination that an individual receiving vocational habilitation is eligible to be paid at special minimum wage rates in accordance with 29 C.F.R. Part 525, "Employment of Workers with Disabilities Under Special Certificates," shall be based on documented evaluations and assessments.

(9) A provider of vocational habilitation shall ensure that appropriate staff are knowledgeable in the Workforce Innovation and Opportunity Act, wage and hour laws, benefits, work incentives, and employer tax credits for individuals with developmental disabilities and ensure that individuals served receive this information.

(10) A provider of vocational habilitation shall comply with applicable laws, rules, and regulations of the federal, state, and local governments pertaining to the physical environment (building and grounds) where vocational habilitation is provided. A provider of vocational habilitation shall be informed of and comply with standards (e.g.,

Americans with Disabilities Act of 1990) applicable to the service setting.

(11 A provider of vocational habilitation shall recognize changes in the individual's condition and behavior as well as safety and sanitation hazards, report to the service and support administrator, and record the changes in the individual's written record.

(5) Vocational habilitation may be provided through virtual support under the following conditions:
a) Virtual support does not have the effect of isolating an individual from the individual’s community or preventing the individual from interacting with people with or without disabilities.
b) The use of virtual support has been agreed to by an individual and the individual’s team and is specified in the individual service plan.
c) The provider ensures the use of virtual support complies with applicable laws governing an individual’s right to privacy and the individual’s protected health information.
d) Teams should consider that the provision of vocational habilitation through virtual support does not include the following, therefore teams should assure that the person’s needs are able to be met with this service:
e) Personal care including supports and supervision in the areas of personal hygiene, eating communication, mobility, toileting, and dressing to ensure an individual’s ability to experience and participate in community living; or
f) Assisting an individual with self-medication or health-related activities or performing medication administration or health-related activities in accordance with Chapter 5123-6 of the Administrative Code
g) Virtual support does not require an in-person visit but it does require the provision of services be by a direct support professional at a distant site who engages with an individual using interactive technology that has the capability for two-way, real-time audio and video communication. A person needs to be present through interactive technology and it must be live audio or video communication.
h) Vocational habilitation shall be provided pursuant to a person-centered individual service plan that conforms to the requirements of rule 5123-4-02 of the Administrative Code and shall be coordinated with other services and supports set forth in the individual service plan. During this process, service and support administrators (SSAs) are responsible to complete an assessment of the individual, identify supports needed, and develop an individual service plan that includes services and supports that ensure health and welfare, assist the individual to engage in meaningful and productive activities; support community connections and networking, assist the individual to improve self-advocacy skills, ensure achievement of outcomes that are important to the individual and outcomes that are important for the individual, and identify risks and include supports to prevent minimize risks.
i) If technology or technology support is needed within the home to participate in remote virtual habilitation, the SSA could authorize one or more components of the assistive technology service. This service could provide assistive technology consultation, assistive technology equipment, or assistive technology support.
j) The Vocational Habilitation Rule, 5123-9-14, requires all employees and contractors who provide vocational habilitation to comply with rule 5123-17-02 of the Administrative Code relating to incidents affecting health and safety

(6) A provider of vocational habilitation shall, in accordance with paragraph (F)(1) of rule 5123-2-05 of the Administrative Code, submit to each individual's team at least once every twelve months, or more frequently as decided upon by the individual's team, a written progress report. The written progress report shall outline the anticipated time-frame for each desired outcome of vocational habilitation. If no progress is reported, the individual service plan shall be amended to identify the barriers toward achieving desired outcomes and the action steps to overcome the identified barriers.

(7) The service and support administrator shall ensure that documentation is maintained to demonstrate that the service provided as vocational habilitation to an individual enrolled in a waiver is not otherwise available as vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973, 29 U.S.C. 730, as in effect on the effective date of this rule.

(8) Individuals receiving vocational habilitation shall be compensated in accordance with applicable federal laws and state laws and regulations. A determination that an individual receiving vocational habilitation is eligible to be paid at special minimum wage rates in accordance with 29 C.F.R. Part 525, "Employment of Workers with Disabilities Under Special Certificates," shall be based on documented evaluations and assessments.

(9) A provider of vocational habilitation shall ensure that appropriate staff are knowledgeable in the Workforce Innovation and Opportunity Act, wage and hour laws, benefits, work incentives, and employer tax credits for individuals with developmental disabilities and ensure that individuals served receive this information.

(10) A provider of vocational habilitation shall comply with applicable laws, rules, and regulations of the federal, state, and local governments pertaining to the physical environment (building and grounds) where vocational habilitation is provided. A provider of vocational habilitation shall be informed of and comply with standards (e.g.,

Americans with Disabilities Act of 1990) applicable to the service setting.

(11 A provider of vocational habilitation shall recognize changes in the individual's condition and behavior as well as safety and sanitation hazards, report to the service and support administrator, and record the changes in the individual's written record.

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

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

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	For-profit and not-for-profit private providers of Vocational Habilitation

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Habilitation - Vocational Habilitation

Provider Category:

Agency

Provider Type:

For-profit and not-for-profit private providers of Vocational Habilitation

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification standards listed in Chapter 5123-2 and rule 5123-9-14 of the Ohio Administrative Code.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Health Care Assessment

HCBS Taxonomy:

Category		Sub-Category	
Category 1:	11 Other Health and Therapeutic Services	**Sub-Category 1:**	11020 health assessment
Category 2:		**Sub-Category 2:**	
Category 3:		**Sub-Category 3:**	
Category 4:		**Sub-Category 4:**	

Service Definition *(Scope):*

Health Care Assessment means using technology to facilitate real-time consultation and support provided by a physician, a physician assistant, or an advanced practice nurse to assist an individual and/or the individual's caregivers to understand the individual's presenting health symptoms and identify appropriate next steps. This service allows the provider to coordinate care with the local emergency departments, urgent care facilities and primary care physicians directly, ensuring advance preparation for the emergency department and potentially decreasing the need for inpatient admission. The goal of the service is not to replace services provided by an individual's primary care physician but rather to provide right-on-time health assessment to determine the best clinical course of action, often avoiding unnecessary emergency room visits. Health Care Assessment services will be available twenty-four hours a day, seven days per week and three hundred sixty-five days per year and includes immediate evaluations, video-assisted examinations, treatment plans and discussion and coordination with individuals and/or caregivers by professionals with extensive specialized expertise in supporting individuals with I/DD.

The service is consultative in nature, reflects the presentations and treatments unique to individuals with developmental disabilities and provides disability-specific guidance on when best to seek additional or in-person medical treatment. The service includes support, which is based on an expertise in I/DD, to an individual and/or the individual's paid and unpaid caregivers, seeking to empower the individual and build the capacity of caregivers to better understand the best approach for supporting the individual based on the individual's symptom presentation. The participant receiving the health care assessment service must have capacity and have access to participate in two-way audio and video interactions with the provider of Telehealth Assessment so that immediate evaluations, video-assisted examinations and development of plans of care may occur. The waiver does not pay for any internet or cellular charges.

The Health Care Assessment service includes clinical transition of care, conducted immediately after conclusion of the consultation, from the provider of health care assessment to the receiving provider to help guide care and provide coordination, when the provider of health care assessment recommends the individual go to the emergency room, urgent care facility, or primary care physician. Includes follow-up and aftercare, as needed, via follow-up consultation with the treated individual and/or caregiver, within eighteen hours after the initial consultation.

The Health Care Assessment service includes a comprehensive quality review and provides a quarterly report of aggregated findings.
•This service will not duplicate or replace other home and community-based services or medical services available to an individual through the Medicaid state plan, including in-person examinations as needed.
•Telemedicine is available under the state plan. However, the service is different from state plan telehealth as it enables waiver enrollees immediate access to healthcare consultation at any time of day from a practitioner specializing in working with the DD population. It may be unscheduled, after hours and although it is covered using telehealth modality, the service is unique. •Individuals will be informed of the right to choose from among all qualified providers in accordance with section OAC 5123-9-11 Home and community based services waivers-free choice of providers and as outlined in Appendix D-1-b Service Planning Safeguards. One unit of service constitutes one month of assessment and consultation from the provider.
•The services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

This is a monthly subscription service.
No more than 1 unit per month per person.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	For Profit and not for Profit Agency Providers of Telehealth Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Health Care Assessment

Provider Category:
Agency
Provider Type:

For Profit and not for Profit Agency Providers of Telehealth Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Certified under standards listed in OAC Chapter 5123-2, rules 5123-2-08 and 5123-9-27.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Developmental Disabilities

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

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 means the preparation, packaging, and delivery of one or more meals to individuals who are unable to prepare or obtain nourishing meals. A maximum of two meals per day shall be provided. Home-delivered meals shall be provided pursuant to an individual service plan that conforms to the requirements of rule 5123-4-02 of the Ohio Administrative Code and specifies what type of home-delivered meals (i.e., standard meals, kosher meals, or therapeutic meals) are to be provided, the number of noontime and/or evening meal to be provided, the location for meal delivery, which will be the individual's residence or an alternative location chosen by the individual and the range of time in which the meals are to be delivered.
The service includes the preparation, packaging, and delivery of a safe and nutritious meal(s) to an individual.

There are three types of home-delivered meals:
1. Standard meal, meaning a meal that is not a kosher meal or a therapeutic meal.
2. Kosher meal, meaning a meal certified as kosher by a recognized kosher certification or a kosher establishment under orthodox rabbinic supervision.
3. Therapeutic meal, meaning a meal that is part of a therapeutic diet ordered by a licensed healthcare professional whose scope of practice includes ordering therapeutic diets:
(a) As part of the treatment for a disease or clinical condition;
(b) To modify, eliminate, decrease, or increase certain substances in the diet; or
(c) To provide mechanically altered food (i.e., the texture of food is altered by chopping, grinding, mashing, or pureeing so that it can be successfully chewed and safely swallowed) when indicated.

Providers of home delivered meals shall:
1. Be able to provide two meals per day, seven days per week;
2. Ensure that each meal:
(a) contains at least one-third of the daily recommended dietary allowance as
established by the food and nutrition board of the national academy of sciences national research council; and
(b) Includes clear instructions on how to maintain, heat, reheat, and/or assemble the meal.
3. Ensure that a licensed dietitian approves and signs all menus and develops all therapeutic meal menus in accordance with the individual service plan;
4. Unless the provider uses a common carrier for meal delivery, maintain a roster of delivery drivers who are trained and have available backup staff for scheduled meal deliveries;
5. Initiate new orders for home-delivered meals within seventy-two hours of referral or as otherwise specified in the individual service plan;
6. Ensure delivery of home-delivered meals is verified by signature of the individual or the individual's representative upon delivery, attestation by the delivery driver, which may be made via an electronic system, that delivery occurred, or retaining the common carrier's tracking statement or returned postage-paid delivery invoice; and
7. Replace any home delivered meal or portion thereof that is lost or stolen between the time of delivery and intended receipt by the individual at no cost to the individual, the Ohio department of Medicaid or the Department of Developmental Disabilities.

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	Independent Provider of Home Delivered Meals
Agency	Agency Provider of Home Delivered Meals

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:
Individual
Provider Type:

Independent Provider of Home Delivered Meals

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Certification standards listed in Chapter 5123-2 and rule 5123-9-29 of the Ohio Administrative Code.

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:
Agency
Provider Type:

Agency Provider of Home Delivered Meals

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Certification standards listed in Chapter 5123-2 and rule 5123-9-29 of the Ohio Administrative Code.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

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:

Homemaker/Personal Care - Daily Billing Unit

HCBS Taxonomy:

Category	Sub-Category
Category 1: 08 Home-Based Services	**Sub-Category 1:** 08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope)*:

Category 4:

Sub-Category 4:

Homemaker/Personal Care (HPC) Daily Billing Unit means a daily rate reimbursement for HPC services. These services are defined as the coordinated provision of a variety of services, supports and supervision necessary for the health and welfare of an individual which enables the individual to live in the community. These are tasks directed at increasing the independence of the individual within his/her home or community. This service will help the individual meet daily living needs, and without this service, alone or in combination with other waiver services, the individual would require institutionalization.

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

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

The provider shall comply with the requirements of rule 5123-2-06 regarding behavior supports. If there is an individual behavior support plan, the provider shall be trained in the components of the plan. The provider shall maintain documentation of such training in accordance with rule 5123-9-31 and present such documentation upon request by the Ohio Department of Medicaid (ODM), the Department of Developmental Disabilities (DODD), or the county board of developmental disabilities (county board).

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

Due to the scope of services available, the HPC Daily Billing Unit service may not be used at the same time as Career Planning, Vocational Habilitation, Individual Employment Support, Group Employment or Adult Day Support services. HPC Daily Billing Unit services shall not be deemed to be services provided under shared living as defined in 5123-9-33. HPC Daily Billing Unit shall not be provided on the same day as shared living. A person may receive shared HPC Daily Billing Unit only on days when shared living is not provided. A provider of HPC Daily Billing Unit cannot bill for both Homemaker/Personal Care and HPC Daily Billing Unit on the same 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	Agency Homemaker/Personal Care Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Homemaker/Personal Care - Daily Billing Unit

Provider Category:

Agency

Provider Type:

Agency Homemaker/Personal Care Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification standards listed in Chapter 5123-2 and rule 5123-9-30 of the Ohio Administrative Code.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Individual Employment Support

HCBS Taxonomy:

Category	Sub-Category
Category 1: 03 Supported Employment	**Sub-Category 1:** 03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:

Individual employment support means individualized support for an individual to maintain competitive integrated employment. Activities that constitute individual employment support include but are not limited to:

(a) Job coaching. Job coaching is identification and provision of services and supports, utilizing task analysis and systematic instruction that assist the individual in maintaining employment and/or advancing his or her career. Job coaching includes supports provided to the individual and his or her supervisor or coworkers on behalf of the individual, either in-person or remotely via technology. Job coaching may include the engagement of natural supports in the workplace to provide additional supports that allow the job coach to maximize his or her ability to fade. Examples of job coaching strategies include job analysis, job adaptations, instructional prompts, verbal instruction, self-management tools, physical assistance, role playing, coworker modeling, written instruction. Job coaching for self-employment includes identification and provision of services and supports, including counseling and guidance, which assist the individual in maintaining self-employment through the operation of a business. When job coaching is provided, a plan outlining the steps to reduce job coaching over time shall be in place within thirty days.

(b) Benefits and work incentive management.

(c) Training in assistive or other technology utilized by the individual while on the job.

(d) Other workplace support services including services not specifically related to job skill training that enable the individual to be successful in integrating into the job setting.

(e) Personal care and assistance, which may be a component of individual employment support but shall not comprise the entirety of the service.

Requirements for service delivery
(1) The expected outcome of individual employment support is sustained competitive integrated employment in a job that is well-matched to the individual's interests, strengths, priorities, and abilities, and that meets the individual's personal and career goals.

(2) Individual employment support shall be provided pursuant to a person-centered individual service plan that conforms to the requirements of rules 5123-4-02 and 5123-2-05 of the Administrative Code and shall be coordinated with other services and supports set forth in the individual service plan.

(3) The service and support administrator shall ensure that documentation is maintained to demonstrate that the service provided as individual employment support to an individual enrolled in a waiver is not otherwise available as vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973, 29 U.S.C. 730, as in effect on the effective date of this rule, or as special education or related services as those terms are defined in section 602 of the Individuals with Disabilities Education Improvement Act of 2004, 20 U.S.C. 1401, as in effect on the effective date of this rule.

(4) Individual employment support shall be provided at a ratio of one staff to one individual.

(5) Individual employment support services may extend to those times when the individual is not physically present and the provider is performing individual employment support on behalf of the individual (e.g., developing coworker supports or meeting with a supervisor).

(6) A provider of individual employment support shall recognize changes in the individual's condition and behavior, report to the service and support administrator, and record the changes in the individual's written record.

(7) A provider of individual employment support shall report identified safety and sanitation hazards that occur at the worksite to employers having the responsibility to remedy the condition.

E. A provider of individual employment support may be eligible for an outcome-based payment following an individual's achievement of a job retention milestone.
(a) A provider may obtain either or both of two possible outcome-based payments for each individual served:
(i) One payment when the individual retains competitive integrated employment for ninety calendar days following the first date the provider delivered individual employment support to the individual.

(ii) One payment when the individual retains competitive integrated employment for one hundred eighty calendar days following the first date the provider delivered individual employment support to the individual.
(b) To obtain an outcome-based payment, a provider will secure one or more pay stubs from the individual served sufficient to document the date span of the individual's competitive integrated employment (i.e., ninety or one hundred eighty calendar days, as applicable) following the first date the provider was authorized to deliver individual employment support to the individual. The provider will submit the pay stub or pay stubs to the individual's service and support administrator, who will authorize the outcome-based payment in the individual service plan. When pay stubs cannot be secured, the provider will instead submit an attestation that the outcome has been achieved.
(c) The amount of an outcome-based payment is determined by the job retention milestone and the acuity assessment group assignment of the individual at the time the individual achieves the milestone.
(d) No more than two outcome-based payments will be made during an individual's waiver eligibility span.
(e) The service codes and payment rates for outcome-based payments are contained in the appendix to rule 5123-9-15.

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

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

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

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	For profit and non-profit private providers of individual employment support
Individual	Independent providers of individual employment support

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual Employment Support

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify)*:

Certificate *(specify):*

Certification standards listed in Chapter 5123-2 and rule 5123-9-15 of the Ohio Administrative Code.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Development Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual Employment Support

Provider Category:

Individual

Provider Type:

Independent providers of individual employment support

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification standards listed in Chapter 5123-2 and rule 5123-9-15 of the Ohio Administrative Code.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Development Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

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:

Interpreter

HCBS Taxonomy:

Category		Sub-Category	
Category 1:	17 Other Services	**Sub-Category 1:**	17020 interpreter
Category 2:		**Sub-Category 2:**	
Category 3:		**Sub-Category 3:**	
Category 4:		**Sub-Category 4:**	

Service Definition *(Scope):*

Interpreter services means the process by which an individual conveys one person's message to another. The process of interpreting should incorporate both the message and the attitude of the communicator. The interpreter will maintain the role of a facilitator of communication rather than the focus or initiator of communication.

Providers of interpreter services shall:

1. Render the message faithfully, always conveying the content and the spirit of the consumer, using language most readily understood by the persons whom they serve;
2. Not counsel, advise or interject personal opinions; and
3. Participate in the consumer's individual services plan (ISP) team if and when requested by the consumer's team.

This service alone or in conjunction with other services prevents institutionalization of the consumer.

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	Agency Provider of Interpreter Services
Individual	Independent Provider of Interpreter services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Interpreter

Provider Category:

Agency

Provider Type:

Agency Provider of Interpreter Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification standards listed in Chapter 5123-2 and rule 5123-9-36 of the Ohio Administrative Code.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Interpreter

Provider Category:
Individual
Provider Type:

Independent Provider of Interpreter services

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Certification standards listed in Chapter 5123-2 and rule 5123-9-36 of the Ohio Administrative Code.

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

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:

Money Management

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation

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

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

Service Definition *(Scope):*

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

Money management means services that provide assistance to individuals who need support managing personal and financial affairs. Money Management may also include training to assist the individual in acquisition, retention and/or improvement in money management skills. The services meet a continuum of individualized needs, from organizing and keeping track of financial records and health insurance documentation, to assisting with bill-paying and maintaining bank accounts. Money management does not take the place of services provided by professionals in the accounting, investment, or social services fields. Money management complements the work of other professionals by facilitating the completion of the day-to-day tasks rather than determining or executing long-term plans. Money management includes a broad range of tasks determined necessary in the individual service plan. Examples of supports that may be provided as a component of money management include:

(a) Bill-paying and preparation of checks for individuals to sign;

(b) Balancing checkbooks, reconciling bank account statements, and maintaining or organizing bank records;

(c) Preparing and delivering bank account deposits;

(d) Assisting an individual with applying for benefits such as Medicaid buy-in for workers with disabilities and other resources as appropriate;

(e) Assist in maintaining eligibility for monthly benefits such as food stamps;

(f) Consulting or making referrals for consultation regarding available benefits;

(g) Making referrals as appropriate for establishment of special needs accounts (e.g., Qualified Income Trusts or Achieving a Better Life Experience Act account);

(h) Organizing tax documents and other paperwork;

(i) Negotiating with creditors;

(j) Deciphering medical insurance papers and verifying proper processing of claims;

(l) Providing referrals to legal, tax, and investment professionals;

(m) Notarizing documents;

(n) Providing assistance associated with money management tasks when an individual relocates (e.g., transferring bank accounts and or updating address with creditors);

(o) Acting as power of attorney or authorized representative for financial affairs;

Requirements for service delivery

(1) Money management shall be provided pursuant to an individual service plan (ISP) that conforms to the requirements of rule 5123-4-02 of the Administrative Code. Providers of money management shall participate in ISP development meetings when a request for their participation is made by the individual.

(2) The scope and intensity of money management services shall be determined by the team based on the individual's needs. Money management shall be authorized for more than ten hours per month.

(3) Persons providing money management shall comply with rule 5123-2-07 of the Administrative Code and the money management code of ethics contained in appendix A to this rule.

(4) A provider shall provide money management to only one individual at a time.

(5) Money management services may extend to those times when the individual is not physically present and the provider is performing money management activities on behalf of the individual.

(6) A provider of money management shall not also provide adult family living, adult foster care, or homemaker/personal care to the same individual.

(7) Money management services involving direct contact with an individual receiving the services shall not be provided at the same time the individual is receiving homemaker/personal care involving direct contact with the individual.

(8) A provider of money management who is also an individual's payee shall:

(a) Obtain and maintain benefits for the individual; for which they are the payee

(b) Pay all of the individual's living expenses prior to providing the individual with discretionary spending money;

(c) Take all necessary measures to maintain the individual's eligibility for benefits such as ensuring bank account balances remain within established resource limitations; and

(d) Maintain documentation, report information, and comply with all other requirements and standards, including audit protocols, established by the payer of benefits as established by the Social Security Administration.

(9) Under no circumstances shall a provider of money management who is also the individual's payee be exempted from a requirement to furnish receipts for purchases or expenditures (including expenditures for travel or vacations when the individual is with his or her guardian).

(10) A provider of money management who is also the individual's payee shall not request or accept reimbursement through more than one funding source for the services that fall under the responsibilities of a payee. Additional money management tasks beyond the responsibilities of a payee may be determined through the person-centered planning process and authorized in the individual service plan.

(11) Money management shall not duplicate or include activities that help link eligible individuals with medical, social, or educational providers, programs, or services that are functions of targeted case management (TCM) pursuant to rule 5160-48-01 of the Administrative Code.

(12) A provider of money management shall maintain and submit financial statements and information (e.g. checking account balance, bank statements savings account statements, trends on spending, income statements, etc.) to the individual upon request by the team.

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

The scope and intensity of money management services shall be determined by the team based on the individual's needs. Money management shall be authorized for no less than two hours per month and no more than ten hours per month.

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	Agency Provider of money management
Individual	Independent provider of money management

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Money Management

Provider Category:

Agency

Provider Type:

Agency Provider of money management

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification standards listed in Chapter 5123-2 and rule 5123-9-20 of the Ohio Administrative Code.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Money Management

Provider Category:

Individual

Provider Type:

Independent provider of money management

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification standards listed in Chapter 5123-2 and rule 5123-9-20 of the Ohio Administrative Code.

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Non-Medical Transportation

HCBS Taxonomy:

Category	Sub-Category
Category 1: 15 Non-Medical Transportation	**Sub-Category 1:** 15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:

Non-Medical Transportation (NMT) as a waiver service is available to enable waiver participants to get to/from a place of competitive integrated employment or to access Adult Day Support, Career Planning, Group Employment Support, Individual Employment Support, and/or Vocational Habilitation, as specified by the Individual Service Plan (ISP). NMT allows individuals access to volunteer opportunities and college or post-secondary activities. This is aligned with Ohio's mission of having all individuals who express an interest in competitive employment create their own unique path to employment. NMT will help support individuals in attaining their employment goals.

Whenever possible, family, friends, neighbors, or community agencies that can provide this service without charge shall be used. Transportation services that are not provided free of charge and are required by enrollees in HCBS waivers administered by the Department to access one or more of these five waiver services and/or the above community activities shall be considered to be NMT services and the payment rates, service limitations and provider qualifications associated with the provision of this service shall be applicable.

NMT is available in addition to the Transportation services described in Ohio Administrative Code 5123-9-06, which will be used primarily in connection with the provision of Homemaker/Personal Care Services.

Special per-trip payment rates apply when an agency provider or an independent provider transports an individual to or from competitive integrated employment. The special per-trip payment rates are established on a per-person basis, depending on the length of the trip and whether the service is provided in a modified vehicle or a non-modified vehicle.

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

Payment for NMT services in combination with adult day support, career planning, group employment support, individual employment support, and vocational habilitation, shall not exceed the budget limitations contained in OAC 5123-9-19 (https://codes.ohio.gov/ohio-administrative-code/rule-5123-9-19).

CODB	Group A-1	Groups A	Group B	Group C
1	$14755	$14755	$26520	$44135
2	$14885	$14885	$26780	$44590
3	$15015	$15015	$27040	$45045
4	$15210	$15210	$27300	$45565
5	$15340	$15340	$27560	$45955
6	$15470	$15470	$27820	$46475
7	$15665	$15665	$28080	$46930
8	$15795	$15795	$28340	$47385

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	Independent private providers of non-medical transportation per trip
Agency	For profit and non-profit private providers of non-medical transportation per mile
Agency	County board of dd providers of non-medical transportation per mile
Individual	Independent private providers of non-medical transportation per mile
Agency	Public bus transit system, public light rail transit system and taxicabs per mile
Agency	County board of dd providers of non-medical transportation per trip

Provider Category	Provider Type Title
Agency	Public bus transit system, public light rail transit system and taxicabs per mile
Agency	For profit and non-profit private providers of non-medical transportation per trip

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:
Individual
Provider Type:

Independent private providers of non-medical transportation per trip

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification Standards are listed in Ohio Administrative Code Chapter 5123-2 and rule 5123-9-18.

Other Standard *(specify):*

Providers of transportation that is not available to the general public are eligible to bill on a per mile or per trip basis when the vehicles/providers/drivers meet the certification standards of the Department. The service type is determined by the team and individual choice and authorized in the individual’s service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rules 5123-9-18 and 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:
Agency
Provider Type:

For profit and non-profit private providers of non-medical transportation per mile

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification Standards are listed in Ohio Administrative Code Chapter 5123-2 and rule 5123-9-18.

Other Standard *(specify):*

Providers of transportation that is not available to the general public are eligible to bill on a per mile or per trip basis when the vehicles/providers/drivers meet the certification standards of the Department. The service type is determined by the team and individual choice and authorized in the individual's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rules 5123-9-18 and 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

County board of dd providers of non-medical transportation per mile

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification Standards are listed in Ohio Administrative Code Chapter 5123-2 and rule 5123-9-18.

Other Standard *(specify):*

Providers of transportation that is not available to the general public are eligible to bill on a per mile or per trip basis when the vehicles/providers/drivers meet the certification standards of the Department. The service type is determined by the team and individual choice and authorized in the individual's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rules 5123-9-18 and 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:

Individual

Provider Type:

Independent private providers of non-medical transportation per mile

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification Standards are listed in Ohio Administrative Code Chapter 5123-2 and rule 5123-9-18.

Other Standard *(specify):*

Providers of transportation that is not available to the general public are eligible to bill on a per mile or per trip basis when the vehicles/providers/drivers meet the certification standards of the Department. The service type is determined by the team and individual choice and authorized in the individual's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rules 5123-9-18 and 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

Public bus transit system, public light rail transit system and taxicabs per mile

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification Standards are listed in Ohio Administrative Code Chapter 5123-2 and rule 5123-9-18.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rules 5123-9-18 and 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

County board of dd providers of non-medical transportation per trip

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification Standards are listed in Ohio Administrative Code Chapter 5123-2 and rule 5123-9-18.

Other Standard *(specify):*

Providers of transportation that is not available to the general public are eligible to bill on a per mile or per trip basis when the vehicles/providers/drivers meet the certification standards of the Department. The service type is determined by the team and individual choice and authorized in the individual's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rules 5123-9-18 and 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

Public bus transit system, public light rail transit system and taxicabs per mile

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification Standards are listed in Ohio Administrative Code Chapter 5123-2 and rule 5123-9-18.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rules 5123-9-18 and 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

For profit and non-profit private providers of non-medical transportation per trip

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification Standards are listed in Ohio Administrative Code Chapter 5123-2 and rule 5123-9-18.

Other Standard *(specify):*

Providers of transportation that is not available to the general public are eligible to bill on a per mile or per trip basis when the vehicles/providers/drivers meet the certification standards of the Department. The service type is determined by the team and individual choice and authorized in the individual's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rules 5123-9-18 and 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

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:

Nutrition

HCBS Taxonomy:

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

Service Definition *(Scope):*

Nutrition services means a nutritional assessment and intervention for consumers who are identified as being at nutritional risk. The service includes development of a nutrition care plan, including appropriate means of nutritional intervention, i.e. nutrition required, feeding modality, nutrition education and nutrition counseling. The Dietitian shall:

1. Participate in the development of the consumer's annual individual service plan (ISP) if requested;
2. Perform nutritional assessments/evaluations in accordance with the ISP;
3. Develop dietary programs, if indicated by the nutritional assessment and the ISP;
4. Document all hands-on programming performed;
5. Inservice and/or train the consumer/family/guardian, professionals, paraprofessionals, direct care workers, habilitation specialists, vocational/school staff (including public personnel) as needed.

Nutrition services will not supplant existing services provided by the Women Infants and Children (WIC) program.

This service alone or in conjunction with other services prevents institutionalization of the consumer.

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	Agency Provider of Nutrition Services
Individual	Independent Provider of Nutrition Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nutrition

Provider Category:

Agency

Provider Type:

Agency Provider of Nutrition Services

Provider Qualifications

License *(specify):*

Licensed dietitian as defined in Section 4759.06 of the Ohio Revised Code

Certificate *(specify):*

Certification standards listed in Chapter 5123-2 and rule 5123-9-28 of the Ohio Administrative code.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nutrition

Provider Category:

Individual

Provider Type:

Independent Provider of Nutrition Services

Provider Qualifications

License *(specify):*

Licensed dietitian as defined in Section 4759.06 of the Ohio Revised Code

Certificate *(specify):*

Certification standards listed in Chapter 5123-2 and rule 5123-9-28 of the Ohio Administrative code.

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

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:

Participant-Directed Homemaker/Personal Care

HCBS Taxonomy:

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

Service Definition *(Scope)*:

Participant-directed Homemaker/personal care (HPC) means the coordinated provision of a variety of services, supports and supervision necessary for the health and welfare of an individual which enables the individual to live in the community. These are tasks directed at increasing the independence of the individual within his/her home or community. This service can be furnished outside the home.

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

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

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

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

integrated in and have full access to the community.
10. Mobility including training or assistance aimed at enhancing movement within the individual's home, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or other means of providing transportation.

The individual/designee responsibilities and authority to direct the delivery of homemaker/personal care are identified in OAC 5123-9-32.

Individuals or their representatives will direct/supervise individual providers of participant-directed homemaker/personal care. In addition to the day-to-day supervision by the individual/designee, Appendix D-1d identifies the continuous review process implemented by the service and support administrator in accordance with OAC 5123-2-04.

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

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

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

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

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Participant-Directed Homemaker/Personal Care

Provider Category:
Individual
Provider Type:

Independent Provider of Participant-directed Homemaker/personal care

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Certification standards listed in Chapter 5123-2 and rule 5123-9-32 of the Ohio Administrative Code.

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:

Remote Supports

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17990 other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Remote supports is the provision of supports by staff at a remote location who are engaged with the individual through technology/devices with the capability for live two-way communication. Equipment used to meet this requirement must include one or more of the following systems: motion sensing system, radio frequency identification, live video feed, live audio feed, GPS tracking, web-based monitoring system, or a device that otherwise meets the requirement for two-way communication. Individual interaction with the staff person may be scheduled, on-demand, or in response to an alert from a device in the remote support equipment system.

Per Ohio Administrative Code (OAC) rule 5123-9-35:

“When remote support involves the use of audio and/or video equipment that permits remote support staff to view activities and/or listen to conversations in the residence, the individual who receives the service and each person who lives with the individual shall consent in writing after being fully informed of what remote support entails including, but not limited to, that the remote support staff will observe their activities and/or listen to their conversations in the residence, where in the residence the remote support will take place, and whether or not recordings will be made. If the individual or a person who lives with the individual has a guardian, the guardian shall consent in writing. The individual’s service and support administrator shall keep a copy of each signed consent form with the individual service plan.”

Individuals and/or guardians who consent to the use of remote supports use this service in lieu of in-person caregiving, most typically provisioned through Ohio’s Homemaker/Personal Care (HPC) service. As an example, a remote support device can be used to set reminders for medication administration for an individual who can self-administer.

Remote supports allow for an individual to choose the method of supportive caregiving which best suits their needs. In this way, remote supports help ensure an individual’s rights of privacy, dignity, and respect, as well as freedom from coercion in that individuals now have a different method of receiving care.

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

Remote supports shall not be provided in a shared living or non-residential setting.

Per Ohio Administrative Code 5123-9-35, "Remote support shall be provided pursuant to an individual service plan that conforms to the requirements of rule 5123-4-02 of the Administrative Code. When remote support involves the use of audio and/or video equipment, the individual who receives the service and each person who lives with the individual shall consent in writing after being fully informed of what remote support entails, including, but not limited to, that the remote support staff will observe their activities and/or listen to their conversations in the residence, where in the residence the remote support will take place, and whether or not recording will be made. If the individual or a person who lives with the individual has a guardian, the guardian shall consent in writing. The individual's service and support administrator shall keep a copy of each signed consent form with the individual service plan."

In general, the use of cameras in bathrooms or bedrooms is not permitted. If ever a unique health and safety situation necessitated the need for cameras in a bathroom or bedroom, beyond a fall sensor, the overseeing Human Rights Committee would be required to authorize the plan and would ensure rights and privacy were specified in the plan.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Providers of Remote Supports

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Remote Supports

Provider Category:

Agency

Provider Type:

Agency Providers of Remote Supports

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification standards listed in Chapter 5123-2 and rule 5123-9-35 of the Ohio Administrative Code.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

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:

Residential Respite

HCBS Taxonomy:

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

Service Definition *(Scope)*:

Residential Respite services means care and support services furnished to an individual on a short- term basis because of the absence or need for relief of those persons who normally provide routinely providing care for the individuals.

Residential respite may be provided to an individual who resides in a shared living setting at the 15-minute billing unit for the temporary relief of the caregiver on a day the shared living caregiver bills for provision of service as long as residential respite and shared living services are not delivered at the same time or by the same caregiver or any other person who resides in the shared living setting. No more than twelve hours of residential respite are provided to the individual on that day.

Residential Respite shall only be provided in the following locations Depending on the circumstances of service provision, residential respite is billed at a daily billing unit or at a fifteen-minute billing unit:

Residential respite at the daily billing unit
1. Residential respite at the daily billing unit will be used when:
Residential respite is provided to an individual for more than seven hours during a twenty-four hour period and the individual stays overnight at the residential respite service delivery location and
A shared living caregiver does not bill for provision of shared living to the individual on that day.

2. Residential respite at the daily billing unit will be provided by:
a) A residential facility;
b) An agency provider; or
c) An independent provider

3. Residential respite at the daily billing unit will be provided at
a) A residential facility;
b) The individual’s home;
c) the home of the employee of an agency provider who is providing the service; or
d) The home of the independent provider who is providing the service.

Residential respite at the fifteen-minute billing unit
1. Residential respite at the fifteen-minute billing unit is available to an individual who resides in a shared living setting and will be used when residential respite is provided to the individual on the same day the shared living caregiver bills for provision of shared living.

2. Residential respite at the fifteen-minute unit billing unit will be provided by:
a) A residential facility other than an intermediate care facility for individuals with intellectual disabilities
b) The individual’s home:
c) The home of the employee of an agency provider who is providing the service;
d) The home of the independent provider who is providing the service; or
e) Another location chosen by the individual

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

Payment for Residential Respite services does not include room and board.

Only one provider of residential respite or community respite shall use a daily billing unit on any given day.

Residential Respite daily billing unit is limited to 90 calendar days of service per waiver eligibility span.

Residential respite at the 15-minute billing unit is limited to two hundred eight units per calendar month.

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	Agency Providers of Residential Respite
Agency	Facilities certified as ICFs/IID
Individual	Individual Providers of Residential Respite (15-minute billing unit and daily unit)
Agency	DODD Licensed Facilities

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Respite

Provider Category:

Agency

Provider Type:

Agency Providers of Residential Respite

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification standards listed in Chapter 5123-2 and rule 5123-9-34 of the Ohio Administrative Code.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Respite

Provider Category:
Agency
Provider Type:

Facilities certified as ICFs/IID

Provider Qualifications
License *(specify):*

Licensed by the Ohio Department of Developmental Disabilities under 5123.19 of the Revised Code.

Certificate *(specify):*

Certification standards listed in Chapter 5123-2 and rule 5123-9-34 of the Ohio Administrative Code.

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Respite

Provider Category:
Individual
Provider Type:

Individual Providers of Residential Respite (15-minute billing unit and daily unit)

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Certification standards listed in Chapter 5123-2 and rule 5123-9-34 of the Ohio Administrative Code.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Developmental Disabilities

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Respite

Provider Category:

Agency

Provider Type:

DODD Licensed Facilities

Provider Qualifications

License *(specify):*

Licensed by the Ohio Department of Developmental Disabilities under 5123.19 of the Revised Code.

Certificate *(specify):*

Certification standards listed in Chapter 5123-2 and rule 5123-9-34 of the Ohio Administrative Code.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

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

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:

Shared Living

HCBS Taxonomy:

Category	Sub-Category
Category 1: 02 Round-the-Clock Services	**Sub-Category 1:** 02023 shared living, other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:

Shared living means personal care and support services provided to an adult by a caregiver who lives with the individual receiving the services. Shared living is provided in conjunction with residing in the home and is part of the rhythm of life that naturally occurs when people live together in the same home. Due to the environment provided by living together in the same home, segregating these activities into discrete services is impractical.

Examples of supports that may be provided as a component of shared living include: basic personal care and grooming, performing household activities including laundry and shopping, assistance with bladder and/or bowel requirements, assistance with medication and support in leading full community lives.

An individual who resides in a shared living setting may receive residential respite at the fifteen-minute billing unit for the temporary relief of the caregiver on a day the shared living caregiver bills for provision of shared living as long as:
a) Residential respite and shared living services are not delivered at the same time
b) Residential respite is not provided by the shared living caregiver or any other person who resides in the shared living setting and
c) No more than twelve hours of residential respite are provided to the individual on that day

Shared living care may be provided to an individual in an acute care hospital to address the individual’s intensive personal care, behavioral support/stabilization, or communication needs when the following conditions are met:
1. The care is provided to meet the needs of the individual that are not met through the provision of acute care hospital services;
2. Care is necessary to ensure smooth transition between the acute care hospital and the individual’s home and to preserve the individual’s functional abilities.
3. The service is not duplicative nor a substitute for service the acute care hospital provides or is obligated to provide through its conditions of participation, federal law, state law, or other applicable requirement.
4. The person providing care is awake.
5. A maximum total of no more than thirty days per waiver span may be provided to an individual in an acute care hospital.
6. The cost of care provided to an individual in an acute care hospital can be accommodated by the individual’s authorized budget in the medicaid billing system.

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

Legal guardians of individuals over the age of 18 are only permitted to be providers when they are related to the individual.
Shared living shall not be billed on the same day as residential respite (daily billing rate), or community respite.
Only one daily unit of shared living may be provided each calendar day.
Payment for shared living does not include room and board, items of comfort or convenience, or costs for the maintenance, upkeep, and improvement of the home in which shared living is provided.
Shared living is provided in a home that is the primary, legal residence of the person served and the provider.
An individual enrolled in the individual options waiver who resides in a setting meeting the definition of shared living may as an alternative to the shared living service choose homemaker/personal care when applicable exemptions are met as outlined in OAC 5123-9-33. Billing may not be claimed for both 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	Agency Providers of Shared Living
Individual	Independent Providers of Shared Living

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Shared Living

Provider Category:
Agency
Provider Type:

Agency Providers of Shared Living

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Certification standards listed in Chapter 5123-2 and rule 5123-9-33 of the Ohio Administrative Code.

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Shared Living

Provider Category:
Individual
Provider Type:

Independent Providers of Shared Living

Provider Qualifications
License *(specify):*

Certificate *(specify)*:

Certification standards listed in Chapter 5123-2 and rule 5123-9-33 of the Ohio Administrative Code.

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

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

HCBS Taxonomy:

Category	Sub-Category
Category 1: 10 Other Mental Health and Behavioral Services	**Sub-Category 1:** 10060 counseling
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

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

Social Work means the application of specialized knowledge of human development and behavior, social, economic and cultural systems. This knowledge is used to assist individuals and their families to improve and/or restore their capacity for social functioning. Services include the provision of counseling and active participation in problem solving with individuals and family members; counseling in relationship to meeting the psychosocial needs of the individuals; collaboration with health care professionals and other providers of service to assist them to understand and support the social and emotional needs and problems experienced by individuals and their families; advocacy; referral to community-based and specialized services; develop social work/counseling plans of treatment; and assist providers of services and family members to understand and implement activities related to implementation of the plan of treatment.

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	Agency Provider of Social Work
Individual	Independent Provider of Social Work

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Social Work

Provider Category:

Agency

Provider Type:

Agency Provider of Social Work

Provider Qualifications

License *(specify):*

An individual licensed in the state of Ohio to provide social work as defined in Division (C) of Section 4757.01 of the Ohio Revised Code and Chapters 4757:15-02 and 4757:15-03 of the Administrative Code or licensed in the state of Ohio to provide professional counseling as defined in Divisions (A) and (B) of Section 4757:01 of the Ohio Revised Code and Chapters 4757:15-02 and 4757:15-03 of the Administrative Code.

Certificate *(specify):*

Other Standard *(specify):*

Standards listed in rule 5123-9-17 of the Ohio Administrative Code.

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Social Work

Provider Category:

Individual

Provider Type:

Independent Provider of Social Work

Provider Qualifications

License *(specify):*

An individual licensed in the state of Ohio to provide social work as defined in Division (C) of Section 4757.01 of the Ohio Revised Code and Chapters 4757:15-02 and 4757:15-03 of the Administrative Code or licensed in the state of Ohio to provide professional counseling as defined in Divisions (A) and (B) of Section 4757:01 of the Ohio Revised Code and Chapters 4757:15-02 and 4757:15-03 of the Administrative Code.

Certificate *(specify):*

Other Standard *(specify):*

Standards listed in rule 5123-9-38 of the Ohio Administrative Code.

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

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:

Transportation

HCBS Taxonomy:

Category	Sub-Category
Category 1: 15 Non-Medical Transportation	**Sub-Category 1:** 15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:

Service offered to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the individual's service plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. A self-directed model of transportation, as described in Ohio waiver rule 5123-9-26, has been established to assist individuals served to navigate their community as defined in the individual's service plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized. Transportation services may be provided in addition to the Non-Medical Transportation services that may only be used to enable individuals to access Adult Day Support, Vocational Habilitation, Individual Employment Support, Group Employment Support and Career Planning. To avoid service duplication with Non-Medical Transportation Service, documentation is required to show what service has been billed at what time. DODD conducts audits on services provided by aligning what is in the individual services plan (ISP) with what has been approved in the Payment Authorization for Waiver Services (PAWS) and what has been billed in the Medicaid Billing System to ensure that no duplication has occurred. The SSA maintains the responsibility for monitoring the services as authorized in the ISP.

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Transportation Providers
Agency	Agency Transportation Providers
Individual	Financial Management Services Entity

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Individual

Provider Type:

Independent Transportation Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification Standards listed in rules 5123-2-09, 5123-9-24 and 5123-9-26 of the Ohio Administrative Code.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:
Agency
Provider Type:

Agency Transportation Providers

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Certification Standards listed in Chapter 5123-2 and rules 5123-9-24, 5123-9-06 of the Ohio Administrative Code.

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:
Individual
Provider Type:

Financial Management Services Entity

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification Standards listed in rules 5123-9-24 and 5123-9-06 of the Ohio Administrative Code.

Other Standard *(specify):*

See additional information provided in Appendix E-1-i

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. Pursuant to OAC 5123-2-04 Compliance Reviews of Certified Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Waiver Nursing Delegation

HCBS Taxonomy:

Category	Sub-Category
Category 1: 05 Nursing	**Sub-Category 1:** 05020 skilled nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope)*:

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

Waiver nursing delegation services means the initial and ongoing supports provided by a licensed nurse who is delegating a nursing task or assuming responsibility for individuals who are receiving delegated nursing care. Waiver nursing delegation services include two distinct components: assessment of the individual receiving delegated nursing care that includes a face-to-face interview and observation of the individual receiving care and supervision of the performance of the nursing task performed by the unlicensed person.

All nurses providing waiver nursing services to individuals enrolled on the Individual Options shall provide services within the nurse's scope of practice as set forth in Chapter 4723. of the Revised Code (Ohio's Nurse Practice Act) and Administrative Code rules adopted there under, and hold a current, valid, and unrestricted license issued by the Ohio board of nursing.

Ohio’s Medicaid state plan does not currently fund nursing delegation.

Related legal guardians of individuals over the age of 18 are permitted to be providers. A family member who lives with the individual is not eligible to be paid for waiver nursing delegation provided to that individual. Family members who live with the individual can delegate to independent providers through the family delegation statute and do not require waiver certification/payment to do so.

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

Waiver nursing delegation shall be provided pursuant to an individual service plan that conforms to the requirements of rule 5123-4-02 of the Administrative Code.

An individual may receive up to one assessment every 60 days in a residential setting and one assessment every 60 days in a non-residential setting.

Waiver nursing delegation may be reimbursed for no more than 10 hours per month for each individual in all settings.

LPNs may not perform waiver nursing delegation assessment.

The scope and intensity of supervision of unlicensed personnel shall be determined by the RN or LPN.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	LPN
Agency	Medicare-certified HHA, an agency accredited by ACHC, CHAP or the Joint Commission or another national accrediting organization approved by CMS, and DODD certified agencies
Individual	RN

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Waiver Nursing Delegation

Provider Category:
Individual
Provider Type:

LPN

Provider Qualifications
License *(specify):*

LPN

Certificate *(specify):*

DODD certification standards listed in rule 5123-2-09 and 5123-9-37 of the Ohio Administrative Code.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)
Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. The term of certification is 3 years, as specified in OAC Chapter5123-2. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Waiver Nursing Delegation

Provider Category:
Agency
Provider Type:

Medicare-certified HHA, an agency accredited by ACHC, CHAP or the Joint Commission or another national accrediting organization approved by CMS, and DODD certified agencies
Provider Qualifications
License *(specify):*

RN, LPN

Certificate *(specify):*

DODD certification standards listed in 5123-2-08 and 5123-9-37 of the Ohio Administrative Code.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. The term of certification is 3 years, as specified in OAC Chapter 5123-2. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Waiver Nursing Delegation

Provider Category:

Individual

Provider Type:

RN

Provider Qualifications

License *(specify):*

RN

Certificate *(specify):*

DODD certification standards listed in 5123-2-09 and 5123-9-37 of the Ohio Administrative Code.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. The term of certification is 3 years, as specified in OAC Chapter 5123-2. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

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		Sub-Category	
Category 1:	05 Nursing	**Sub-Category 1:**	05020 skilled nursing
Category 2:		**Sub-Category 2:**	
Category 3:		**Sub-Category 3:**	
Category 4:		**Sub-Category 4:**	

Service Definition *(Scope):*

Waiver nursing services are defined as services provided to individuals who require the skills of a registered nurse (RN) or licensed practical nurse (LPN) at the direction of an RN. All nurses providing waiver nursing services to individuals enrolled on the Individual Options shall provide services within the nurse's scope of practice as set forth in Chapter 4723. of the Revised Code (Ohio's Nurse Practice Act) and Administrative Code rules adopted there under, and hold a current, valid, and unrestricted license issued by the Ohio board of nursing.

Waiver nursing service authorization is outlined in the Ohio Administrative Code 5123-9-39 Waiver Nursing, paragraph (D)(1) through (5).

It is different than state plan nursing because its approved provider pool is not limited to Medicare-certified home health agencies. Waiver nursing services that can be covered under the State Plan should be furnished to waiver participants under the age of 21 as services required under Early and Periodic Screening, Diagnostic and Treatment (EPSDT).

Related legal guardians of individuals over the age of 18 are permitted to be providers.

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

Waiver nursing services shall be provided pursuant to an individual service plan that conforms to the requirements of rule 5123-4-02 of the Administrative Code. Waiver nursing services shall be utilized only when an individual's needs cannot be met through medication administration and nursing delegation as outlined in Chapter 5123-6 of the Administrative Code, and/or state plan nursing services as defined in Chapter 5160-12 of the Administrative Code.

A provider of waiver nursing services shall be identified as the provider and have specified in the individual service plan the number of hours for which the provider is authorized to furnish waiver nursing services.

Waiver nursing services shall not include:
Services delegated in accordance with Chapter 4723. of the Revised Code and rules adopted thereunder, and to be performed by persons who are not licensed nurses in accordance with Chapter 4723. of the Revised Code;

Services that require the skills of a psychiatric nurse;

Visits performed for the purpose of conducting a registered nurse assessment as set forth in rule 5160-12-08 of the Administrative Code, including but not limited to, an outcome and assessment information set or any other assessment;

Registered nurse consultations as set forth in rule 5160-12-08 of the Administrative Code, including but not limited to, those performed by registered nurses for the sole purpose of directing licensed practical nurses in the performance of waiver nursing services or directing personal care aides or home health aides employed by a Medicare-certified home health agency or otherwise accredited agency;

Visits performed for the sole purpose of meeting the home care attendant service registered nurse visit requirements set forth in rules 173-39-02.24 of the Administrative Code; or

Services performed in excess of the number of hours approved pursuant to, and as specified in, the individual 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
Individual	RN/LPN
Agency	Medicare-certified HHA, an agency accredited by ACHC, CHAP or the Joint Commission or another national accrediting organization approved by CMS, and DODD certified Homemaker/Personal Care Agencies

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:

RN/LPN

Provider Qualifications

License *(specify):*

RN/LPN

Certificate *(specify):*

DODD certification standards listed in rule 5123-2-09 of the OAC.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. The term of certification is 3 years, as specified in OAC 5123-2. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

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, an agency accredited by ACHC, CHAP or the Joint Commission or another national accrediting organization approved by CMS, and DODD certified Homemaker/Personal Care Agencies

Provider Qualifications

License *(specify):*

RN/LPN

Certificate *(specify):*

DODD certification standards listed in OAC rules 5123-2-08 and 5123-9-39.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Ohio Department of Developmental Disabilities (DODD)

Frequency of Verification:

DODD has the statutory authority in section 5123.16 of the Revised Code to establish a period of recertification. The term of certification is 3 years, as specified in OAC 5123-2. Pursuant to rule 5123-2-04 HCBS Waivers: Compliance Reviews of HCBS Waiver Providers, DODD compliance reviews of certified providers shall be conducted so that each certified provider is reviewed once during the term of their certification.

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:

County boards of developmental disabilities (county boards) conduct case management services (Targeted Case Management, or TCM) through Service and Support Administrators (SSAs) who are certified or registered through the Ohio Department of Developmental Disabilities.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

No. Criminal history and/or background investigations are not required.

Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

At the time of initial certification and renewal certification, the Ohio Department of Developmental Disabilities (DODD) requests that every independent provider and every agency have a report sent to DODD as part of their application requirements. Certification will not be granted without this document, which must be sent directly from the Bureau of Criminal Identification and Investigation (BCII) to DODD. For agency employees, criminal background checks must be conducted at initial hire and at least once every 5 years.

DODD does not enroll an applicant who provides direct services to individuals with developmental disabilities as an Individual Options waiver provider until a background investigation has been satisfactorily completed.

Criminal history/background checks are conducted for all providers having direct contact with waiver participants. Background investigations follow the requirements listed in Section 5126.281 of the Ohio Revised Code and rule 5123:2-2-02of the Ohio Administrative Code (OAC).

A report is submitted by BCII directly to DODD regarding an applicant's criminal record. If the applicant who is the subject of a background investigation does not present proof that he/she has been a resident of Ohio for the five-year period immediately prior to the date of the background investigation, a request that BCII obtain information regarding the applicant's criminal record from the Federal Bureau of Investigation (FBI) shall be made. If the applicant presents proof that he/she has been a resident of Ohio for that five-year period, a request may be made that BCII include information from the FBI in its report.
An individual provider is required to report to DODD if he or she is ever formally charged with, convicted of, or pleads guilty to any of the disqualifying offenses listed or described in divisions (A)(3)(a) to (e) of section 109.572 of the Revised Code. The individual provider shall make such report, in writing, not later than fourteen calendar days after the date of such charge, conviction or guilty plea.

An agency provider shall require any employee in a direct services position to report, in writing, to the agency provider if the employee is ever formally charged with, convicted of, or plead guilty to any of the disqualifying offenses listed or described in divisions (A)(3)(a) to (e) of section 109.572 of the Revised Code not later than fourteen calendar days after the date of such charge, conviction or guilty plea.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

No. The state does not conduct abuse registry screening.

Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; 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):

At the time of initial certification and renewal certification, the Ohio Department of Developmental Disabilities (DODD) completes a registry search for each independent provider and every agency by entering the provider information on the Abuser Registry website. The results are then saved in the provider's file to confirm that this search has been completed. Certification will not be granted without this document. For agency employees, registry checks must be completed at the time of initial hire and at least every five years after.

The requirements for the Abuser Registry are contained in Sections 5123.50 through 5123.54 of the Ohio Revised Code. DODD maintains an Abuser Registry and screens applicants for Individual Options waiver positions having direct contact with waiver participants against the abuser registry. Certification as an individual waiver provider is not approved until the screening has been satisfactorily completed. Agency providers must assure that employees or contractors have been screened against the abuser registry.

Certification shall be denied to any applicant whose name appears on the abuser registry. For waiver providers who previously have been certified, DODD regulations require the revocation of all providers' certifications whose names have been placed on the registry.

Contact is also made with the Ohio Department of Health to inquire whether the Nurse Aide Registry established under section 3721.32 of the Revised Code reveals that its director has made a determination of abuse, neglect, or misappropriation of property of a resident of a long-term care facility or residential care facility by the applicant. DODD will deny certification to an applicant whose name appears on the nurse aide registry with regard to abuse, neglect or misappropriation. DODD staff are also responsible for checking the list of excluded persons and entities maintained by the Office of Inspector General in the United States Department of Health and Human Services pursuant to section 1128 of the Social Security Act. A check must be conducted of the sex offender and child-victim offender database which was established pursuant to division (A)(11) of section 2950.13 of the Revised Code; the United States general services administration system for award management database; and the database of incarcerated and supervised offenders established pursuant to section 5120.066 of the Revised Code. Agency providers are required to conduct all of these registry checks for employees or contractors.

For employees, subcontractors of the applicant, and employees of subcontractors who provide specialized services to an individual with a developmental disability as defined in division (G) of section 5123.50 of the Revised Code, the applicant shall provide to DODD written assurance that, as of the date of the application, no such persons are listed on the abuser registry established pursuant to sections 5123.50 to 5123.54 of the Revised Code.

Appendix C: Participant Services

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

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law 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: adoptive and biological parents of a minor child or spouse of an individual may serve as a direct care worker for homemaker/personal care services and waiver nursing services, as described below.

Through assessment and care planning activities, the support coordination entity determines each of the following are met:
*Services are needed from the parent of a minor child or spouse while a willing and able direct care worker/provider is sought;
*The health and safety needs of the individual may be assured through the parent of a minor child or spouse serving as a direct care worker;
*Services authorized to be provided by the parent of a minor child or spouse are determined to meet extraordinary care requirements, as determined through Ohio's Extraordinary Care Instrument (ODM Form 10372).
"Extraordinary care" refers to hands-on assistance with activities of daily living, incidental activities of daily living, and supervisory monitoring care exceeding the range of activities a parent of a minor child would ordinarily perform in the household on behalf of an individual without a disability or chronic illness of the same age, or on behalf of a spouse without a disability or chronic illness. The Extraordinary Care Instrument is an assessment tool that indicates if extraordinary criteria is met. Using a ratings cale, the assessing agency will assign one value that indicates the greatest level of support required by the individual to meet each need. All needs must be assessed. Medical documentation is not required to meet the standard of extraordinary care for any of the needs listed. Authorization requires meeting both a standard of extraordinary care and applicable provider certification requirements. The rating scale is 0- Independent or N/A, 1- requires assistive device, 2-sometimes requires physical/verbal support, and 3- always requires physical/verbal support. If the individual scores a (3) in at least 3 of the listed needs, the extraordinary care is met. Needs that are assessed include feeding assistance, respiratory/pulmonary care, turning positioning, transfer assistance, dressing, behavioral support, hair, nail and skin care, basic purchases, basic household chores, accessing transportation, cognition/decision making, seizure protocol, catheter or ostomy care, ambulation, oral hygiene, toileting, bathing, communication, basic meal preparation, laundry, accessing personal funds and medication administration.
Limitations:

Limitations:
*The parent of a minor child or spouse must be employed through an agency or as a participant directed service.
*Service is not authorized for respite purposes.
*The maximum number of hours a parent of a minor child or spouse may be authorized is forty hours, unless DODD, ODM or their designee determines additional hours are necessary to meet the health and safety needs of the individual.

Routine strategies outlined throughout the waiver application are employed to ensure permitting a legally responsible individuals to serve as a direct care worker is in the best interest of the participant. This includes increased care coordination/SSA oversight activities when this allowance is implemented.

Service payments: Routine agency billing procedures apply.
The state ensures payments are made only for services rendered through care coordination oversight and authorization, person-centered planning and routine provider oversight activities described throughout this waiver application.
A parent of a minor or spouse serving as a direct care worker is required to meet provider certification requirements for the service provided.

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 (authority granted to an individual or entity to act on behalf of an individual through the designation of authorized representative, declaration for mental health treatment, general power of attorney, representative payee, or appointment of legal custody or guardianship pursuant to a court order are prohibited from serving as a direct care worker for an individual, except as follows:

Parent of an adult individual with the following designations may serve as a direct care worker of homemaker personal care services or waiver nursing services, as an independent provider or through agency employment.
*representative payee
*designations listed below.

An adult child, grandparent, grandchild, great-grandparent, great-grand-children, brother, sister, aunt, uncle, nephew, niece, and step relations of an individual above the age of eighteen with the following designations may serve as a direct care worker of homemaker personal care services or waiver nursing services, as an independent provider or through agency employment:

*authorized representative
*declaration for mental health treatment
*general power of attorney
*healthcare (medical) power of attorney
*appointment of legal custody of a minor
*guardianship pursuant to a court order, if granted court authority to serve as a direct care worker for the individual.

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

Relatives with designated legal decision-making authority may be authorized the number of hours necessary to meet the needs determined by their person centered plan and authorized by ODM, DODD or the designee.

Relatives without legal decision-making authority as described in 5160-44-32 may receive payment for providing waiver services, in accordance with chapter 5123-9 of the Ohio administrative code.

Routine strategies outlined throughout the waiver application are employed to ensure permitting a legally responsible individuals to serve as a direct care worker is in the best interest of the participant. This includes increased care coordination/SSA oversight activities when this allowance is implemented.
Service payments: Routine agency billing procedures apply.
The state ensures payments are made only for services rendered through care coordination oversight and authorization, person-centered planning and routine provider oversight activities described throughout this waiver application.
A parent of a minor or spouse serving as a direct care worker is required to meet provider certification requirements for the service provided.

Other policy.

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The Department of Developmental Disabilities (DODD) continuously certifies applicants to be providers of Individual Options waiver services. The documents required to be certified as a waiver provider, along with information regarding the certification process, are posted on DODD's website. Prospective providers may call or email DODD for information about the requirements or assistance with the application process.

Once certified by the DODD, the Medicaid Provider application is forwarded to ODM for review and assignment of a Medicaid provider number.

County boards of developmental disabilities (county boards) also assist in the open enrollment of providers by passing along information regarding the waiver services and the provider application process to potential providers. DODD has an online Provider Certification Wizard which has streamlined the process potential providers use to become certified for waiver services.

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:
C-1: Number and percent of new independent providers that meet initial certification requirements prior to providing waiver services. Numerator: Total number of new independent providers enrolled that meet initial certification requirements prior to providing waiver services. Denominator: Total number of new independent providers enrolled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD's Provider Certification Wizard

Responsible Party for data 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:
C-4: Number and percent of agency providers that continue to meet certification requirements at recertification or review. Numerator: Number of agency providers that continue to meet certification requirements at recertification or review. Denominator: Total number of agency providers due for a re-certification or review.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD's Provider Certification Wizard

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

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(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:
C-5: Number and percent of enrolled providers for which an appropriate background and registry checks were conducted timely. Numerator: Number of enrolled providers for which an appropriate background and registry checks were conducted timely. Denominator: Total number of enrolled providers due for a background and registry checks.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD's Provider Certification Wizard

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	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:
C-3: Number and percent of independent providers that continue to meet certification requirements at recertification or review. Numerator: Number of independent providers that continue to meet certification requirements at recertification or review. Denominator: Total number of independent providers due for a re-certification or review.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD's Provider Certification Wizard

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and 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:
C-2: Number and percent of new agency providers that meet initial certification requirements prior to providing waiver services. Numerator: Number of new agency providers that meet initial certification requirements prior to providing waiver services. Denominator: Total number of new agency providers enrolled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD's Provider Certification Wizard

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

		Sample Confidence Interval =
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
C-9: Number and percent of HCBS residential settings reviewed as part of ongoing review that meet OAC 5123-9-02 requirements. Numerator: Number of HCBS residential settings reviewed that meet all requirements of OAC 5123-9-02. Denominator: Total HCBS residential settings reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Office of Provider Standards and Review (OPSR) Ongoing provider compliance reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify: Records Review - Sample selected based on regulatory review schedule and number of settings subject to OAC 5123-9-02.
	Other Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
C-10: Number and percent of HCBS non-residential settings reviewed as part of ongoing review that meet OAC 5123-9-02 requirements. Numerator: Number of HCBS non-residential settings reviewed that meet all requirements of OAC 5123-9-02. Denominator: Total HCBS non-residential settings reviewed.

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

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

		Sample Confidence Interval =
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify: Records Review - Sample selected based on regulatory review schedule and number of settings subject to OAC 5123-9-02.
	Other Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
C-11: Number and percent of reviewed residency agreements or leases which meet the specifications as required by OAC 5123-9-02. Numerator: Number of residency agreements or leases reviewed which meet all specifications as required by OAC 5123-9-02. Denominator: Total number of residency agreements or leases reviewed.

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

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

		Records Review - Sample selected based on regulatory review schedule and number of members subject to a residency agreement or lease requirement.
	Other Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance,

complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
N/A CMS acknowledged in the IO Evidence Report, that the IO waiver does not permit non-licensed/non-certified providers to deliver waiver services. This sub-assurance does not apply. At renewal, the state should indicate in the application that this sub-assurance does not applicable and a PM is not required.

Data Source (Select one):
Other
If 'Other' is selected, specify:
N/A

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

	N/A	

Data Aggregation and Analysis:

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
C-7: Number and percent of independent providers who were certified because they met training requirements. Numerator: Number of independent providers who were certified because they met training requirements. Denominator: Total number of independent providers due for a review.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD's Provider Certification Wizard

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

Data Aggregation and Analysis:

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

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

Performance Measure:
C-8: Number and percent of agency providers who were certified because they met training requirements. Numerator: Number of agency providers who were certified because they met training requirements. Denominator: Total number of agency providers due for a review.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD's Provider Certification Wizard

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

	Other Specify:	

Data Aggregation and Analysis:

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

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

Activities by ODM for assuring compliance:
ODM conducts quality briefings with the operating agency at least four times per year to review data generated through the departments' quality processes, including results of any completed targeted reviews, waiver performance measure data, and data presented by the operating agency on the oversight activities conducted by that department. This data includes but is not limited to problems detected, corrective measures taken, and how the operating agency verified, or intends to verify, that the actions were effective.
Performance Measures data reports are submitted to ODM by DODD on a quarterly basis.
The information is gathered from county board and DODD compliance activities. DODD is able to identify and address individual problems as they are discovered and provide technical assistance that may include plans of corrective action. When problems are discovered, the individual county board is notified and technical assistance is provided using e-mail, phone contact and/or letters to county board staff. When issues are noted that are systemic, DODD will provide statewide training and incorporate that corrective action into its monitoring during the next monitoring cycle.
Case Specific Resolution: During the course of any review conducted by ODM or DODD, when staff encounter a situation in which a waiver recipients health or welfare is at risk, or when case management deficiencies are identified, the staff follow a protocol to report these observations. Depending on the severity of the situation, the staff will take immediate action, coordinate intervention with providers or case managers, and report the finding to ODM managers. ODM communicates findings to DODD for further review and appropriate intervention, and with explicit variable timeframes within which a report back to ODM is expected. ODM logs and tracks all such findings and referrals to assure appropriate case-specific resolution.

b. Methods for Remediation/Fixing Individual Problems

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

Provider applicants cannot provide waiver services prior to meeting initial certification requirements. Providers are not given their DODD contract number or Medicaid Provider number until the standards of certification have been met as established in OAC 5123-2-08 and 5123-2-09. Requirements are specific to independent providers verse agency providers; all approved providers are identified in the provider database as either being an agency or independent provider. Effective dates of certification are not granted until DODD has received all documentation supporting the initial certification requirements. Requirements, including documents, for certification are currently listed by provider type on the DODD website. Provider applicants must use the online certification tool, the Provider Services Management (PSM) system to apply for certification. The application process consists of the applicant being asked a series of questions that will determine a list of required documentation based on their answers. Once the application is submitted by the applicant, it is forwarded to an electronic workflow program that is used to ensure requirements of initial and renewal certification are met.

All providers are notified within 90 days of their expiration date that they must renew their certification. They are sent a list of requirements via letter sent through the US Postal Service; this letter includes information pertaining to their expiration date and instructions as to how to proceed with certification renewal. If the provider does not meet the standards of certification to renew, the provider can no longer provide services and will not be able to bill for services provided after their expiration date. If the provider submits their application after their expiration date, a new effective date will be assigned that will align with the date that all completed documentation was received. This can result in a lapse in the certification record for the provider. If the application is submitted prior to expiration, but is incomplete, per OAC 5123-2-08 and 5123-2-09, the provider has 90 days to submit a completed application.

Providers are able to apply for certification for services under all of the DODD waivers using PCW. The services are listed within the application and the request for documentation is dependent upon the services selected. Goods and service providers are not included as DODD certified providers. Providers are only certified once the requirements of certification have been verified. Providers who do not submit documentation within the required timeframe are not denied; they are simply not certified. This includes providers who have not met the requirement for training documentation for initial and renewal certification. The DODD Office of Compliance will conduct compliance reviews to ensure anyone working for an agency in a direct service position has met any certification requirements. If they have not, citations will be issued by the Department. Reports can be accessed by DODD staff outlining the number of providers who have been certified for initial or renewal certification, the type of provider, and the services for which they have been certified.

ii. Remediation Data Aggregation

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

Responsible Party*(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*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	Continuously and Ongoing
	Other Specify: Semi-annually

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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.

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.

The budget limits are established by individual acuity scores on the Ohio Developmental Disabilities Profile (ODDP), an instrument that was standardized years ago with the involvement of waiver participants and stakeholders at the time. The analysis resulted in scoring weights that were consistent with individuals' needs and service costs also at the time. Since then, it has served as the statewide tool to assure consistency in individual funding levels for all served on the Individual Options (IO) Waiver. Funding ranges are updated and located in Ohio Administrative Code rule 5123-9-06. The ODDP is available on the website https://dodd.ohio.gov/about-us/rfp-reimbursement/ODDP%20Tool and the scored tool is to be done with the involvement of the individual.

Each enrollee's need for waiver services is evaluated using the ODDP. The ODDP is a standardized instrument used to assess the relative needs and circumstances of an individual (OAC 5123-9-06) in order to determine the amount of service needs available for a person's IO waiver services. The ODDP is submitted electronically to DODD, and the answers are electronically scored to assign a funding range. The SSA is responsible to develop a plan that corresponds to the individual's funding range, as assessed and calculated by the ODDP.

The process for determining a funding range that is linked to an individual and to other individuals with similar needs throughout the state is defined in the Ohio Administrative Code, OAC 5123-9-06 and is found on DODD's website. The rule specifically outlines the purpose of the tool and the key variables that are considered in determining the funding range, e.g. supports available to the individual, the living arrangement, medical and behavioral needs, and more. The rule requires the input of the individual and the team in the completion of the ODDP and, with consent of the individual, the team can review the completed tool to ensure its accuracy.

The entire process outlined here is available to the public and is communicated to individuals who are impacted by it. The ODDP instrument is available on the website as are the rules discussed here. Each individual's completed ODDP and resulting ranges that are linked to the individual plan is completed with the participation of the individual and is found online. Individuals may appeal any item completed on the tool if it is felt that another response for the item is more accurate.

The Service and Support Administrator (SSA) informs the individual of the assigned funding range at the time of enrollment and any time the ODDP is reviewed or updated. The SSA also ensure the individual has access to review the ODDP and other assessments used in relation to the completion of the ODDP.

The funding range applies to all services except the Adult Day Support, Vocational Habilitation, Individual Employment Support, Group Employment Support, Career Planning, and Non-Medical Transportation, Waiver Nursing and Nursing Delegation. Participant-directed homemaker/personal care services are to be included in the limitations specified for the existing homemaker/personal care services. Payment for the provider competency add on are excluded from the overall cost limitation. As an individual's situation changes, responses to the assessment tool are changed and the funding range is adjusted accordingly. Whenever an individual's funding range changes, the county board notifies them of this change.

If an individual's needs cannot be met within the annual range expected, enrollees have a right to work with their county board to develop a request for prior authorization to exceed the assigned funding range, based on a process that includes the application of statewide criteria specifically developed for waiver services.

The Prior Authorization process is as follows: The Individual Services Plan (ISP), developed in conjunction with the individual, establishes the individual's needs and matches services to address them. When the costs of waiver services identified in his/her ISP exceeds the range set by the individual's ODDP score, the individual or guardian may request from DODD that the services be authorized. To do this, the individual or guardian submits to the county board a form that lists the services that are being requested. The county board is required to submit the documentation that relates to the prior authorization request to DODD. The county board also provides a rationale for the services and costs, along with a statement of their support or lack of support for the plan. DODD's qualified intellectual disabilities professionals (QIDPs) review the documents to verify the needs, corresponding services, and costs, and then either approve or deny the proposed request. The individual or guardian is notified of their appeal rights following any determination.

Other Type of Limit. The state employs another type of limit.
Describe the limit and furnish the information specified above.

Sets of Services to Which Annual Budget Limits Are Applied:

Budget limitations that apply to Adult Day Support, Vocational Habilitation, Individual Employment Support, Group Employment Support, and Career Planning waiver services, when these services are provided separately or in combination, are provided in OAC 5123-9-19 Appendix B.(https://codes.ohio.gov/ohio-administrative-code/rule-5123-9-19).

CODB	Group A-1	Groups A	Group B	Group C
1	$14755	$14755	$26520	$44135
2	$14885	$14885	$26780	$44590
3	$15015	$15015	$27040	$45045
4	$15210	$15210	$27300	$45565
5	$15340	$15340	$27560	$45955
6	$15470	$15470	$27820	$46475
7	$15665	$15665	$28080	$46930
8	$15795	$15795	$28340	$47385

The annual service limit that is applicable to the adult day service set of Adult Day Support, Vocational Habilitation, Individual Employment Support, Group Employment Support and Career Planning Waiver services is determined by use of a projected service utilization of 260 days per year multiplied by 6.25 hours of attendance each day multiplied by four 15-minute units per hour to obtain the maximum base of 6,500 15-minute units of service that may be received per person per twelve month waiver year. The 6,500 units are then multiplied by the rate for Vocational Habilitation/Adult Day Support that corresponds to the group to which each individual would be assigned based on completion of the Acuity Assessment Instrument. The rate selected when calculating an individual's service limit will be further determined by the cost of doing business adjustment (category) that applies to the county in which the individual is anticipated to receive the preponderance of Vocational Habilitation, Adult Day Support, Individual Employment Support, Group Employment Support or Career Planning waiver services during the individual's twelve-month waiver span.

Service and Support Administrators (SSA's) employed by county boards will be assigned the responsibility to submit to the Department of Developmental Disabilities (DODD) information contained on the DODD Acuity Assessment Instrument for each waiver recipient for whom Adult Day Supports, Vocational Habilitation, Individual Employment Support, Group Employment Support and Career Planning waiver services have been authorized through the individual planning process. The SSA will be responsible to inform the waiver enrollee/guardian of the assessment score and resulting group assignment initially and at each time the assessment instrument is re-administered.

An administrative review processes internal to DODD and subject to the Ohio Department of Medicaid (ODM) oversight will be available to individuals who believe that their DODD Acuity Assessment Instrument scores and subsequent placement in Group A, A-1 and B prohibit their access to or continuation in the Vocational Habilitation or Adult Day Support, Individual Employment Support, Group Employment Support and/or Career Planning services they have selected. In no instance will the total annual budget limit approved through the administrative review exceed the published amount for Group C in the cost of doing business region in which the individual receives the preponderance of his/her adult service set.

The competency-based add-on rate only applies to routine homemaker/personal care services and not the self-directed homemaker/personal care service.

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.

Applicable services and description of settings:

Provider owned and controlled settings permissible in the waiver program include adult day services, residential and permissible non-residential settings.
Descriptions:
In the Persons Home – services are delivered in the person's home.
Shared Living – residential services are provided to the recipient in a home shared by the individual and provider. The home must be the provider's primary residence.
Licensed Facility – services provided in a licensed by DODD facility which is owned or controlled by the provider.
Non-Residential Setting (Adult Day Support and/or Vocational Habilitation) -facility based services in which the participant receives person centered services based on assessed needs in their individual service plan.

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.

County boards/local delegated administrative authorities are only permitted to authorize services in HCBS compliant settings. Ongoing monitoring by the local administrators ensures that settings continue to meet the requirements, including the need for any modifications of the requirements that are documented in the individual service plan or assessment to ensure compliance with regulation, based on the specific need of the person. If, through the monitoring process, there are questions about the setting and whether it is compliant with the setting rules, they will be referred for a special compliance review. The frequency of monitoring is determined by the support team and identified in the service plan.

These reviews ensure compliance with all HCBS Settings requirements, as well as those additional requirements for settings that are considered provider owned or controlled.

DODD will complete the following reviews:
*Certified Agency waiver providers (residential and non-residential)
*Certified Independent waiver providers (residential)
*Licensed providers (provider controlled or owned settings)
*Adult Day Support
*Employment services

Review Types
*Routine: Occurs once during each period of certification or licensure term
*Special: Can occur at any time based on any of the following information: Pertaining to the health, safety, or welfare of an individual, Complaints or allegations, Based on an MUI that may indicate failure to comply with applicable requirements.

The compliance review process includes visits to service settings and individual interviews for each recipient in the review sample. The visit assesses compliance with HCBS requirements in each setting. If deficiencies are identified, the provider will receive a written compliance report within 10 days and in turn, the provider will have 14 days to provide a Plan of Correction (POC) for each deficiency. The POC must include corrective actions and the timeline by which the corrective actions will be completed. Once the provider submits the POC, the reviewer has 20 days to approve and/or disapprove the provider's plan. The compliance reviewer will then verify that the POC has been fully implemented within 90 days of POC approval.

If the review identifies significant health and welfare concerns or an ongoing pattern of non-compliance, DODD will propose sanctions against the provider's certification. Sanctions include a suspension of admissions and/or a proposal to revoke the provider's certification.

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.
The State recognizes protection and advocacy entities are key partners in ongoing compliance by informing individuals of their right to file a complaint regarding a specific setting and/or to report directly to the State any concerns with a setting's ability to comply. Upon receiving a report by an individual or another entity, the State will initiate a formal review, as appropriate.
Using the existing complaint processes, individuals have the right to file a complaint regarding a specific setting Individuals may report complaints through their care coordination entity, long term state ombudsman and/or to report directly to the State any concerns with a setting's ability to comply. Upon receiving a report by an individual or another entity, the State will initiate a formal review, as appropriate.
Case Manager/Service and Support Administrator
The case manager/service and support administrator or waiver service coordinator also is an independent resource that the consumer can notify of any ongoing issue whether it is related to the HCBS settings rule or not. The waiver service coordinator serves as an invaluable resource for the HCBS participant to help with authorizing paid supports, locating and informing the HCBS participant about community related resources, acting as support when there are provider related concerns including the HCBS settings rule, and just and a trusted 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 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:

Individual Service Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(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:

Service and support administrators (SSA) are responsible for service plan development and revision (ORC 5126.15 and rule 5123-4-02 of the Administrative Code). An SSA must be, regardless of title, employed by or under subcontract with a county board of developmental disabilities (county board) to perform the functions of service and support administration, and must hold the appropriate certification in accordance with rule 5123-5-02 of the Administrative Code. The minimum qualifications for certification are an associate degree from a college or university and the successful completion of following:

An orientation program of at least eight hours that addresses: Organizational background of the county board or contracting entity. Components of quality care for individuals served including Person-centered philosophy. Health and safety. Positive behavior support. Services that comprise service and support administration.

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:*

County boards of developmental disabilities (county boards) currently serve as the single provider of case management through Ohio's Targeted Case Management (TCM) services.

County boards of developmental disabilities (county boards) receive payments for waiver services provided only when no other qualified or available provider is found for the purposes of service provisioning: Non-Medical transportation (token/voucher) and Community Transition.

So long as a county board of developmental disabilities is a provider of home and community-based services, the county board shall ensure administrative separation between county board staff doing assessments and service planning and county board staff delivering direct services.
Case management shall not be assigned responsibilities for implementing other services for individuals and shall not be employed by or serve in other administrative functions for any other entity that provides programs or services to individuals with developmental disabilities in accordance with section 5126.15 of the Ohio Revised Code.

Personnel providing TCM shall inform individuals, at least annually, of the right to choose from among all qualified providers and shall provide assistance, as needed, with the provider selection process in accordance with section Ohio Administrative Code rule 5123-9-11 section (C)(1): The county board will notify each individual at the time of enrollment in a home and community-based services waiver and at least annually thereafter, of the individual's right to choose any qualified and willing provider of home and community-based services. The notification will specify that:
(a) The individual may choose agency providers, independent providers, or a combination of agency providers and independent providers;
(b) The individual may choose providers from all qualified and willing providers available statewide and is not limited to those currently providing services in a given county;
(c) When a provider offers more than one service, the individual may choose to receive only one of the offered services from that provider.
(d) The individual may choose to receive services from a different provider at any time;
(e) An individual choosing to receive homemaker/personal care in a licensed residential facility is choosing both the place of residence and the homemaker/personal care provider, but maintains free choice of providers for all other home and community-based services and the right to move to another setting at any time if a new homemaker/personal care provider is desired; and
(f) The service and support administrator will assist the individual with the provider selection process if the individual requests assistance.

Additionally, as part of service plan development, the person centered planning process requires the CBDD to provide the Choice of Provider fact sheet to the individual, as well as due process rights, complaint filing information and other important safeguards. The individual or their authorized rep review the safeguards and acknowledge by checking the box and check attesting they received the information (or it was explained to them).

Individuals who wish to appeal a decision related to their HCBS services may request a state hearing in accordance with section 5101.35 of the Revised Code and Chapters 5101:6-1 to 5101:6-9 of the Administrative Code. In addition to this oversight, the DODD compliance team reviews individual support plans to ensure individuals rights are explained and they are acknowledging through the person centered planning process.

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.

Services and supports are planned and implemented in accordance with each individual's needs, expressed preferences, and decisions concerning his/her life in the community. To that end, individuals participate in the development of their service plans and plans of care and choose the providers from whom they would like to receive services. Those providers may be traditional agency providers or non-agency providers approved by the Ohio Department of Medicaid (ODM), including non-legally responsible family members.

Each individual receives information and support from the service and support administrator to direct and be actively engaged in the service plan development process (OAC 5123-4-02). The Department of Developmental Disabilities (DODD) website publishes a variety of handbooks and brochures to assist individuals and family members to understand home and community-based services (HCBS) waivers and the service planning process. Services and supports are planned and implemented in accordance with each individual's needs, expressed preferences, and decisions concerning his/her life in the community. available handbooks and brochures, DODD

The participant’s authority to determine who is included in the service planning process is also specified in OAC 5123-4-02, Service and Support Administration.

Additionally, OAC 5123-4-02 states that an individual shall be responsible for making all decisions regarding the provision of services, and that even individuals with guardians have the right to participate in the decisions that affect their lives. The rule also requires that the service planning process occurs with the active participation of the individual to be served and other persons selected by him/her; that the individual services plan (ISP) shall be reviewed and/or revised at the request of the individual; and that the individual will receive a complete copy of the ISP.

Individuals have the right to request a state hearing anytime they disagree with an action that has been taken by the county board, DODD, or ODM.
Additionally, an Ohio Individual Service Plan plain language document is available along with trainings offered on the website. The planning process and team process are reviewed in the posted material. In addition, county boards of developmental disabilities have a requirement to promote advocacy for and by individuals served. The state of Ohio has several advocacy organizations that also provided in person and virtual training to people with developmental disabilities about service plan development.

In addition to handbooks and brochures provided on services and supports, DODD offers on-going support through forums, training series, social media and a dedicated family website. Toolkits and plain language resources have been developed for varying subjects including advocacy and understanding services, self-determination- Ohio Family Network, Ohio Rights, Essential elements of a person centered plan, charting the life course, DD services toolkit, among many others. Specifically, the Ohio Individual Service Plan plain language document and the trainings are offered on the website on a continuing basis. The planning process and team process are reviewed in the posted material. In addition, county boards of developmental disabilities have a requirement to promote advocacy for and by individuals served. The state of Ohio has several advocacy organizations that also provided in person and virtual training to people with developmental disabilities about service plan development. DODD ensures this education and information is provided by county boards through the Accreditation review process.

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):

The service and support administrator (SSA) is responsible to develop and revise the ISP and to ensure that this process occurs with the active participation of the individual to be served, the guardian of the individual, as applicable, other persons selected by the individual, and the provider(s) selected by the individual. The SSA is also responsible to ensure the ISP addresses the results of the assessment process and results from service monitoring, that the plan focuses on the individual's strengths, interests and talents; and that the plan integrates all services and supports, including natural supports and those funded through state plan or other resources, available to meet the needs and desired outcomes of the individual. The service and support administrator is responsible to inform the individual of all the services available under the waiver and what the rates are for those services. Staff who are responsible for writing an individual's plan do not provide any direct services to the individual. The Service and Support Ohio Revised Code (ORC) 5126.15 prohibits direct service to individuals by SSAs, and DODD compliance reviews verify that entities responsible for plan development do not provide services to individuals.

Input from the individual, the individual's guardian, other advocates, and team members determines the types of assessments that are included in the assessment process. Assessments and evaluations by certified and/or licensed professionals shall be completed as dictated by the needs of the individual. Assessments shall also include evaluation of the individual's likes, dislikes, priorities, and desired outcomes, as well as what is important to and for the individual, including skill development, health, safety, and welfare needs, as applicable.

The SSA is responsible for developing a service plan that corresponds to the individual's funding range, as assessed and calculated by the standardized Ohio Developmental Disabilities Profile (ODDP). If a service plan that meets the individual's health and welfare needs cannot be developed within the individual's ODDP funding range, then the SSA is required to work with the individual to obtain prior authorization for a service plan that will meet his/her needs.

The ISP shall include services and supports that assist the individual to engage in meaningful, productive activities and develop community connections. All services and activities indicated shall include the provider type, the frequency, payment rates, and the funding source; and specify how services will be coordinated among providers and across all settings for the individual. The ISP is to be reviewed and, as appropriate, revised at the request of the of the individual or a member of the individual's team; whenever the individual's assessed needs, circumstances or status changes; or as a result of ongoing monitoring of ISP implementation, quality assurance reviews, and/or identified trends and patterns of unusual incidents or major unusual incidents. The SSA shall convene an ISP meeting within ten working days of a request from an individual for a review of the ISP; however, if there is an urgent need or an emergency that needs to be addressed, an ISP team meeting would be held immediately. At a minimum, all service plans are updated annually. Temporary, interim service plans are not utilized prior to service plan initiation.

Back-up providers are identified by the individual and their ISP team and are named in the individual's ISP as such. On those occasions when the primary provider is not able to provide services, the primary provider must notify the back-up provider per the process identified in the individual's ISP. If the back-up provider cannot be reached, the primary provider will notify the SSA, who will make arrangements for coverage so that the individual is not left without needed services.

The service and support administrator is responsible to ensure that services are effectively coordinated by facilitating communication with the individual and among providers across all settings and systems. Such communication includes ISP revisions; relocation plans of the individual; changes in individual status that result in suspension or disenrollment from services; and coordination activities to ensure that services are provided to individuals in accordance with their ISPs and desired outcomes. The SSA also ensures the process
includes facilitating effective communication and coordination among the individual and members of the team by ensuring that the individual and each member of the team has a copy of the current individual service plan unless otherwise directed by the individual, the individual's guardian or the adult whom the individual has identified, as applicable. Ohio Administrative Code (OAC) 5123-4-02, includes the requirement for providers to sign the plan and for copies to be made available to providers at least 15 days in advance of implementation, unless extenuating circumstances make the 15-day advance copy impractical and the individual and providers agree to a delay.

As a part of the service plan development, the Ohio ISP service planning template requires the individual and/or their guardian to review and sign off on the ISP. Per 5123-4-02 section (b)(f), "verify by signature and date that prior to implementation each individual service plan:
(i) indicates the provider, frequency, and funding source for each service and support; and
(ii) Specifies which provider will deliver each service or support across all settings".

The service and support administrator is responsible to monitor the implementation of the ISP in order to verify the health, safety and welfare of the individual; consistent implementation of services; achievement of the desired outcomes for the individual as stated in the ISP; and that services received are those reflected in the ISP. This monitoring includes, but is not limited to, behavior support plan implementation; emergency intervention; identified trends and patterns of unusual incidents and major unusual incidents and the development and implementation of prevention and/or risk management plans; results of quality assurance reviews; and other individual needs determined by the assessment process. (OAC 5123-4-02)

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The Service and Support Administrator (SSA) is required to coordinate assessments after the initial request for services and at least annually thereafter to identify what is important for the individual to maintain health and welfare, as well as known and likely risks. The SSA is also required to review and revise the individual service plan (ISP) if the individual's assessed needs change, as a result of the continuous review process, or upon identification of trends and patterns of unusual or major unusual incidents. If significant risks are identified, a formal risk assessment may be requested. The results of the risk assessment would be identified and needs would be addressed through person centered planning. The team, with active participation of the individual, would balance what is important to and important for the individual.

Certification requirements for independent and agency providers of homemaker/personal care services specify that a provider may only arrange for substitute coverage for an individual from the list of certified providers identified in the ISP and that the provider must notify the individual or legally responsible person in the event that substitute coverage of services is necessary. Several types of back-up plans may be used. In some cases a natural support could be utilized as a back-up. In other cases, other certified waiver providers would serve as a back-up provider. The team identifies possible back-up options and tailors the service plan to meet the needs of the individual.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The Department of Developmental Disabilities (DODD) ensures individuals have Free Choice of Provider through interviews and documentation reviews conducted during the accreditation review process. In accordance with Ohio Administrative Code (OAC) 5123-9-11 DODD assures the free choice of provider processes are adhered to and emphasize the right of individuals to choose any qualified provider of home and community-based services (HCBS).

DODD maintains a current list of all qualified providers on its website. Annually county boards of developmental disabilities (county boards) are required to provide to all individuals enrolled on the waiver a description of the individual's right to choose any qualified provider from all those available statewide; the procedures that Service and Support Administrators (SSAs) will follow to assist individuals in the selection of providers of home and community-based services; and a description of the information available on the website and instructions for accessing this information.

When an individual chooses a qualified provider who is willing to provide services to him/her, the SSA assists the individual in making arrangements to initiate services with the chosen provider.

If an individual requires assistance to choose qualified providers, the county board informs the individual of the list of qualified providers available on the DODD website; assists the individual to access the website information, if needed; assists the individual to obtain outcomes of past monitoring reviews of services provided by the qualified provider(s) whom the individuals wishes to consider, if requested, and contacts the preliminary provider(s) selected by the individual to determine the provider's interest in providing services to the individual, unless the individuals wishes to contact the provider(s) directly.
To the extent that the individual requests assistance in the provider choice selection process, the SSA follows the Provider Choice Process approved by DODD and Ohio Department of Medicaid (ODM) to facilitate communication, meetings, and information sharing between the individuals and qualified providers until the individual has selected a qualified provider. (OAC 5123-9-11)

The Free Choice of Provider rule requires that county boards annually provide consumers with information regarding the availability of alternate providers and how to access the list of all providers on the DODD website. This may be done at the service plan review for each person and/or can be a mass mailing to all individuals on an annual basis. Throughout the year communication between the SSA and individual would address this information as appropriate following the process specified in the Free Choice of Provider rule (OAC 5123-9-11). ODM ensures this during reviews and hearing requests and DODD ensures this as part of the accreditation review process. In addition, if either department receives a complaint that this is not occurring, it can be reviewed on a case-by-case basis.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Service and Support Administrators (SSA) develop services plans in accordance with OAC 5123-4-02. Changes to plans that result in a decrease in services or changes that result in an increase in the cost of services within the individual's funding range are approved by the service and support administrator (SSA). Changes to plans that result in an increase in the cost of an individual's services in excess of their funding range are approved by the Department of Developmental Disabilities (DODD). In addition, the Ohio Department of Medicaid (ODM) monitors service planning activity through the quality performance measures, as well as periodic reviews. ODM also retains the right to review and modify service plans at any time.

The single State Medicaid Agency (ODM) assures the compliant performance of this waiver by: delegating specific responsibilities to the Operating Agency (DODD) through an interagency agreement; managing Medicaid provider agreements; establishing general Medicaid rules; approving the Operating Agency's program-specific rules related to Medicaid requirements; processing claims for federal reimbursement, conducting audits; conducting post-payment review of Medicaid claims; monitoring the compliance and effectiveness of the Operating Agency's operations; leading the development of quality improvement plans; and facilitating interagency data-sharing and collaboration. If ODM identifies a need to require modification of a person-centered service plan, ODM works collaboratively with DODD to ensure identified modifications are made and education has been provided to their delegate as identified as needed.

Responsibilities delegated to the Operating Agency include: assuring compliant and effective case management for applicants and waiver participants by county boards of developmental disabilities; managing a system for participant protection from harm; certifying particular types of waiver service providers; assuring compliance of non-licensed providers; assuring that paid claims are for services authorized in individual service plans; setting program standards/expectations; monitoring and evaluating local administration of the waiver; providing technical assistance; facilitating continuous quality improvement in the waiver's local administration; and more generally, ensuring that all waiver assurances are addressed and met for all waiver participants. These requirements are articulated in an interagency agreement which is reviewed and re-negotiated at least every two years.
Requirements to comply with federal assurances are also codified in state statute and administrative rules and clarified in procedure manuals. While some rules and guidelines apply narrowly to specific programs administered by the operating agency, other rules promulgated by ODM authorize those rules or guidelines, establish overarching standards for Medicaid programs, and further establish the authority and responsibility of ODM to assure the federal compliance of all Medicaid programs.

Participants can request a State Hearing regarding plans of care and ODM has general authority to provide oversight of the Operating Agency actions regarding the waiver, which includes plans of care.

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 service plans are maintained by the local County Board of Developmental Disabilities and are available upon request.

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 Service and Support Administrator (SSA) is responsible for monitoring the implementation of the service plan in accordance with OAC 5123-4-02 in order to verify the health, safety and welfare of the individual; consistent implementation of services; achievement of the desired outcomes for the individual as stated in the service plan; and individual's service plan is reviewed at least annually and more often should the needs of the individual change. This on-going monitoring is tailored to the individual and occurs through regular interaction with the individual and his or her provider(s). The scope, type, and frequency of reviews are specified in the individual service plan (ISP).

The Department of Developmental Disabilities (DODD) monitors service plan implementation through the provider compliance and accreditation review processes. Reviewing service plan documentation and the corresponding service plans is one component of the accreditation and provider compliance review processes conducted by DODD field review staff.

Reviewing service plans and the monitoring activities of SSAs is one component of the accreditation review process. Accreditation reviews are scheduled at least once every three years based on the term of the county board's accreditation award. A county board may be accredited for one to three years based on the outcome of their review.

Provider compliance reviews are scheduled at least once every three years for each provider who has actively billed during the last calendar year and is providing services in an unlicensed setting. Special reviews for each review process are conducted based on requests and/or complaints received from individuals and family members, advocates, other stakeholders, and concerned citizens. County boards of developmental disabilities (county boards) cannot complete compliance reviews of day services while providing day services. This function can only be performed by DODD.

b. Monitoring 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:
D-1: Number and percent of participants whose service plans address their assessed needs, including health and safety risk factors, and personal goals. Numerator: Number of participants whose service plans address their assessed needs, including health and safety risk factors, and personal goals. Denominator: Total number of participants service plans reviewed.

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

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

	Continuously and Ongoing	**Other** Specify: Records Review - Sample selected based on regulatory review schedule & number of members receiving services through that provider
	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.

Performance Measure:
D-2: Number and percent of service plans that were developed according to policies and procedures as described in the approved waiver. Numerator: Number of service plans that were developed according to policies and procedures as described in the approved waiver. Denominator: Total number of participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

		Records Review-Sample selected based on regulatory review schedule and number of members receiving services through that provider
	Other Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-assurance: 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:
D-3: Number and percent of service plans reviewed that were updated at least annually. Numerator: Number of service plans reviewed that were updated at least annually. Denominator: Total number of service plans reviewed that an annual update were due.

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

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

		Records Review - Sample selected based on regulatory review schedule & number of members receiving services through that provider
	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:

D-4: Number and percent of service plans reviewed that were updated when the participant's needs changed. Numerator: Number of service plans reviewed that were updated when the participant's needs changed. Denominator: Total number of service plan reviewed for whom participants experienced a change in need.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify: Records Review - Sample selected based on regulatory review schedule & number of members receiving services through that provider
	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: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
D-5: Number and percent of participants reviewed who received services in the type, scope, amount, duration and frequency specified in the service plan. Numerator: Number of participants reviewed who received services in the type, scope, amount, duration and frequency specified in the service plan. Denominator: Total number of participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify: Records Review - Sample selected based on regulatory review schedule & number of members receiving services through that provider
	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:

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:
D-6: Number and percent of participants notified of their rights to choose among waiver services. Numerator: Number of participants notified of their rights to choose among waiver services. Denominator: Total number of participants reviewed.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
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: Participants Interview - Sample selected based on regulatory review schedule & number of members receiving services through that provider
	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:
D-7: Number and percent of participants notified of their rights to choose among waiver providers. Numerator: Number of participants notified of their rights to choose among waiver providers. Denominator: Total number of participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

		Participants Interview - Sample selected based on regulatory review schedule & number of members receiving services through that provider
	Other Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

It is the responsibility of the Service and Support Administrator (SSA) to ensure that the individual service plan is compiled correctly and timely. During the DODD regulatory review process in the areas of Service Plan Development and Service Plan Implementation the following are reviewed:
1) the service plan meets the assessed needs and the wants of the waiver recipient;
2) it was developed within ten days of the waiver recipient's enrollment date;
3) it is developed according to the required processes;
4) it is developed utilizing the correct forms;
5) it is updated at least annually;
6) it updated when the needs of the waiver recipient change; and
7) the recipient receives services in the type, scope, amount, duration, and frequency identified in the service plan.

When non-compliance in an area is identified, a citation is issued to the county board and the county board will be required to submit a plan of correction by the specified due date. Verification of the plan of correction will be done to ensure that the plan of correction has been implemented to correct the area of non-compliance. When issues are noted that are systemic, DODD will provide statewide training and additional technical assistance and monitor for improvement during subsequent monitoring cycles.
During the DODD regulatory review process the waiver recipient's SSA is asked to complete a questionnaire which asks for copies of the Freedom of Choice and the Freedom Choice of Provider forms. When non-compliance in this area is identified, a citation is issued to the county board. The county board will be required to submit a plan of correction by the specified due date. Verification of the plan of correction will be done to ensure that the plan of correction has been implemented to correct the area of non-compliance. When issues are noted that are systemic, DODD will provide statewide training and additional technical assistance and monitor for improvement during subsequent monitoring cycles.

ii. Remediation Data Aggregation

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

Responsible Party*(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):*
	Semi-annually

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

Yes

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. 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.

This waiver includes many opportunities for participants to control and manage his or her supports and services by allowing the participant to:

• Develop a person-centered plan that ensures health and welfare (with assistance from the Service and Supports Administrator (SSA)
• Negotiate rates within a range for applicable services
• Serve as the employer of record
• Recruit, hire, and manage providers
• Establish work schedules
• Train and supervise providers
• Discharge providers when necessary
• Participate in the development and implementation of a backup/emergency plan

Individuals who require homemaker/personal care services or transportation may elect to direct those services by choosing participant-directed homemaker/personal care and/or participant directed transportation through his/her person-centered planning process. Each person's SSA is responsible for sharing this option with individuals and providing information necessary to support individuals with making an informed choice regarding engaging in participant-direction.

The entities involved in supporting participant direction include any representative designated by the individual, the individual's SSA and the financial management service.
Appendix E-1f specifies that an individual may choose a legal or non-legal representative to direct waiver services. Unless otherwise limited by the individual, the non-legal representative may exercise direction of the individual services plan (ISP), selection of residence and providers, and negotiation of rates.

Appendix E-1e identifies the role of the SSA in sharing information to inform individuals of the rights and responsibilities associated with choosing participant-directed services.

Appendix E-1iii identifies the scope of supports provided by the financial management services (FMS), including verifying support worker citizenship status collecting/processing timesheets, processing payroll, disbursing funds for the payment of participant-directed services, and providing periodic reports of expenditures.

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

Individuals who require homemaker/personal care or transportation services have the opportunity to direct that service by choosing participant-directed homemaker/personal care or self-directed transportation services.

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.

Training materials created as a means to inform the participant about the rights, responsibilities and services available under this waiver. This information is available on the Department of Developmental Disabilities' (DODD's) website and will be given to the participant by the service and support administrator (SSA) prior to selection of participant-directed homemaker/personal care services to ensure the participant understands the responsibilities associated with participant-direction. This information will also be revisited with the participant by the SSA at least annually when the individual services plan (ISP) is reviewed and revised.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

The state does not provide for the direction of waiver services by a representative.

The state provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: *(check each that applies)*:

Waiver services may be directed by a legal representative of the participant.

Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The participant who wishes to designate a non-legal representative/designee would do so by signing a form. A power of attorney may be used for this. Unless otherwise limited by the participant, the non-legal representative/designee would have direction over the individual services plan (ISP), selection of providers, and negotiation of rates. If the participant objects to a decision made by the non-legal representative/designee, the participant's decision prevails. The participant may revoke the designation at any time, and the revocation should be in writing.

The non-legal representative/designee cannot be a provider, nor can they be employed by a county board, or a provider, or a contractor of either. The individual services plan (ISP) process, along with the involvement of the Service and Support Administrator (SSA), will provide the mechanism for ensuring decisions are made in the best interests of the participant. Safeguards include the participation and watchfulness of the SSA as would be expected in their roles.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Participant-Directed Homemaker/Personal Care		
Transportation		

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

Yes. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

Governmental entities

Private entities

No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

FMS are covered as the waiver service specified in Appendix C-1/C-3

The waiver service entitled:

FMS are provided as an administrative activity.

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The entity who provides the financial management services (FMS) service is a statewide FMS vendor that was selected via a competitive bidding request for proposals (RFPs) process which the Department of Developmental Disabilities participated in.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The Financial Management Services (FMS) vendor will be paid as monthly fee per participants as part of their contract with the state.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

Assist participant in verifying support worker citizenship status

Collect and process timesheets of support workers

Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

Other

Specify:

Supports furnished when the participant exercises budget authority:

Maintain a separate account for each participant's participant-directed budget

Track and report participant funds, disbursements and the balance of participant funds

Process and pay invoices for goods and services approved in the service plan

Provide participant with periodic reports of expenditures and the status of the participant-directed budget

Other services and supports

Specify:

Additional functions/activities:

Execute and hold Medicaid provider agreements as authorized under a written agreement with the

Medicaid agency

Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency

Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget

Other

Specify:

iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

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

(DODD) monitors and assesses the performance of the FMS in the following ways:

Annual reviews conducted by DODD Audit staff or by a contract with an audit agency that review a representative sample of participant files including all fiscal and financial records.

Expenditures are reviewed for being allowed under the waiver and Ohio Administrative Code (OAC), and whether expenditures are accurately and appropriately assigned and reported.

All expenditures are reported monthly to DODD from the FMS. DODD staff identifies inconsistencies based on information including utilization, individual budgets, expenditures, dates of service, waiver enrollment date and then follow up with FMS staff to see correction of errors.

The FMS will be required by contract to comply with applicable audit requirements and responsibilities of the Office of Management and Budget (OMB) Circular A-133.

On a quarterly basis, DODD will review the timeliness of processing payroll and payment of other invoices by the FMS.

Periodically, DODD will randomly select a number of provider files maintained by the FMS to verify qualifications of these providers.

At the end of the first year, DODD will review all systems and practices to confirm compliance with the contract and Medicaid regulations.

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:

The waiver participant's Service and Supports Administrator (SSA) and the Financial Management Services (FMS) entity are responsible for supporting the waiver individual in exercising employer authority under the waiver.

The information and assistance supports are case management activities of the county board of developmental disabilities (county board) SSA and the State contracts with an FMS vendor to furnish the services statewide.

The SSA provides the support to the participant in gaining knowledge of the responsibilities of self-direction, hiring and training their direct service workers, developing the person-centered service plans, and the associated service budgets.

The SSA provides support to participant through education and training sessions with the participant/authorized representative prior to waiver enrollment.

The FMS provides support to the participant/representative through the provision of a participant's reference manual for support with the duties of being the employer of record. The reference manual provides information on hiring, firing, and training workers. It will also contain forms to assist the participant with tracking worker's time sheets.

The FMS agency provides support to the participant through assistance with completion of IRS and State workers compensation forms, and performance of payroll functions.

The oversight of the participant-directed service delivery method is the shared responsibility of Department of Developmental Disabilities and the Ohio Department of Medicaid.

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
Individual Employment Support	
Remote Supports	
Specialized Medical Equipment and Supplies	
Social Work	
Habilitation - Adult Day Support	
Interpreter	
Money Management	
Participant-Directed Homemaker/Personal Care	
Waiver Nursing Delegation	
Community Transition Service	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Non-Medical Transportation	
Health Care Assessment	
Community Respite	
Residential Respite	
Environmental Accessibility Adaptations	
Career Planning	
Habilitation - Vocational Habilitation	
Assistive Technology	
Transportation	
Nutrition	
Waiver Nursing	
Homemaker/Personal Care - Daily Billing Unit	
Group Employment Support	
Homemaker/Personal Care	
Shared Living	
Home Delivered Meals	

Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

No. Arrangements have not been made for independent advocacy.

Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

If a participant chooses to voluntarily terminate self-directed services, the Service and Support Administrator (SSA) will assist the participant in order to responsibly transfer the participant to traditional community-based services and the individual and their SSA will devise and implement a transition plan that will assure the individual's health and welfare is not put in jeopardy if an individual decides they no longer want to direct their services.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

If the participant’s health and welfare can no longer be assured, the participant may be involuntarily terminated from self-directed services. The Service and Support Administrator (SSA) will assist the participant in order to responsibly transfer the participant to traditional community-based services.

When a participant is involuntarily terminated from the use of participant-direction, they will be offered fair hearing rights and provided with an explanation of how to access these rights.

The SSA is required to implement a transition plan in the case of an individual’s involuntary termination of participant direction.

Appendix E: Participant Direction of Services

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		1708
Year 2		1708
Year 3		1708
Year 4		1708
Year 5		1708

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

The contracted FMS entity may serve as the Employer of Record in a Co-Employer status if the individual chooses them. The FMS entity's qualifications will be detailed in the requirements of the contract that the FMS holds with the State.

Agencies with Choice may also serve as the Employer of Record in a Co-Employer arrangement. In those instances, the agencies must meet the qualifications for the waiver service they are certified to provide.

In alignment with all participant directed services, monitoring and oversite provided by the local county board and DODD Provider Compliance ensures compliance with rules and regulations of self-direction. SSA's, Support Brokers, authorized representatives are responsible for supporting the participant is the managing employer and the Employer of Record operates in accordance with the participant's preferences.

Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

Recruit staff

Refer staff to agency for hiring (co-employer)

Select staff from worker registry

Hire staff common law employer

Verify staff qualifications

Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

Provider applicants incur the expenses of the background (BCII) check.

Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Determine staff duties consistent with the service specifications in Appendix C-1/C-3.

Determine staff wages and benefits subject to state limits

Schedule staff

Orient and instruct staff in duties

Supervise staff

Evaluate staff performance

Verify time worked by staff and approve time sheets

Discharge staff (common law employer)

Discharge staff from providing services (co-employer)

Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

Reallocate funds among services included in the budget

Determine the amount paid for services within the state's established limits

Substitute service providers

Schedule the provision of services

Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3

Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3

Identify service providers and refer for provider enrollment

Authorize payment for waiver goods and services

Review and approve provider invoices for services rendered

Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

This waiver includes many opportunities for participants to control and manage his or her supports and services by allowing the participant to:
- Develop a person-centered plan that ensures health and welfare (with assistance from the Service and Supports Administrator (SSA)
- Negotiate rates within a range for applicable services
- Serve as the employer of record
- Recruit, hire, and manage providers
- Establish work schedules
- Train and supervise providers
- Discharge providers when necessary
- Participate in the development and implementation of a backup/emergency plan

Individuals who require one or more of the self-directed services may elect to direct that service by choosing participant- direction through his/her person-centered planning process. Each person's service and support administrator is responsible for sharing this option with individuals and providing information necessary to support individuals with making an informed choice regarding engaging in participant-direction.

The entities involved in supporting participant direction include any representative designated by the individual, the individual's SSA and the financial management service.

Appendix E-1-f specifies that an individual may choose a legal or non-legal representative to direct waiver services. Unless otherwise limited by the individual, the non-legal representative may exercise direction of the individual service plan (ISP), selection of residence and providers, and negotiation of rates.

Appendix E-1-e identifies the role of the SSA in sharing information to inform individuals of the rights and responsibilities associated with choosing participant-directed services.

Appendix E-1-i identifies the scope of supports provided by the financial management service (FMS), including verifying support worker citizenship status collecting/processing timesheets, processing payroll, disbursing funds for the payment of participant-directed services, and providing periodic reports of expenditures.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The participant and their team will devise the participant's Individual Budget based on the services listed in the individual support plan (ISP). Participants will be notified of the cost limitations associated with the waiver by the service and support administrator (SSA) prior to enrolling on the waiver.

If an individual wants to adjust their plan or budget, the individual their team will contact and set up a meeting with the SSA to discuss this request for an adjustment. If the request for an adjustment is reasonable, is within the established cost limitations for the waiver, and does not jeopardize the individual's health and welfare, the SSA should approve the request, then notify the Financial Management Service (FMS) about the changes.

Determining the reasonableness of a participant's request for a budget adjustment will take into consideration the extent to which the request addresses the participant's needs, goals and preferences as described in the service plan and strategies identified there to mitigate risks to the participant.

DODD's Service and Support Administration rule (OAC 5123-4-02) requires that an individual must be provide with written notification and an explanation of the individual's right to a Medicaid fair hearing if the ISP process results in a recommendation for the approval, reduction, denial, or termination of a home and community-based (HCBS) waiver service or Medicaid case management service. The participant's request for a budget adjustment would be predicated on an underlying service request, the denial of which would trigger the hearing rights referenced in the rule.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

Modifications to the participant directed budget must be preceded by a change in the service plan.

The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The service and support administrator (SSA) and the individual’s teamwork with the individual to ensure that the budget is utilized according to the Individual Service Plan (ISP). When problems are identified such as underutilization, SSA works together with the individual to find solutions and make changes as necessary.

In addition, the Financial Management Service (FMS) entity, based on the participant’s individual budget, pays expenditures that are in accordance with the authorized budget, and provides the participant, the county board of developmental disabilities, and the Department of Developmental Disabilities (DODD) with a monthly report of expenditures and budget status to ensure that the budget is not depleted prematurely. The FMS entity will not submit claims for reimbursement if they are not included in the ISP.

It is the FMS' responsibility to monitor and track the budget; provide reports to the individual, SSA, and DODD; and to identify and provide notification of any problems that occur. It is the SSA's responsibility to convene a meeting with the individual and their team to address any problems identified by the FMS.

It is the FMS' responsibility to make adjustments in a timely manner, and it is the responsibility of DODD to ensure that this occurs as part of its contract with the FMS.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

At the time of application for benefits, the individual or authorized representative is informed, in writing of the right to a state hearing, of the method by which a state hearing may be requested and that the case may be presented by an authorized representative, such as legal counsel, relative, friend, or other spokesperson. Individuals receive an “Explanation of State Hearing Procedures,” JFS 04059 (rev 1/2015) to provide this notice in accordance with Ohio Administrative Code (OAC) 5101:6-2-01.

Applicants for Individual Options waiver enrollment and waiver enrollees who are affected by any decision made to approve, reduce, deny or terminate enrollment or to deny the choice of a qualified and willing provider or to change the level and/or type of waiver service delivered, including any changes made to the individual service plan, shall be afforded Medicaid due process. All waiver enrollees receive prior notice for any adverse action proposed. This notice includes the right to a state hearing and an explanation of the hearing procedures and is either generated manually by county boards or electronically by county departments of job and family services. Each agency retains copies of notices issued.

The individual must call or write their local county agency or write the Ohio Department of Job and Family Services (ODJFS), Office of Legal Services, Bureau of State Hearings (BSH). A hearing request must be received within 90 days of the mailing date of the notice of action.

Pursuant to OAC 5101:6-6-02, DODD assures participation through an agency representative (DODD and/or county board of developmental disabilities (county board)) at hearings requested by applicants, enrollees and disenrolled individuals of the Individual Options waiver.

Individuals who request hearings are notified about the action to be taken regarding the hearing request and are informed of the date, time, and location of the hearing at least ten days in advance. Services proposed to be reduced or terminated must be continued at the same level when the hearing is requested within fifteen days of the mailing date on the notice. Hearing decisions are rendered no later than 90 days after the hearing request. When agency compliance with a hearing decision is required, it must be acted upon within fifteen calendar days of the decision or within 90 days of request for hearing, whichever is first.

Individuals are informed in writing of the hearing decision and are notified of the right to request an administrative appeal if they disagree with the hearing decision. The administrative appeal process is defined in OAC 5101:6-8-01.

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.

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:

The Department of Developmental Disabilities

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 Department of Developmental Disabilities (DODD) receives and acts upon complaints in a variety of ways. DODD's Major Unusual Incident (MUI)/Registry Unit receives complaints through a toll-free number for reporting abuse/neglect and other MUIs. Complaints are also received via email and U.S. mail. Each complaint received is logged and acted upon the same or next day and followed up until the issue is resolved. Some calls result in MUIs while other calls are assorted complaints which are referred to other department staff, county boards, or outside entities such as the Department of Health. These include medical, behavior, environmental and other miscellaneous subjects. Complaints are resolved by MUI/Registry unit managers when a MUI has occurred, other complaints are resolved by the appropriate DODD unit managers.

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

DODD Office Compliance will follow up on any complaints and/or compliance issues regarding county boards of developmental disabilities (county boards) or certified waiver providers. This could result in citations being issued. Citations require a plan of correction that must be approved by DODD. Individuals may also contact their Service and Support Administrator (SSA) to voice any concerns or complaints. Each county board is required to have a complaint resolution process.

None of the above complaint resolution processes may be used in place of or to delay a Medicaid state hearing. As an alternative dispute resolution process that does not involve a decision by the SSA or county board, individuals who wish to appeal a decision related to their home and community-based services may request a state hearing in accordance with Ohio Revised Code Section 5101.35 and Ohio Administrative Code (OAC) Chapters 5101:6-1 to 5101:6-9.

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, and responding to, investigation and remediation of all critical incidents. The State has identified and established reporting standards for reportable incidents which do not meet the criteria for a critical incident. The State has defined the responsibilities of all incident reporters, case management entities and investigative entities.

"Major Unusual Incident" (MUIs) means the alleged, suspected, or actual occurrence of an incident when there is reason to believe the incident has occurred. MUIs include the following:

Category A:
1. Accidental or Suspicious death
2. Exploitation
3. Failure to report
4. Misappropriation
5. Neglect
6. Physical abuse
7. Prohibited sexual relations
8. Rights code violation
9. Sexual abuse
10. Verbal abuse

Category B
1. Attempted Suicide
2. Death other than accidental or suspicious death
3. Medical emergency
4. Missing individual
5. Peer-to-peer acts
6. Significant injury

Category C
1. Law enforcement
2. Unapproved behavioral support
3. Unanticipated Hospitalization

The following is a list of required reporters for all incidents:
1) County Boards of Developmental Disabilities (County Boards)
2) Ohio Department of Developmental Disabilities (DODD)
3) DODD operated Developmental Centers
4) All Developmental Disabilities Waiver providers
5) All Developmental Disabilities DD licensed or certified providers
6) Developmental Disabilities employees providing specialized services
7) The Ohio Department of Medicaid
The timeframe for reporting abuse, neglect, misappropriation, exploitation, and suspicious or accidental death is immediate to four hours. The remaining MUIs must be reported no later than three p.m. the next working day. DODD is notified by the county board through the Ohio Incident Tracking & Monitoring System (OITMS) by five p.m. on the working day following notification by the provider or becoming aware of the MUI.

Immediate action to protect the individual(s) is taken by the provider and ensured by the county board. Notifications are made immediately to law enforcement for alleged criminal acts and to Children's Services if the individual is under twenty-two.
Reference Rule: Ohio Administrative Code (OAC) 5123-17-02.

Ohio's has a robust critical incident system that addresses the following required incidents in G-1-b as defined below. These incidents are reported, investigated, and remediated in accordance with Ohio Administrative Code 5123-17-02.

a. Unauthorized use of restraint, seclusion and restrictive measures defined as Unapproved Behavioral Supports Major Unusual Incidents (MUIs).
"Unapproved behavioral support" means the use of a prohibited measure as defined in rule 5123:2-2-06 of the

Administrative Code or the use of a restrictive measure implemented without approval of the human rights committee or without informed consent of the individual or the individual's guardian in accordance with rule 5123:2-2-06 of the 5123-17-02 Administrative Code, when use of the prohibited measure or restrictive measure results in risk to the individual's health or welfare. When use of the prohibited measure or restrictive measure does not result in risk to the individual's health or welfare, the incident shall be investigated as an unusual incident.

b. Serious injuries that require medical intervention defined as Significant Injuries and Medical Emergency MUIs.
"Significant injury" means an injury to an individual of known or unknown cause that is not considered abuse or neglect and that results in concussion, broken bone, dislocation,
second or third degree burns or that requires immobilization, casting, or five or more sutures. Significant injuries shall be designated in the incident tracking system as either known or
unknown cause.

"Medical emergency" means an incident where emergency medical intervention is required to save an individual's life (e.g., choking relief techniques such as back blows or
cardiopulmonary resuscitation, use of an automated external defibrillator, or use of an epinephrine auto injector).

c. Criminal victimization defined through Abuse, Neglect and Misappropriation MUIs.
"Physical abuse" means the use of physical force that can reasonably be expected to result in physical harm to an individual. Such physical force may include, but is not limited to,
hitting, slapping, pushing, or throwing objects at an individual.

"Sexual abuse" means unlawful sexual conduct or sexual contact as those terms are defined in section 2907.01 of the Revised Code and the commission of any act prohibited by Chapter 2907. of the Revised Code (e.g., public indecency, importuning, and voyeurism) when the sexual conduct, sexual contact, or act involves an individual.

"Verbal abuse" means the use of words, gestures, or other communicative means to purposefully threaten, coerce, intimidate, harass, or humiliate an individual.

"Neglect" means when there is a duty to do so, failing to provide an individual with medical care, personal care, or other support that consequently results in serious injury or places an individual or another person at risk of serious injury. Serious injury means an injury that results in treatment by a physician, physician assistant, or nurse practitioner.

"Misappropriation" means depriving, defrauding, or otherwise obtaining the real or personal property of an individual by any means prohibited by the Revised Code, including Chapters 2911. and 2913. of the Revised Code.
d. Activity involving law enforcement defined as Law Enforcement MUIs.
"Law enforcement" means any incident that results in the individual served being tased, arrested, charged, or incarcerated.

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.

DODD has an online complaint form that is available for participants, individuals, families and legal representatives.

DODD and county boards of developmental disabilities (county boards) conduct annual trainings on reporting and investigation of MUIs for county boards, developmental center staff, providers, and families.
DODD sends out Health and Welfare Alerts on health and safety issues through an online newsletter that goes to families, providers, and county boards. The Alerts also go to all county boards and certified and licensed providers through a list serve.

Reports are made by phone, online and via fax. A MUI contact person has been identified at each county board to receive reports of possible MUIs. Incidents may be reported to that person or to any county board or DODD employee. DODD also has a hotline 1-866-617-6733, which may be used if there are concerns or difficulties in reporting to the county board.

DODD's Online Reporting System is located at DODD-Online Complaint Form (ohio.gov) and county boards have Hotlines or Help Lines for receiving reports that have been communicated to providers and families. DODD letterhead includes the Hotline telephone number for reporting Abuse, Neglect, and MUIs. DODD, in addition to the hotline for reporting abuse and neglect, lists each county board's after-hours number for reporting MUIs on its website.

DODD distributed a MUI Family Fact Sheet on MUIs which was distributed through the county boards and placed on the Department's website.

All providers shall be trained on the requirements of Ohio Administrative Code (OAC) rule 5123-17-02 prior to application for initial certification in accordance with rule 5123-2-08 and 5123-2-09 of the OAC. Providers shall receive annual training on the requirements of this rule including a review of Health and Welfare alerts issued by DODD since the previous year's training.

As technology has improved over time, the opportunity to provide Ohioans education and training regarding abuse and neglect for individuals, families, providers and constituents has been greatly enhanced. Currently, Ohio provides in person, online training modules, webinar-based training, social media and written correspondence options for obtaining the annual training. DODD offers free interactive health and welfare modules through the My Learning system to satisfy annual training requirements. The module reviews reporting requirements, immediate actions, health welfare alerts from the previous year and falls and choking prevention. The modules are available to anyone, and those who successfully complete all five modules, receive a certificate of completion.

In person trainings are scheduled in advance with registration required to assure attendee tracking and the opportunity for Continuing Professional Development (CPDs). DODD successfully scheduled larger venues and was able to increase the number of people able to attend in person trainings.

The web-based trainings are taped and cataloged so attendees can listen at the time of the webinar or go back and access the training information via our web-based resource library at a more convenient time. The trainings are cataloged by topic and housed on the DODD website. Ohio made these changes several years ago at the request of families and providers who appreciated the trainings but could not always attend at the time the training was scheduled. This has been successful and allows our State to share information with individuals, families and providers in a timely and comprehensive manner.

In addition, Ohio has provided training via "Facebook Live." Social media enhancements allow Ohio to expand training opportunities to reach individuals, families and providers in ways that were not possible in the past.

Written information is shared through the DODD list serve, on the website and through subscription. The MUI Family Fact Sheet has been a tremendous resource to individuals, families and providers regarding abuse and neglect reporting. In addition, the health and welfare alerts are widely distributed and hold valuable information on protecting the health and welfare of individuals supported in Ohio. Pipeline is a DODD publication that routinely includes information on abuse and neglect reporting and prevention and is an excellent resource for all stakeholders. Pipeline reaches over 16,000 subscribers. Local county boards operate hotlines for reporting incidents of abuse and neglect as well, and the contact numbers are readily available on the county board and DODD websites.

MUI training is required for all direct support professionals. The training is required annually and DODD's Office of

Compliance conducts provider compliance reviews to assure that the training is completed as required by OAC 5123-17-02

Medication errors as listed in OAC 5123-6-01(Z) https://codes.ohio.gov/ohio-administrative-code/rule-5123-6-01
(Z) "Medication/treatment error" means:
(1) Wrong prescribed medication/treatment administered or performed;
(2) Medication/treatment administered or performed at the wrong time;
(3) Medication/treatment administered or performed by a route not prescribed or in the case of over-the-counter medication, not as indicated by the manufacturer;
(4) Incorrect dose or amount of medication/treatment administered or performed;
(5) Expired medication/treatment administered or performed;
(6) Contaminated medication/treatment administered or performed;
(7) Improperly stored medication/treatment administered or performed;
(8) Medication/treatment, other than over-the-counter medication authorized in accordance with section 5123.42 of the Revised Code, administered or performed without corresponding order from a licensed health professional authorized to prescribe drugs;
(9) Not performing or administering a prescribed medication/treatment during the prescribed time, including but not limited to, failure to ensure the medication/treatment, equipment, or supplies needed to administer or perform the medication/treatment are available at the prescribed time or declination of a prescribed medication/treatment by an individual;
(10) Not documenting a medication/treatment that was administered or performed;
(11) Administration or performance of prescribed medication/treatment by developmental disabilities personnel without certification or whose certification has expired;
(12) Administration of over-the-counter medication authorized in accordance with section 5123.42 of the Revised Code by developmental disabilities personnel without required training; and
(13) Administration or performance of medication/treatment without nursing delegation when nursing delegation is required.

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The county board of developmental disabilities' (county board) Major Unusual Incident (MUI) Unit receives reports of critical incidents from providers, families, and county board operated programs. This Unit is responsible for determining if it meets the criteria of a MUI, ensuring immediate actions have been taken to protect the individual(s), making notifications, and initiating the investigation for all MUIs.

Investigations into allegations of abuse, neglect, misappropriation, exploitation, and suspicious or accidental deaths are initiated within twenty-four hours. For all other MUIs the investigation is initiated within a reasonable amount of time based on the initial information received and consistent with the health and safety of the individual(s), but no later than three working days. All investigations are to be completed within thirty working days unless extensions are granted by the Department of Developmental Disabilities (DODD) based upon established criteria. These criteria are referenced in Ohio Administrative Code (OAC) 5123-17-02.
The Ohio Department of Medicaid's (ODM) Clinical Operations Bureau also provides monitoring and oversight to assure the health and welfare of individuals enrolled on DODD home and community-based waivers (HCBS). The Clinical Operations Bureau monitors the progress of an investigation and contributes to the investigatory process by mandated state agencies for certain incidents that impacted those individuals. Those incidents include but are not limited to incidents of alleged neglect or abuse resulting in ER treatment or removal by law enforcement; suspicious, unusual, accidental deaths, and misappropriations valued at over $500.
ODM is made aware of these incidents through various means including: notification by DODD, discovered during other ODM oversight activities, contacted by other agencies, media sources, stakeholders and citizens.

The monitoring is completed by viewing the report and all investigation updates recorded in Ohio's Incident Tracking & Monitoring System (OITMS) and other DODD and ODM electronic sources. Inquiries and concerns by ODM regarding any aspect of the investigation process/progress are added to the report by DODD with timelines for responses included.

Prior to ODM considering a case closed, ODM's Clinical Operations Bureau ensures if the steps taken to assure the immediate health and safety of the individual(s) involved in the incident are and continue to be adequate; that appropriate notification was made to law enforcement, children's services, guardians, other appropriate agencies and parties; that all of the causes and contributing factors are identified, and are adequately remedied and/or addressed in the prevention plans; and that all questions by all parties have been answered, that the recommendations and prevention plans have been implemented/completed.

Participants and other relevant parties are notified in writing of the outcome as outlined in OAC 5123-17-02 no later than five working days following the county board's or DODD's recommendation via OITMS ITS that the report be closed.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

In accordance with Ohio Administrative Code rule 5123-17-02, the Department of Developmental Disabilities (DODD) reviews all initial Major Unusual Incident (MUI)/Registry Unit incident reports to ensure the health and safety of individuals. All substantiated reports of abuse, neglect, and misappropriation involving staff are reviewed. Other incidents are reviewed as deemed necessary to ensure the health and safety of individuals.

The DODD MUI/Registry Unit conducts assessments of county boards of developmental disabilities (county boards) to ensure the following:

1. Incidents are reported appropriately;
2. Immediate actions are taken;
3. Necessary notifications are made;
4. Thorough investigations are conducted;
5. Preventative measures have been identified to address the cause and contributing factors;
6. Trend and pattern analysis is completed and appropriate remediation is identified;
7. Unusual incidents are appropriately reported locally; and
8. Required training is completed.

MUI Assessments are conducted based on the performance of the county board but at least on a three-year cycle. Triggers are identified which could result in the assessment being done sooner.

There is a MUI assessment that is part of the Accreditation review; however, the MUI division also conducts their own three-year performance-based cycle of reviews (which are separate from the Accreditation reviews) based on the MUI division's assessment of a county board's performance.

MUI Trend and Pattern analyses and remediation is done once a year by providers and county boards. DODD reviews all analyses completed by county boards and samples those completed by providers. County boards are responsible for reviewing the analyses for providers in their county.

The DODD MUI/Registry Unit flags serious or egregious incidents as Director's Alerts. These cases are closely monitored for a thorough investigation and good prevention planning.

DODD holds a quarterly Mortality Review Committee compiled of stakeholders, including the Ohio Department of Medicaid (ODM), to review deaths for the purpose of/or licensing boards. In addition, the committee looks at causes of deaths and what steps might be taken to educate the field on the causes.

A statewide Trend and Pattern Committee, made up of stakeholders, including ODM, meets twice a year to review statewide trends and patterns along with activities and initiatives being taken by DODD in regard to health and safety.

DODD's MUI/Registry Unit conducts annual, in-depth analysis on Abuse, Neglect, and Misappropriation to determine who, what types, root causes, and provides interventions to reduce reoccurrences. This is communicated through Alerts and during annual trainings.

DODD's MUI/Registry Unit notifies the county board of individual trends and requires the county board to identify what action will be implemented to address the trends.

DODD works in conjunction with Office of Compliance when trends and patterns are noted with a particular provider.

The ODM Clinical Operations Bureau participates in DODD’s semi-annual Trends and Patterns Committee and DODD’s quarterly Mortality Review Committee as part of their additional oversight responsibilities.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses*

regarding seclusion appear in Appendix G-2-c.)

The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The State of Ohio has in place a “Behavioral Support Strategies that Include Restrictive Measures” (5123-2-06) (Behavior Support Rule) that regulates the use of all restraints (including manual, mechanical, and chemical).
Safeguards and protocols in the rule include:

• Behavior support strategies that include restrictive measures (including restraint) may only be used as a last resort when necessary to keep people safe and with informed consent of the person and prior approval by a human rights committee;

• A list of prohibited measures, including: prone restraint; use of manual or mechanical restraint that has the potential to inhibit or restrict an individual’s ability to breathe or that is medically contraindicated and that causes pain or harm; using any restrictive measure for punishment, retaliation, instruction or teaching, convenience of providers, or substitute for services;

• A comprehensive assessment process that takes into consideration a person’s: interpersonal, environmental, medical, mental health, and emotional needs and other motivational factors;

• Requirements for people who are conducting and developing behavior support strategies that include restrictive measures;

• Behavior support strategies that include restrictive measures shall be designed in a manner that promotes healing, recovery, and emotional well-being; be data-driven; recognize the role of environment; capitalize on strengths; delineate measures to be implemented and those responsible for implementation; specify steps to be taken to ensure the safety of the individual and others;

• Behavior support strategies that include restrictive measures shall be implemented with sufficient safeguards and supervision to ensure the health, welfare and rights of individuals receiving specialized services and anyone serving the individual must be trained on the strategy prior to serving;

• Shall be reviewed at least every ninety days;

• All county boards of developmental disabilities (county boards) must have a human rights committee to safeguard individual’s rights and protect individuals from physical, emotional, and psychological harm – their role and responsibility is clearly defined in the Behavior Support Rule;

• Use of restrictive measures without prior approval by the human rights committee must be reported as an “unapproved behavior support”;

• The Department of Developmental Disabilities (DODD) must be notified after approval of the human rights committee and prior to implementation of all behavior support strategies that include restrictive measures;

• All county boards must collect and analyze data regarding behavior support strategies that include restrictive measures and furnish data to their human rights committee.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The Department of Developmental Disabilities (DODD) is responsible for overseeing the use of restraints. The following specifies how the oversight is conducted:

• After approval by the human rights committee and prior to implementation, a county board of developmental disabilities must notify DODD through its “Restrictive Measure Notification” system. (Note: DODD does not use the notification system as a means to approve plans, the approval of plans that include restrictive measures occurs at the local level. The notification system is used to collect and monitor data for trends and patterns, provide oversight, and to identify cases where technical assistance may be needed.) The notification must be submitted initially, when revised or renewed, and (optionally) when discontinued.

• DODD may select a sample of behavior support strategies for additional review to ensure that the strategies are developed and implemented and monitored in accordance with this rule.

• DODD shall take immediate action, as necessary, to protect the health and safety of individuals served.

• DODD shall compile and analyze data regarding the use of behavior support strategies throughout the state for the purposes of determining methods for enhancing risk reduction efforts and outcomes, reducing the frequency of restrictive measures, and identifying technical assistance and training needs.

• DODD conducts both Major Unusual Incident (MUI), and regular regulatory reviews (Accreditation, Licensure, & Provider Compliance Reviews) to ensure consistent and routine reviews of behavior support policies and procedures that are in place for individuals.

The rule Addressing Major Unusual Incidents and Unusual Incidents to Ensure Health, Welfare and Continuous Quality Improvement, and the Behavior Support Rule requires a MUI to be filed when there is an unapproved behavior support. The system has required fields that must be completed plus the intake staff at DODD follow-up on any reports that are incomplete. If an unreported incident is identified during the course of the review or as a part of a complaint received, a MUI is filed, a citation is issued, and a plan of correction is required.

When the Ohio Department of Medicaid (ODM) discovers a case of the improper or unauthorized use of restraint(s) and restrictive intervention(s) that have not yet been reported through the DODD Incident Tracking System (ITS) system the case is reported to the proper DODD parties. If the unauthorized use of restraints is identified during the course of a review by ODM clinical staff, that case will be managed through the Unmet Needs process described in Appendix A in order to ensure that the waiver individual's health or welfare is being assured.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

The state does not permit or prohibits the use of restrictive interventions

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other

individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The State of Ohio has in place a "Behavioral Support Strategies that Include Restrictive Measures" (5123-2-06) (Behavior Support Rule) that regulates the use of all restrictive measures.

Safeguards and protocols in the rule include:

• Behavior support strategies that include restrictive measures may only be used as a last resort when necessary to keep people safe, and in the case of rights restrictions, when an individual's actions may result in legal sanction. The strategies require informed consent of the person and prior approval by a human rights committee;

• A list of prohibited measures, including: prone restraint; use of manual or mechanical restraint that has the potential to inhibit or restrict an individual's ability to breathe or that is medically contraindicated and that causes pain or harm; using any restrictive measure for punishment, retaliation, instruction or teaching, convenience of providers, or substitute for services;

• A comprehensive assessment process that takes into consideration a person's: interpersonal, environmental, medical, mental health, and emotional needs and other motivational factors;

• Requirements for people who are conducting and developing behavior support strategies that include restrictive measures;

• Behavior support strategies that include restrictive measures shall be designed in a manner that promotes healing, recovery, and emotional well-being; be data-driven; recognize the role of environment; capitalize on strengths; delineate measures to be implemented and those responsible for implementation; specify steps to be taken to ensure the safety of the individual and others;

• Behavior support strategies that include restrictive measures shall be implemented with sufficient safeguards and supervision to ensure the health, welfare and rights of individuals receiving specialized services and anyone serving the individual must be trained on the strategy prior to serving;

• Shall be reviewed at least every ninety days;

• All county boards (county boards) must have a human rights committee to safeguard individual's rights and protect individuals from physical, emotional, and psychological harm – their role and responsibility is clearly defined in the Behavior Support Rule;

• Use of restrictive measures without prior approval by the human rights committee must be reported as an "unapproved behavior support";

• The Department of Developmental Disabilities (DODD) must be notified after approval of the human rights committee and prior to implementation of all behavior support strategies that include restrictive measures;

• All county boards must collect and analyze data regarding behavior support strategies that include restrictive measures and furnish data to their human rights committee.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The Department of Developmental Disabilities (DODD) is responsible for overseeing the use of restrictive interventions. The following specifies how the oversight is conducted:

• After approval by the human rights committee and prior to implementation, a county board of developmental disabilities (county board) must notify DODD through its “Restrictive Measure Notification” system (Note: DODD does not use the notification system as a means to approve plans, the approval of plans that include restrictive measures occurs at the local level. The notification system is used to collect and monitor data for trends and patterns, provide oversight, and to identify cases where technical assistance may be needed.) The notification must be submitted initially, when revised or renewed, and (optionally) when discontinued.

• DODD may select a sample of behavior support strategies for additional review to ensure that the strategies are developed and implemented and monitored in accordance with this rule.

• DODD shall take immediate action, as necessary, to protect the health and safety of individuals served.

• DODD shall compile and analyze data regarding the use of behavior support strategies throughout the state for the purposes of determining methods for enhancing risk reduction efforts and outcomes, reducing the frequency of restrictive measures, and identifying technical assistance and training needs.

• DODD conducts both Major Unusual Incident (MUI), and regular regulatory reviews (Accreditation, Licensure, & Provider Compliance Reviews) to ensure consistent and routine reviews of behavior support policies and procedures that are in place for individuals.

The rule addressing Major Unusual Incidents and Unusual Incidents (UIs) to Ensure Health, Welfare and Continuous Quality Improvement and the Behavior Support Rule requires a MUI to be filed when use of a prohibited measure or restrictive measure results in a risk to the individual’s health and safety. The system has required fields that must be completed plus the intake staff at DODD follow-up on any reports that are incomplete. If an unreported incident is identified during the course of the review or as a part of a complaint received, a MUI is filed, a citation is issued, and a plan of correction is required.

When the Ohio Department of Medicaid (ODM) discovers a case of the improper or unauthorized use of restraint(s) and restrictive intervention(s) that have not yet been reported through Ohio Incident Tracking & Monitoring System (OITMS) the case is reported to the proper DODD parties. If the unauthorized use of restrictive interventions is identified during the course of a review by ODM staff, that case will be managed through the Unmet Needs process described in Appendix A in order to ensure that the waiver individual's health or welfare is being assured.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The State of Ohio has in place a “Behavioral Support Strategies that Include Restrictive Measures” (5123-2-06) (Behavior Support Rule) that regulates the use of all restrictive measures, including “Time Out.”

Safeguards and protocols in the rule include:

• Behavior support strategies that include restrictive measures (including Time Out) may only be used as a last resort when necessary to keep people safe and with informed consent of the person and prior approval by a human rights committee;

• A list of prohibited measures, including: prone restraint; use of manual or mechanical restraint that has the potential to inhibit or restrict an individual’s ability to breathe or that is medically contraindicated and that causes pain or harm; using any restrictive measure for punishment, retaliation, instruction or teaching, convenience of providers, or substitute for services;

• Time Out may not exceed thirty minutes for any incident or one hour in a twenty-four hour period; may not be key-locked; shall be adequately lighted and ventilated and provide a safe environment for the person;

• An individual in a time-out room or area must be protected from hazardous conditions, shall be under constant visual supervision, and time out shall cease immediately once risk of harm has passed or the individual engages in self-abuse, becomes incontinent, or shows other signs of illness;

• A comprehensive assessment process that takes into consideration a person’s: interpersonal, environmental, medical, mental health, and emotional needs and other motivational factors;

• Requirements for people who are conducting and developing behavior support strategies that include restrictive measures;

• Behavior support strategies that include restrictive measures shall be designed in a manner that promotes healing, recovery, and emotional well-being; be data-driven; recognize the role of environment; capitalize on strengths; delineate measures to be implemented and those responsible for implementation; specify steps to be taken to ensure the safety of the individual and others;

• Behavior support strategies that include restrictive measures shall be implemented with Use of restrictive measures without prior approval by the human rights committee must be reported as an “unapproved behavior support”;

• The Department of Developmental Disabilities (DODD) must be notified after approval of the human rights committee and prior to implementation of all behavior support strategies that include restrictive measures;

• All county boards of developmental disabilities must collect and analyze data regarding behavior support strategies that include restrictive measures and furnish data to their human rights committee.
• Sufficient safeguards and supervision to ensure the health, welfare and rights of individuals receiving specialized services and anyone serving the individual must be trained on the strategy prior to serving;

• Shall be reviewed at least every ninety days;

• All county boards must have a human rights committee to safeguard individual’s rights and protect individuals from physical, emotional, and psychological harm – their role and responsibility is clearly defined in the Behavior Support Rule.

ii. **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The Department of Developmental Disabilities (DODD) is responsible for overseeing the use of restrictive interventions, including seclusion (“time out”). The following specifies how the oversight is conducted:

• After approval by the human rights committee and prior to implementation, a county board of developmental disabilities (county board) must notify DODD through its “Restrictive Measure Notification” system. (Note: DODD does not use the notification system as a means to approve plans, the approval of plans that include restrictive measures occurs at the local level. The notification system is used to collect and monitor data for trends and patterns, provide oversight, and to identify cases where technical assistance may be needed.) The notification must be submitted initially, when revised or renewed, and (optionally) when discontinued.

• DODD may select a sample of behavior support strategies for additional review to ensure that the strategies are developed and implemented and monitored in accordance with this rule.

• DODD shall take immediate action, as necessary, to protect the health and safety of individuals served.

• DODD shall compile and analyze data regarding the use of behavior support strategies throughout the state for the purposes of determining methods for enhancing risk reduction efforts and outcomes, reducing the frequency of restrictive measures, and identifying technical assistance and training needs.

• DODD conducts both Major Unusual Incident (MUI), and regular regulatory reviews (Accreditation, Licensure, & Provider Compliance Reviews) to ensure consistent and routine reviews of behavior support policies and procedures that are in place for individuals.

The rule addressing Major Unusual Incidents and Unusual Incidents to Ensure Health, Welfare and Continuous Quality Improvement and the Behavior Support Rule requires a MUI to be filed when there is an unapproved behavioral support that results in a risk to the individual’s health and welfare. The system has required fields that must be completed plus the intake staff at DODD follow-up on any reports that are incomplete. If an unreported incident is identified during the course of the review or as a part of a complaint received, a MUI is filed, a citation is issued, and a plan of correction is required.

When the Ohio Department of Medicaid (ODM) discovers a case of the improper or unauthorized use of restraint(s) and restrictive intervention(s) that have not yet been reported through DODD Incident Tracking System (ITS) system the case is reported to the proper DODD parties. If the unauthorized use of restrictive interventions is identified during the course of a review by ODM staff, that case will be managed through the Unmet Needs process described in Appendix A in order to ensure that the waiver individual's health or welfare is being assured.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

No. This Appendix is not applicable *(do not complete the remaining items)*

Yes. This Appendix applies *(complete the remaining items)*

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.

Individual medication management and follow up is the responsibility of the physician, clinical nurse specialist, psychiatrist or other prescribing authority. These various health care professionals determine the need to monitor and follow up based on the individual's diagnoses, individual's medication regimen and stability of the individual being served. Quality assessment is completed for each individual receiving administration of prescribed medications, performance of health-related activities, and/or tube feedings at least once every three years or more frequently if needed (see OAC 5123-6-07). Quality assessment includes:

• Observation of administering prescribed medication or performing health-related activities;

• Review of documentation of prescribed medication administration and health-related activities for completeness of documentation and for documentation of appropriate actions taken based on parameters provided in prescribed medication administration and health-related activities training (See OAC 5123-6-06);

• Review of all prescribed medication errors from the past twelve months;

• Review of the system used by the employer or provider to monitor and document completeness and correct techniques used during oral and topical prescribed medication administration and performance of health-related activities.

Plans that incorporate medication for behavior control is prohibited unless it is prescribed by and under the supervision of a licensed physician who is involved in the interdisciplinary planning process. The protocols for this are described under Appendix G-2.

Prior documented informed consent is obtained from the individual receiving services from the county board of developmental disabilities (county board) program, or guardian if the individual is eighteen years old or older, or from the parent or guardian if the individual is under eighteen years of age.

The medication administration Quality Assessment (QA) review is conducted by an RN, thus assuring professional evaluation of the systems in place for providing safe, accurate and effective administration of all medications. Only medications prescribed for an individual (by a professional with prescribing authority under Ohio law) may be administered. Only personnel who are relevantly professionally credentialed or who have completed the training and skills validation for the Department of Developmental Disabilities (DODD) Medication Administration Certification may administer medications. The use of the standards of practices established for Medication Administration Certification is evaluated as part of the RN QA review. Any potentially harmful practices identified would be addressed via the Plan of Improvement (POI) element of the RN QA. The reviewing RN confirms the plan of improvement and
notifies the county board of the RNQA review outcome.
During all compliance reviews: if an individual in the sample receives medications for behavior, the plan is reviewed to ensure the appropriate process has been followed. Medications prescribed for behavior modification must be approved by the Human Rights Committee and reviewed by the team monthly.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The Department of Developmental Disabilities (DODD) monitors medication administration through regularly scheduled reviews. The frequency of these reviews is based upon the terms of a provider's certification, license or accreditation, which range from one to five years. Special reviews (not scheduled) can be conducted by DODD if requested by an individual, parent or guardian or if there is suspicion of abuse, neglect, or non-compliance with laws or rules especially those related to medication administration.

DODD also becomes aware of potentially harmful practices through the review of Major Unusual Incidents (MUIs). These incidents are initially investigated by local county board of developmental disabilities (county board) personnel and the results of the investigation forwarded to the state for review. Medication errors that result in harm or reasonable risk of harm to an individual are classified, reported, and investigated as major unusual incidents.

Personnel who do not safely administer medications are reported to DODD by employers, County boards, Quality Assessment (QA) RNs and delegating nurses by electronic record and uploading of documentation to the unlicensed personnel's Medication Administration Certification record. Unresolved issues identified via the RN QA Reviews are reported to the DODD RN and to the Office of Compliance for follow through on resolutions. MUI reports require plans of correction to prevent future events; MUI cases are followed by DODD until appropriate plan of improvement (POI) is confirmed.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

Not applicable. *(do not complete the remaining items)*

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

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).

A self-medication administration assessment is done to determine if an individual is capable of self-medicating administration and specifies how and when it is to be reviewed, revised, and redone. This must be reviewed annually and completely re-done at least every 3 years if an individual does not meet the criteria for self-administration. Medication. This can be done more frequently than every 3 years if there is change in that affects the individual's medication routine, service setting, service provider or health status or if there is a problem with self-administration. (Ohio Administrative Code 5123-6-02).
In accordance with Section 5123.47 of the Revised Code, a family member of a person with a developmental disability may authorize an independent provider to administer oral and topical prescribed medications or perform other health care task as part of the in-home care the worker provides to the individual, if all of the following apply:

• The family member lives with the individual and is the primary supervisor of the care.

• The independent provider has been selected by the family member or the individual receiving care and is under the direct supervision of the family member.

• The independent provider is providing the care through an employment or other arrangement entered into directly with the family member and is not otherwise employed by or under contract with a person or government entity to provide services to individuals with developmental disabilities.

• A family member shall obtain a prescription, if applicable, and written instructions from a health care professional for the care to be provided to the individual. The family member shall authorize the independent provider to provide the care by preparing a written document granting the authority. The family member shall provide the independent provider with appropriate training and written instructions in accordance with the instructions obtained from the health care professional.

• A family member who authorizes an independent provider to administer oral and topical prescribed medications or perform other health care tasks retains full responsibility for the health and safety of the individual receiving the care and for ensuring that the worker provides the care appropriately and safely. No entity that funds or monitors the provision of in-home care may be held liable for the results of the care provided under this section by an independent provider, including such entities as the county board of developmental disabilities and the department of developmental disabilities.

• An independent provider who is authorized under this section by a family member to provide care to an individual may not be held liable for any injury caused in providing the care, unless the worker provides the care in a manner that is not in accordance with the training and instructions received or the worker acts in a manner that constitutes wanton or reckless misconduct.

Per OAC 5123-6-03 (B), staff that will be administering medication to individuals that do not self-administer is required to become certified to administer medications. For general medication administration staff are required to meet specific standard and then must attend a class that is a minimum of 14 hours per OAC 5123-6-06 (C)(1)(a), perform return demonstration of proficiency skills, and take a written test that must be passed with at least a score of 80% as described in OAC 5123-6-06 (E)(1). This certification must be renewed annually. To do this, the staff must complete at least 2 hours of continuing education and complete a successful return demonstration of skills per 5123-6-06 (E)(1)(a). To administer medication per gastrostomy or jejunostomy, the staff must take the general medication administration class and become certified. After completing the initial certification they must take an additional four-hour class per 5123-6-06 (C)(2)(a), complete a return demonstration of skill and take a written test and pass with at least 80% as described in OAC 5123-6-06 (D)(1). This certification is available to them for one year and must be renewed annually. The renewal process is described in OAC 5123-6-06 (E)(1) and includes annual completion of at least one hour of continuing education and a successful return demonstration of skill. In addition initially individual specific training must be completed and a nurse (an RN or an LPN under the direction of an RN) must delegate this to the staff prior to the medication administration beginning as required per OAC 5123-6-06(C)(2).

Unlicensed personnel may administer insulin or other injectable treatments for metabolic glycemic disorders after being certified as in 5123-6-06 (E). The staff must take the general medication administration class and then per 5123-6-06 (B)(3)(a) they must take an additional minimum four-hour class. OAC 5123-6-06 (D)(1) states that

during the class the staff must complete a successful return demonstration, take a written test and pass with at least 80%. In addition, prior to doing medication administration each certified staff must be provided individual specific training related to the individuals they will be serving per OAC 5123-6-06 (C)(3)(b)(xii) and a nurse (an RN or an LPN under the direction of an RN) must delegate that specific medication administration to the staff per OAC 5123-6-06 (C)(3)(b)(xii).
Ohio Revised Code (ORC) 5123.41 through 5123.46 and 5123.65, along with OAC 5123-6-01 govern administration of medication to be completed by waiver providers. These laws and rules require staff who will be administering medications to individuals that cannot self-medicate to meet certain standards and to become and maintain certification as described above. Specific curriculum has been developed and must be used unless an individual has developed his/her own and had it approved by the Department of Developmental Disabilities (DODD). All tests are developed by the DODD must be administered as the “written test” and no exceptions are granted. Medication administration must be documented on a medication administration record although a specific form is not required. Mandated elements to be included on the form are specified in OAC 5123-6-07.

The renewal process for certifications required for medication administration are contingent on continuing education requirements and annual skills verification. Multiple notations on the provider’s Medication Administration Certification record results in DODD review of the specific performance problems and may result in denial of renewed certification.

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:

Errors are reported to the Department of Developmental Disabilities per OAC 5123-6-07 (F)(2)(b), “Immediately notify the department…” by making a notation in the personnel’s certification record (via MAIS notation system).

(b) Specify the types of medication errors that providers are required to *record:*

Medication errors as listed in OAC 5123-6-01(Z) https://codes.ohio.gov/ohio-administrative-code/rule-5123-6-01
(Z) "Medication/treatment error" means:
(1) Wrong prescribed medication/treatment administered or performed;
(2) Medication/treatment administered or performed at the wrong time;
(3) Medication/treatment administered or performed by a route not prescribed or in the case of over-the-counter medication, not as indicated by the manufacturer;
(4) Incorrect dose or amount of medication/treatment administered or performed;
(5) Expired medication/treatment administered or performed;
(6) Contaminated medication/treatment administered or performed;
(7) Improperly stored medication/treatment administered or performed;
(8) Medication/treatment, other than over-the-counter medication authorized in accordance with section 5123.42 of the Revised Code, administered or performed without corresponding order from a licensed health professional authorized to prescribe drugs;
(9) Not performing or administering a prescribed medication/treatment during the prescribed time, including but not limited to, failure to ensure the medication/treatment, equipment, or supplies needed to administer or perform the medication/treatment are available at the prescribed time or declination of a prescribed medication/treatment by an individual;
(10) Not documenting a medication/treatment that was administered or performed;
(11) Administration or performance of prescribed medication/treatment by developmental disabilities personnel without certification or whose certification has expired;
(12) Administration of over-the-counter medication authorized in accordance with section 5123.42 of the Revised Code by developmental disabilities personnel without required training; and
(13) Administration or performance of medication/treatment without nursing delegation when nursing delegation is required.

(c) Specify the types of medication errors that providers must *report* to the state:

Per Ohio Revised Code 5123-17-02 (C)(25) "...medication errors without a likely risk to health and welfare;" are unusual incidents unless additional circumstances warrant it to be classified as a Major Unusual Incident in accordance with Ohio Administrative Code 5123-17-02 (C)(16)(a), (b) & (c).
Per 5123-6-07 (F)(1) "…if an employer of developmentally disabilities personnel believes or is notified…that developmental disabilities personnel have not or will not safely perform health related activities or administer prescribed medication the employer will shall prohibit the action from continuing or commencing."
AND per 5123-6-07 (F)(2)(b) "Immediately notify the department…" by making a notation in the personnel's certification record (via MAIS notation system).

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

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.

The Department of Developmental Disabilities (DODD) monitors performance of waiver providers through review of various county board of developmental disabilities (county board) reports and county board quality assessment reviews. Incidents or issues that may be questioned can be reported to the county board or the DODD at times other than when a report is filed or a Quality Assessment (QA) review is completed. When reported directly to DODD, DODD will complete an investigation to determine necessary action.

Personnel who do not safely administer medications are reported to DODD by employers, county boards, QA RNs and delegating nurses by electronic record and uploading of documentation to the unlicensed personnel's Medication Administration Certification record. Unresolved issues identified via the RN QA Reviews are reported to the DODD RN and to the Office of Compliance for follow through on resolutions. Major Unusual Incidents (MUI) reports require plans of correction to prevent future events; MUI cases are followed by DODD until appropriate POC is confirmed.

RN Trainers, QA RNs, Employers and DODD use the Medicaid Administration Information System (MAIS) to track certifications issued to unlicensed personnel. "Notations" can be entered on a personnel's certification record related to medication administration problems. The medication administration rule (Ohio Administrative Code (OAC) 5123-6-07) mandates that if a certified personnel is not administering medication safely the employer or county board or delegating nurse must take them off medication administration duty and report that to DODD (via the MAIS notation system); an additional notation must be added if/when the personnel is able to be adequately reeducated to return to safe practice.

Notations are entered with preselected categories and documentation of the details of each event must be uploaded to DODD along with the notation. Notations are also made if personnel are substantiated in a medication related MUI and if problems are noted during QA reviews.

If personnel have four notations recorded in an eighteen-month period, renewal of MA Certification cannot happen without specific DODD review of the personnel's record. QA RNs and DODD reviewers have the ability to see the event notations as part of the QA review processes. Notation documentation details are only visible to DODD.

The MAIS also mandates significantly more data entry to track where personnel work and who is providing the mandated employer oversight of medication administration safety and performance by MA Certified unlicensed personnel. DODD is working to include all the data fields from the MAIS into the Data Warehouse where it can be queried for data mining of patterns and trends.

When the Ohio Department of Medicaid (ODM) discovers non-compliance with laws or rules governing medication administration without an occurrence or potential of harm which not been discovered or not adequately being addressed by DODD that case will be processed through the Unmet Needs process described in Appendix A. When ODM discovers an instance of harm occurring or where there is a reasonable risk of harm to an individual due to medication management or administration issues case it is reported to the proper DODD parties and processed through the Unmet Needs process described in Appendix A.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the 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:
G-1: Number and percent of Abuse (physical, verbal, emotional, sexual), Neglect, Exploitation, and Misappropriation Incidents (over $500) reported into the ODM approved incident management system(s) within the required timeframe. N= Total number of ANEM incidents/cases reported into the ODM approved incident management system within the required timeframe. D= Total number of ANEM incident/cases.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD's Incident Tracking System (ITS)

Responsible Party for data collection/generation *(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:
G-2: Number and percent of unexplained or suspicious deaths with a required need for investigation for which an investigation was completed according to Rule requirements. N= Total number of unexplained or suspicious death investigations completed according to the Rule requirements. D= Total number of unexplained or suspicious death investigations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD Incident Tracking System (ITS)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(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:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
G-3: Number and percent of Abuse (physical, verbal, emotional, sexual), Neglect, Exploitation, and Misappropriation Incidents (over $500) incident investigations that were completed according to the Rule requirements. N= Total number of ANEM investigations completed according to the Rule requirements. D= Total number of ANEM investigations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD's Incident Tracking System (ITS)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =

Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(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:

G-4: Number and percent of substantiated Abuse (physical, verbal, emotional, sexual), Neglect, Exploitation, and Misappropriation Incidents (over $500) with a prevention plan developed as a result of the incident. N= Total number of ANEM prevention plans completed. D= Total number of ANEM incidents needing a prevention plan.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD's Incident Tracking System (ITS)

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

Data Aggregation and Analysis:

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

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
G-5: Number and percent of substantiated unauthorized (or unapproved) restraint, seclusion or other restrictive intervention incidents with a prevention plan developed as a result of the incident. N= Total number of unauthorized (or unapproved) restraint prevention plans completed. D= Total number of unauthorized (or unapproved) restraint incidents needing a prevention plan.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD's Incident Tracking System (ITS)

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(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:
G-6: Number and percent of incidents investigated for Abuse (physical, verbal, emotional, sexual), Neglect, Exploitation, and all Misappropriation (over $500) incidents investigated that involved paid caregivers. N= Total number of ANEM incidents investigated that involved a paid caregiver. D= Total number of ANEM incidents that involved a paid caregiver.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD Incident Tracking System (ITS)

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

	Other Specify:	

Data Aggregation and Analysis:

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

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

Activities by ODM for assuring compliance:
ODM conducts quality briefings with the operating agency at least four times per year to review data generated through the departments' quality processes, including results of any completed targeted reviews, waiver performance measure data, and data presented by the operating agency on the oversight activities conducted by that department. This data includes but is not limited to problems detected, corrective measures taken, and how the operating agency verified, or intends to verify, that the actions were effective.
Performance Measures data reports are submitted to ODM by DODD on a quarterly basis.
The information is gathered from county board and DODD compliance activities. DODD is able to identify and address individual problems as they are discovered and provide technical assistance that may include plans of corrective action. When problems are discovered, the individual county board is notified and technical assistance is provided using e-mail, phone contact and/or letters to county board staff. When issues are noted that are systemic, DODD will provide statewide training and incorporate that corrective action into its monitoring during the next monitoring cycle.
Case Specific Resolution: During the course of any review conducted by ODM or DODD, when staff encounter a situation in which a waiver recipients health or welfare is at risk, or when case management deficiencies are identified, the staff follow a protocol to report these observations. Depending on the severity of the situation, the staff will take immediate action, coordinate intervention with providers or case managers, and report the finding to ODM managers. ODM communicates findings to DODD for further review and appropriate intervention, and with explicit variable timeframes within which a report back to ODM is expected. ODM logs and tracks all such findings and referrals to assure appropriate case-specific resolution.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.

All critical incidents are reported and tracked in the Ohio Incident Tracking & Management System (OITMS). Incidents are given a unique tracking number that allows the state to ensure case specific resolution and remediation. DODD tracks the number of incidents of abuse, neglect, exploitation, misappropriation or death and case specific remediation through the quarterly performance measures submitted to Ohio Department of Medicaid (ODM).

The responsibility for remediation actions for each critical incident is the joint responsibility of the county boards and DODD. DODD ensures case specific resolution for each participant critical incident was completed and documented in accordance with the process described in the approved waiver and in accordance with OAC 5123-17-02 Incidents adversely affecting health and safely. Case specific resolution is tracked through the Incident Tracking System (ITS). All incidents are given a unique tracking number that allow DODD to ensure case specific remediation. Remediation activities such as plan of correction, personnel action, prevention plans are put in place, service plan changes and staff training were reviewed and determined to be sufficient by the Regional Manager prior to closing the case. ODM and DODD will continue to monitor and will address any issues or concerns that may arise regarding MUIs and the health and safety of individuals being served.

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**

Responsible Party(*check each that applies):*	**Frequency of data aggregation and analysis**(*check each that applies):*
	Continuously and Ongoing
	Other Specify: Semi-annually

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

No

Yes

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §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.

The quality oversight strategy for this waiver relies on the collaborative efforts of staff at the Ohio Department of Medicaid (ODM) and the Department of Developmental Disabilities (DODD) to generate and analyze both data and other performance related information to measure compliance with federal waiver assurances and to assure participant health and welfare.
Role of the State Medicaid Agency: ODM oversees the operation and performance of DODD to ensure operation is in accordance with the approved waiver and assess the effectiveness of DODD's oversight of the County Boards operating the waiver locally. Operation of the waiver is delegated by ODM to DODD through an interagency agreement. This agreement includes authorizing ODM to perform oversight activities to establish the program's compliance with federal and state laws and regulations as well as auditing and fiscal compliance. ODM will employ a multifaceted monitoring and oversight process that includes the following activities:

Quality Steering Committee (QSC)-Convening 4 times per year, the QSC provides administrative oversight for ODM's HCBS Waiver Quality Strategy. Collaboratively, the QSC reviews and analyzes data across waivers to identify promising practices and opportunities for quality improvement. It uses these discussions to assess and compare performance and innovative data analytics across Ohio's HCBS waivers to support collaborative efforts, improve waiver systems, and help move Ohio toward more unified quality management. The committee includes sub activities including the Health Safety and Welfare Committee, Quality Briefings, Targeted Reviews and Quality Improvement Plans.
Convening the Health, Safety and Welfare Oversight Committee 2 times per year. The Health, Safety and Welfare committee meets to review and aggregate data compiled from a variety of sources to identify trends and systemic issues in waiver program operations and participant outcomes. The output from this group includes technical assistance to the case management agencies and continuous evaluation and updates to the policy. ODM assures case-specific resolution through the oversight of the Health, Safety, and Welfare Committee.
Quality Briefings-ODM conducts quality briefings with the operating agency at least four times per year to review data generated through the departments' quality processes. Quality Briefings may be initiated by the Quality Steering Committee, ODM policy staff or stem from identified issues or trends. Quality Briefings may also be used as a venue to discuss the results and performance from current projects undertaken by either or both departments, such as the findings from targeted reviews administered by ODM. In these meetings, the departments include discussion about opportunities for program improvement that were detected, what corrective measures are/or were taken, and how the operating agency verified, or intends to verify, that the actions were effective. The quality briefings will also serve as the forum for ODM and DODD to share and review the validity and/or usefulness of performance metrics identified in this application. Throughout the process, if areas of non-compliance or opportunities to improve performance are identified, ODM may require DODD to develop and implement quality improvement plans and monitor their effectiveness at achieving desired outcomes. Briefings may include other subject matter experts, outside of waiver managing staff for targeted discussions.
Targeted Reviews: At least once per program year, ODM will identify a target group of waiver participants using data from reporting systems. ODM's staff will perform reviews of the target group to identify best practices as well as areas for improvement in waiver operations, including both service delivery and case management. These reviews will help the State identify and implement system changes that address vulnerabilities and improve individuals' experiences and health outcomes. Targeted reviews may also be included as part of a quality briefing.

On-going assurance of the resolution of case specific issues completed by ODM staff and Clinical Operations staff to address unmet needs and health and welfare of the waiver participant. Resolution is tracked including any needed remediation. An unmet need includes any health and safety risk for the individual, grievance, and/or concerns with case management performance identified. Unmet needs may be identified through the course of any review conducted by ODM or DODD, when staff encounter a situation in which a waiver recipients health or welfare is at risk, or when case management deficiencies are identified, the staff follow a protocol to report these observations. Additionally, constituent inquiries may spark resolution of an unmet need. The unmet needs are tracked for response and resolution. Depending on the severity of the situation, staff will take immediate action, coordinate intervention with providers or SSAs, or identify other interventions to assure health and welfare. ODM communicates findings for further review and appropriate intervention, and with explicit variable timeframes within which a report back to ODM is expected. ODM logs and tracks all findings and referrals to assure appropriate case-specific resolution.
Also, the ODM Clinical operations section monitors both prevention and outcome activities performed by DODD to protect Medicaid individuals on HCBS waivers from significant incidents impacting their health and safety. ODM staff review incident alerts, track and monitor them until resolution has been reached, the individual is healthy and safe, the cause has been identified and remedied, and preventive measures have been taken.

The discovery of potential Incident Alerts may occur through the following means: ODM may be notified by DODD via Director's Alert email or other means; by the ODM health and welfare review committee; through ODM monitoring of DODD Ohio Incident Tracking and Management System; through other service delivery systems; media; or complaints received directly by ODM.
Open, on-going communication and collaboration with DODD through bi-weekly meetings with DODD Medicaid administration staff, ODM clinical staff and ODM policy. These meetings address outstanding individual issues, current projects, updates and any additional items for discussion to assure the waiver program is meeting the needs of persons served. Additional ODM or DODD staff may be included depending on concerns and issues.
ODM staff participates in DODD workgroups, taskforces and other programmatic committees. On an ongoing basis, ODM staff participate in quarterly DODD Major Unusual Incident Trends and Patterns reviews and DODD Mortality Reviews. Standing committees with ODM staff engagement include waiver redesign workgroups, Assistive Technology Taskforce, Employment First initiative and others as requested.
Continuous Review of DODD performance measure data. Under continuous review and oversight, including quarterly performance review reports and through annual 372 reporting, ODM examines performance data and other information gathered both by ODM and DODD to measure compliance and performance with respect to the federal waiver assurances including service planning, care management, free choice of provider, level of care, health and welfare, hearing rights, participant satisfaction, and validation of service delivery. This data and any remediation (if necessary) will be submitted in accordance with the approved performance measures in the waiver. This information will also be used by ODM to complete the quality sections of the CMS 372 report required to demonstrate cost neutrality in the waiver.
ODM ensures systemic remediation through a Quality Improvement Plan. Whenever a performance measure is not fully met, falling below a threshold of 86% and cannot be remediated, a systemic remediation Quality Improvement Plan (QIP) would be conducted to determine the cause. A QIP must be implemented once the cause is found unless the state provides justification accepted by CMS that a QIP is not necessary. A QIP may take any of several forms. It may be training, revised policies/procedures, additional waiver services, etc. Each QIP must measure the impact to determine whether it was effective.
Fiscal Reviews – ODM staff perform regular desk reviews of administrative costs, with A-133 Audits being performed every one to three years based on risk. On a biennial basis, ODM staff conduct audits of CBDD prepared cost reports. Additional detail about Ohio's practice for maintaining fiscal oversight of the waiver can be found in Appendix I.
Role of the Operating Agency (DODD): Through an interagency agreement, ODM delegates to DODD responsibility for the administration of the wavier program. These responsibilities include managing and monitoring the waiver program to assure compliance and quality improvement.
Monitoring by DODD focuses on: 1) assuring compliant and effective case management for applicants and waiver participants by County Boards; 2) managing a system to assure prevention and effective response to incidents of participant abuse and neglect; 3) assuring the qualifications and compliance of particular waiver service providers; 4) assuring that paid claims are for services authorized in individual service plans; 5) setting program standards/expectations; 6) compliance and performance of County Boards which administer the program locally; 7) providing technical assistance; 8) facilitating continuous quality improvement in the waiver's local administration; and more generally, 9) ensuring that all waiver assurances are addressed and met for all waiver participants.
DODD's Office of Compliance conducts compliance reviews in licensed waiver funded settings, unlicensed waiver funded settings, and County Board settings. To ensure consistency, the review process and tools are the same in all settings to determine compliance with administrative rules and waiver assurances. A standardized review tool is used to determine if health, safety and individual satisfaction criteria are met. DODD uses an individual interview process when interviewing individuals/families as part of the department's regulatory review processes.
Compliance Review – regularly scheduled reviews of a provider are conducted prior to the end of the provider's term license, accreditation term or at least once every 3 years for non-licensed waiver settings. The review is conducted utilizing a single review tool. A report is issued to the county board and/or provider identifying areas of deficiencies and requiring a plan of improvement. The plan of improvement is reviewed and approved by the Office of Compliance and follow-up visits are conducted to verify that the appropriate corrections have been made. In cases where an immediate risk to health or safety is identified, the reviewer remains onsite until corrective action is taken. Special Compliance Review – an unscheduled review, which occurs due to identified concerns such as complaints, Major Unusual Incidents, reports of fraud, or adverse outcomes identified by other entities such as the Ohio Department of Health or the ODM. A report is issued to the county board and/or provider identifying areas of deficiencies and requiring a plan of compliance (POC)improvement. The findings

are reported to appropriate State agency.

ii. System Improvement Activities

Responsible Party_(check each that applies):_	**Frequency of Monitoring and Analysis**_(check each that applies):_
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Quality Improvement Committee	**Annually**
Other Specify: County Boards & IO Waiver Providers	**Other** Specify: semi-annually

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Ohio Department of Medicaid (ODM) monitoring and oversight responsibilities include ensuring that the Department of Developmental Disabilities (DODD) is exercising its authority for the day-to-day operation of the waiver in accordance with federal Medicaid requirements. ODM supports and facilitates qualitative improvements in the systems, procedures, and protocols DODD employs to ensure conformity of providers, recipients, and other entities with federal Medicaid requirements. ODM will work with DODD to assess the root cause and develop and implement an appropriate course of action to remedy the program.

DODD monitoring and oversight responsibilities include ensuring that the local county boards are establishing and implementing systems, procedures and protocols to ensure conformity of providers, recipients, staff, or other entities with federal Medicaid requirements. The DODD supports and facilitates qualitative improvements in the systems, procedures, and protocols at the county boards level. When a program component is determined to be out of compliance with federal Medicaid requirements, ODM will work with DODD to assess the root cause and develop and implement an appropriate course of action to remedy the program.

ODM is responsible for ensuring DODD and county boards are in compliance with federal regulations, including the amount, duration and scope of services, free choice of providers, timeliness of delivery of services to waiver eligible participant and the availability of services statewide and conducts A-133 audits at least once every three years based on risk.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Ohio Department of Medicaid (ODM) in conjunction with the Department of Developmental Disabilities (DODD) will review the effectiveness of the State’s Quality Oversight Strategy including DODD performance data, fiscal reviews results, case-specific resolutions data, quality improvement plans, and technical assistance provided. These discussions will occur through quality briefings outlined in this appendix.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months ***(Select one):***

No

Yes *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

The Ohio Department of Developmental Disabilities (DODD), Division of Fiscal Administration – Audit Office performs waiver reviews of Medicaid Individual Options (IO) waiver claims paid utilizing a risk-based approach. The risk-based approach covers a wide range of providers, individuals, and claims paid. A risk analysis is performed for each waiver review period to identify riskier providers. The review period is not a 'cycle,' but a review period based on the state fiscal year. The review period varies based on staffing and resources. The length of the post-payment review period typically has been a two-year period of claims paid but can vary based on staffing and resources available.

Claims paid are chosen based on State fiscal years, and the length of the review period varies from a 1 to 3-year review period, based on staffing and resources available. Risk factors used in the analysis include but are not limited to: dollar amount of claims paid; number of individuals served; high overtime hours; complexity of services provided; prior noncompliance issues; prior findings; referrals from the Office of Compliance; and changes in compliance requirements to services provided. Once the selection of higher risk providers is determined, selected claims paid are reviewed for each provider for the respective individuals selected for review, depending on the number of individuals served, types of services provided, and/or the number of and dollar amount of claims paid. The DODD Audit Office also performs a comparison of Payment Authorization for Waiver Services (PAWS) data to Individual Service Plan (ISP) data for the claims paid selected for review to verify the waiver services authorized in PAWS match those contained in the county board of developmental disabilities (county board) approved ISP.

DODD contracts with the Auditor of the State of Ohio to perform Agreed-Upon Procedures of the county board's Cost Reports. DODD utilizes a risk-based approach to determine which county boards and their respective Council of Governments (COGs) will be reviewed. The Agreed-Upon Procedures include a review of program revenues and expenditures; reporting requirements; and program monitoring for allowable costs, activities allowed, and cash management.

The Auditor of the State of Ohio conducts an annual Single Audit of the State of Ohio, which includes the Department of Medicaid (ODM) and DODD in accordance with the requirements of the Single Audit Act (31 U.S.C. 7501-7507) as amended by the Single Audit Act Amendments of 1996 (P.L. 104- 146).

In accordance with OAC rule 5160-1-29, ODM is required to have in effect a program to prevent and detect fraud, waste, and abuse in the Medicaid program. The definition of fraud, waste, and abuse incorporates the concept of payment integrity. ODM, the Auditor of the State of Ohio, and/or the Ohio Office of Attorney General may recoup any amount in excess of that legitimately due to the provider based on review or audit.

The Department of Medicaid has a Bureau of Program Integrity whose primary function is to conduct audit and review activities to assure the allowability of claims paid to Medicaid providers. The scope of providers subjected to audit and review activities includes claims paid through sister state agencies which administer Medicaid programs on behalf of ODM.

DODD recovers any overpayments pursuant to Section 5164.58 of the Ohio Revised Code. DODD notifies the provider of the overpayment and requests voluntary repayment. If DODD is unable to obtain voluntary repayment, it shall give the provider notice of an opportunity for a hearing in accordance with Chapter 119 of the Ohio Revised Code. DODD shall conduct the hearing to determine the legal and factual validity of the overpayment. DODD shall submit the hearing examiner's report and recommendation and a complete record of the proceedings, including all transcripts to the Director of Ohio Department of Medicaid. The Director of ODM may issue a final adjudication order in accordance with Chapter 119 of the Ohio Revised Code. When inappropriate billing is identified, the State has two options to ensure that the claims are removed from the FFP calculation. Claims may be either voided through the regular billing system, which would remove them from the FFP calculation, or the amount may be manually removed from the FFP records.

Agency and independent providers must submit claims using designated procedure codes for the competency-based add-on. These claims will be sampled by DODD's Office of Compliance when conducting routine and/or special provider compliance reviews in accordance with Ohio Administrative Code 5123-2-04 Compliance reviews of certified providers. In addition, claims paid which include a competency-based add-on will be reviewed if applicable to those providers selected as part of the risk-based waiver reviews conducted in accordance with the methodology specified in appendix I.

The claims paid to Medicaid providers are not considered federal awards, therefore they are not considered sub-recipients and do not meet the criteria for a Single Audit. Additionally, since the providers are not sub-recipients, they are not required to submit or have a financial statement audit.

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:
I-2: Number and percent of waiver claims paid for individuals who were enrolled on the waiver on the date of services. Numerator: Total number of waiver claims paid for individuals who were enrolled on the waiver on the date of services. Denominator: Total number of submitted waiver claims.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
DODD's Waiver Payment System/ODM's Medicaid Information Technology System (MITS)

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
State Medicaid Agency	***Weekly***	***100% Review***
Operating Agency	***Monthly***	***Less than 100% Review***
Sub-State Entity	***Quarterly***	***Representative Sample*** *Confidence Interval =*

Other *Specify:*	***Annually***	***Stratified*** *Describe Group:*
	Continuously and Ongoing	***Other*** *Specify:*
	Other *Specify:*	

Data Aggregation and Analysis:

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

Performance Measure:
I-1: Number and percent of paid waiver claims submitted that were authorized. Numerator: Total number of paid waiver claims submitted that were authorized. Denominator: Total number of submitted waiver claims.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
DODD's Waiver Payment System/ODM's Medicaid Information Technology System (MITS)

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

Data Aggregation and Analysis:

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

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:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
I-3: Number and percent of waiver claims that were paid using the correct rate as specified in Chapters 5123:2-9 of the Ohio Administrative Code. Numerator: Total number of paid claims that were paid using the correct rate. Denominator: Total number of approved waiver claims.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
DODD's Waiver Payment System/ODM's Medicaid Information Technology System (MITS)

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

		Sample *Confidence Interval =*
Other *Specify:*	***Annually***	***Stratified*** *Describe Group:*
	Continuously and Ongoing	***Other*** *Specify:*
	Other *Specify:*	

Data Aggregation and Analysis:

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

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the*

State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the 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 Department of Developmental Disabilities (DODD) monitors claims rejections on a quarterly basis by rejection/error reason code. If there is a large negative change for a county board of developmental disabilities (county board) or if a county board continuously has a large number of claims rejected, DODD staff will contact the county board and offer technical assistance to the county board and their providers. Similarly, if a rejection or error reason code spikes up in a certain quarter, claims staff will research the reason.

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).*

Legislative actions, primarily resulting from biennial budget initiatives have been the primary driver for establishing service rates. The Department of Developmental Disabilities (DODD) frequently engages individuals, providers, advocates, and other stakeholders in discussions regarding rate setting, in routine forums, most notably the monthly Waiver Workgroup. Analysis of appropriate rates for services occurs throughout the life of the waiver, through these forums, and are frequently updated prior to a renewal application of a waiver.

DODD maintains fee schedules codified in Ohio Administrative Code Chapter 5123-09 at https://codes.ohio.gov/ohio-administrative-code/chapter-5123-9. Fee schedules incorporate geographic and acuity factors, depending on the service. OAC 5123-9-06 and 5123-9-19 document the use of these factors in relationship to the IO waiver services. When necessary to comply with Fair Labor Standards Act, the reimbursement to non-agency providers will be adjusted for overtime compensation. Overtime payments are calculated based on the wage component of the service rate. DODD is responsible for the development of statewide rates for waiver services, which they oversee, through an Interagency Agreement with ODM. The rate development process includes input from stakeholders. Once developed by DODD, ODM is responsible for the final review and approval of all rates. Rates are incorporated into OAC rules for each service. In addition to review and updates from state budget appropriations, completed at least every other year, each rule is required to be reviewed every five years.

Once approved by ODM, all reimbursement rates are incorporated into OAC, which includes a period for public comment as well as a public hearing process that allows for public testimony before Ohio's Joint Commission on Agency Rule Review (JCARR), a body compromised of representatives from the Ohio Senate and the Ohio House of Representatives. Public comments are solicited during the public hearing phase for any new/amended/to be rescinded administrative rules in Ohio. Information about payment rates is posted on DODD's website. Additionally, proposals concerning payment rate restructuring are made public via the Federal Rate change process whereby the State posts the notice of a payment rate restructuring to the Ohio Registrar's website. Payment rates are made available to the individual during the Individual Service Planning and waiver service planning processes. The Cost Projection Tool, developed and maintained by DODD, is used to determine the total expected amount of payment for each individual's waiver span as well as the total service hours that are expected to be rendered. The projection of service costs and payment standards are in accordance with Chapters 5160-41, 5123-9 of OAC.

The State broadly categorizes services into three different rate models below:

-Equipment Rate Model: services that use an Equipment Rate Model are as follows: Assistive Technology Equipment; Community Transition Services (CTS); Environmental Accessibility Adaptations; and Specialized Medical Equipment and Supplies.

Except for CTS, these services are based on the manufacturer's suggested retail price defined as: The current retail price of an equipment item that is recommended by the product's manufacturer. If a provider of equipment is also the manufacturer, the provider may establish a suggested retail price provided that the price is equal to or less than the suggested retail price for the same or a comparable item recommended by one or more other manufacturers. The CTS rate is comparable to the rate previously offered under Ohio Medicaid's Money Follows the Person Program (HOME Choice) for the same service.

Statewide maximum rates are in place for Assistive Technology Equipment, Environmental Accessibility and Adaptations, Specialized Medical Equipment and Supplies, and CTS. Reimbursement for these services is the lower of the provider's usual charge or the established statewide maximum.

-Service-Specific models: the following services are paid using their own, individually customized, rate models: Career Planning; Individual Employment Supports; Interpreter, Home Delivered Meals; Nursing and Nursing Delegation; Nutrition; Social Work; and Transportation. The Individual Employment Supports and Career Planning service rates were developed by using a blend of two components (initial and retention supports) of a historical service under the SELF waiver. Ohio assumed that 70% of all employment services are for retention and 30% for placement. This cost is then adjusted for inflation and eight CODB categories. The rates for employment quality were developed as the product of the hours of service required to achieve the outcome for each individual and the cost of the services that result in the desired outcome. The Employment Quality Program only applies to Career Planning and Individual Employment Support providers. The source of the non-Federal share of the supplemental payment is paid according to the standards specified in Appendix I-4-a. Eligible providers will retain 100% of the computable expenditure claimed.

Rates for transportation are based on federal mileage reimbursement guidelines as specified in the OAC. Claims are reimbursed at the lower of the rate established or the provider's usual and customary charge for the service. As of January 1, 2020, Ohio will reimburse transportation per mile at the Federal per mile reimbursement rate as of 2019. Ohio is also adding $1.00 per mile for vehicle modifications under the transportation service. This is not in addition to the regular $.58 per mile rate.

To establish home delivered meal service rates, in 2019, the State reviewed the methodology to ensure economy, efficiency, quality of care and found it to be sufficient to meet these requirements and ensure sufficient provider capacity.

The rate methodology was based on assumptions for three categories of cost: meal preparation, transportation and delivery, and administration and overhead. The methodology was developed as the sum of the following cost components: wages (based upon the Bureau of Labor Statistics data), employment related expenses, transportation costs, supplies, administration, and other overhead expenses. The methodology included a review of ODM claims and enrollment data, research of public resources, and a comparison to similar waiver service offerings in other state Medicaid programs. Initial rates established were effective July 1, 2019 and later increased on November 1, 2021 as a result of Ohio's House Bill 110. Home delivered meal types and associated Medicaid maximum rates are standard meal at $7.20 and therapeutic and kosher meals at $8.68. Effective July 1, 2022, the State will modify the home delivered meal service available through Level 1 and I/O waiver programs. Service changes will include aligning with home delivered meal rates and types available through the Ohio's 1915(c) nursing-based facility based waiver programs, as in effect on November 1, 2021. This includes the addition of kosher and therapeutic meal types.
ODM engaged an actuary to study factors such as labor market data, education, licensure status and length of service visit in the development of the waiver nursing and nursing delegation rates. The model begins with BLS information specific to Ohio's job market and incorporates reimbursement for employee related expenses, administrative overhead, and non-billable work time. Waiver Nursing Delegation rates were developed to align with Ohio Department of Medicaid's (ODM) rates. The rates are being increased (July 2022) and updated to align with ODM's most recent rate increase. The social worker, nutritionist and interpreter waiver services were all developed on a per service basis. The models include BLS information specific to Ohio's job market and incorporated reimbursement for employee related expenses, administrative overhead, and productivity assumptions for agency and independent providers. All associated rates for these three services are proposed for an increase in July 1, 2022 to align with industry standards the State's five year rule review process. Rates will increase between 33-40%, depending on the type of provider and service.
The source of the non-Federal share of the supplemental payment is paid according to the standards specified in Appendix I-4-a. Eligible providers will retain 100% of the computable expenditure claimed.
Independent Rate Model: services that use the independent model (or are based on other services that used an independent model) are as follows: Adult Day Support (ADS), Vocational Habilitation (VH), Group Employment, Non-Medical Transportation (per mile), Homemaker/Personal Care (HPC), Participant-Directed HPC (PD-HPC), HPC Daily Billing Unit, Shared Living, Money Management, Remote Supports, Assistive Technology Consultation/Supports, and Community and Residential Respite.
The independent rate model was developed by third party consultants for the HPC service and has since served as the basis for the above services. Reimbursement rates for HPC and the additional direct services are created by utilizing the independent rate setting model. The model uses Bureau of Labor Statistics information specific to Ohio's job market, reimbursement for employee related expenses (ERE), administrative overhead and non-billable work time to calculate a statewide rate for each service. This statewide rate is then adjusted for eight CODBs. The base wage rate used in the independent rate model was set using the average of the BLS job categories of Home Health Aides (31-1011) and Nursing Aides, Orderlies and Attendants (31-1012).
Rates are paid in fifteen-minute units for services to individuals who do not share services with others (e.g., live alone or live with others who do not receive HPC services from the same provider). A Daily Billing Unit (DBU) is paid for services to individuals who share the same provider in the same site. The DBU for homemaker/personal care was developed using the HPC rates for individuals who share services in a consistent and predictable pattern. The estimated DBU includes the base fifteen- minute unit rates currently approved by CMS as well as any applicable rate add-ons to determine the total expected amount of payment and service hours for the site and for each individual during their waiver span. After services are rendered, the provider will report the hours of service rendered by a provider in a given month to determine the amount of the total month's reimbursement claim that is attributable to each individual during that month. The provider will then submit an individual-specific claim, the DBU, for the service period. The Shared Living rate was calculated using the costs of HPC services delivered to adults identified as living with family and utilizing a provider and the cost of providing adult foster care. There are four daily rates which apply to the Ohio Developmental Disabilities Profile (ODDP) groups.
ERE was projected at 30% of the base wage for agencies and 32% for independent providers. Productivity adjustments of 1.02 and 1.10 for agencies and independents, respectively, were used. Overhead was estimated at 18% for agencies and 7% for independents.

Please see Main Section B for additional information

b. *Flow of Billings.* *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Claims are submitted electronically to the Department of Developmental Disabilities (DODD) from all Individual Options service providers, in order to submit claims to the Ohio Department of Medicaid's (ODM) claims payment system, the Medicaid Information Technology System (MITS). On a weekly basis, DODD compiles all claims received from providers during that week into one billing file and submits the file to ODM for processing and adjudication through MITS.

DODD providers of waiver nursing and waiver nursing delegation directly bill Medicaid through the Medicaid Information Technology System (MITS). All other DODD services are billed through the eMBS (electronic Medicaid Billing System) application. eMBS preprocess all claims submissions and electronically sends a weekly batch of claims for MITS to adjudicate and approve for payment. The Ohio Medicaid MITS system does not currently have the capacity to preprocess DODD waiver services claims.

Electronic Visit Verification (EVV)
Ohio's EVV program requirements are outlined in chapter 5160-32 of the Ohio administrative code.
ODM operates an EVV system to electronically document services furnished to individuals. Providers of personal care and nursing type services verify service delivery using the EVV system. EVV captures and logs visit data electronically and includes visit elements required under Section 1903 of the Social Security Act (42 U.S.C. 1396b). ODM, ODA, DODD or their designee edits against visit information before provider payment processing.
As of the date of submission of this waiver application, claims payment is not impacted by EVV status.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Certified public expenditures are incurred by county boards of developmental disabilities (county boards) when the waiver services are delivered by the boards. The claims for these services are accompanied by an attestation that the services delivered were fully paid for with public funds and are eligible expenditures for FFP. Claims delivered by county boards are reimbursed at the lower of the county board's usual and customary charge for the service or the statewide rates established for those services as described in Section I-2-a of this Appendix.

It is the State of Ohio's responsibility to monitor and audit its subrecipients as Federally required. Ohio Department of Developmental Disabilities (DODD) monitors and audits the cost reports that are prepared as a result of the cost-based activity. It is the responsibility of DODD to ensure timely reviews and audits of its subrecipients in order to settle the associated costs for the period under review.

Adult Day Services Reconciliation:
The total annual cost of providing services to the Medicaid consumers will be derived from the cost report. The annual revenue will be derived by taking reimbursement received for the units of services delivered multiplied by unit rates approved by CMS. The total annual cost of providing services will be reconciled to reimbursement received.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

The Department of Developmental Disabilities (DODD) uses a comprehensive system, comprised of the Waiver Enrollment System, the Medicaid Service System (MSS), and the Medicaid Billing System (MBS) to validate claims. Together, these applications validate the individual's eligibility for waiver services, the service identified on the Individual Service Plan (ISP), the provider(s) authorized to deliver each service, the frequency and duration of the service, and the dollar amount allotted to each provider.

The Medicaid Billing System (MBS) edits the waiver claims to assure the service codes and the number of units match what the county board has submitted as authorized services. This automated system compares 100% of submitted claims against the MSS/PAWS system. No payments are issued when a discrepancy arises. In addition to the validation through DODD systems, the Ohio Department of Medicaid (ODM's) MITS adjudicates all claims for reimbursement and makes the determination that both the individual receiving the service and the provider delivering the service were eligible for Medicaid waiver payment on the date the service was delivered.

In addition to the automated validations conducted within the web-based applications, post review processes are also used to track paid claims to actual service documentation.

The process by which FFP removal is processed for inappropriate billings is documented in I-1.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

The Department of Developmental Disabilities (DODD) is the limited fiscal agent for the Individual Options waiver program. DODD is responsible for paying the provider claims as authorized in an Interagency Agreement with the Ohio Department of Medicaid (ODM). ODM will adjudicate the claims and maintain ongoing dialogue, as needed, with the Fiscal and Information Systems sections of DODD to assure that claims are paid efficiently, and systems concerns are addressed timely.

Providers have access to billing guidance and tutorials on the Department of Medicaid website: https://medicaid.ohio.gov/Provider/Training/MITSOnlineTutorialsforProviders/InstitutionalWebBilling .

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the

entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. ***Supplemental or Enhanced Payments.*** *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

The competency add-on rate only applies to routine homemaker/personal care services delivered by direct support staff with two years' full-time equivalent experience in providing direct support to people with developmental disabilities and completion of 60 hours of accredited competency-based training.

The add-on of $0.39/unit was developed with stakeholder input in response to the existing workforce shortage. The intent was to promote retention of direct support professionals by making available an additional $1.00/hour. Upon increasing the wage component of the homemaker/personal care rate to reflect the additional $0.25/unit, the employee-related expenses, productivity assumptions, and administrative assumptions that are part of the rate methodology were increased accordingly.

The competency-based add-on rate applies to routine homemaker/personal care services and not the self-directed homemaker/personal care service. Eligible providers will retain 100%of the computable expenditure claimed. The competency rate add on is paid according to standards specified in Appendix I-4-a.

The nature of the Employment Quality Program payment will be outcome-based and rely on the achievement of pre-planned goals and measures. The payments will vary based on the acuity of the individual receiving services and the goal achieved. The nature of the payments will be as follows:
·Job placement in competitive, integrated settings will result in one supplemental payment for acuity levels A1, A, and B and a higher supplemental payment for acuity level C.
·Job placement in competitive, integrated settings (at least $12 an hour, or 30 hours per week) will result in one supplemental payment for acuity levels A1, A, and B and a higher supplemental payment for acuity level C.
·Job retention at 90 days will result in one supplemental payment for acuity levels A1, A, and B and a higher supplemental payment for acuity level C.
·Job retention at 180 days will result in one supplemental payment for acuity levels A1, A, and B and a higher supplemental payment for acuity level C.

The rates were developed as the product of the hours of service required to achieve the outcome for each individual and the cost of the services that result in the desired outcome.
The Employment Quality Program only applies to Career Planning and Individual Employment Support providers. The source of the non-Federal share of the supplemental payment is paid according to the standards specified in Appendix I-4-a. Eligible providers will retain 100% of the computable expenditure claimed.

The Non-medical transportation to competitive integrated employment rates are organized into the following mileage bands, each with four rates under each band (non-modified vehicles for agency providers, non-modified vehicles for independent providers, modified vehicles for agency providers, modified vehicles for independent providers): 0-15 miles, 16-30 miles, 31+ miles.
The independent rate model assumes wages for a driver and supervisor/dispatcher (aligned with Ohio House Bill 33 mentioned in the July 2023 update), employee related expenses (e.g., benefits, employee taxes), administrative expenses (7% for independent providers/15% for agency providers), fleet maintenance ($.73/mile for modified vehicles and $.67/mile for non-modified vehicles), direct time (e.g., unload/load time, transportation time), indirect time (e.g., documentation, vehicle check, wait time), and a 2% no show adjustment for canceled services that cannot be rescheduled.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

No. State or local government providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

Yes. State or local government providers receive payment for waiver services. *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

County boards of developmental disabilities (county boards) receive payments for waiver services provided only when no other qualified or available provider is found for the purposes of service provisioning: Non-Medical transportation (token/voucher) and Community Transition. This is noted in Appendix D-1-b.

Refer to Appendix C, containing the detail for waiver services delivery, including specifying which services may be provided by county boards when there is no other qualified and willing provider.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

The Ohio Department of Developmental Disabilities.

ii. Organized Health Care Delivery System. *Select one:*

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §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:

The Department of Developmental Disabilities (DODD) provides a portion of the non-federal share of computable waiver costs through funds appropriated in its budget. These funds are not transferred to the State Medicaid Agency (Ohio Department of Medicaid), as DODD makes the requests for provider payment to the Auditor and Treasurer of State.
DODD attests to ODM that expenditures included in Intra-State Transfer Vouchers (ISTVs) are based on the state's accounting of actual recorded expenditures.

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. *Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.* *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

Not Applicable*. There are no local government level sources of funds utilized as the non-federal share.*

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

County boards of developmental disabilities (county boards) provide a portion of the non-federal share of computable waiver costs. The Department of Developmental Disabilities (DODD) operates as the Fiscal Agent and will maintain the administrative control of the non-federal share. The non-federal share is comprised of local tax revenue. Ohio utilizes a Certified Public Expenditure (CPE) arrangement for the non-federal share when county boards are the providers. The non-federal share for CPE arrangements is also from local tax revenue.

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

County boards of developmental disabilities (county boards) provide a portion of the non-federal share of computable waiver costs. The Department of Developmental Disabilities (DODD) operates as the Fiscal Agent and will maintain the administrative control of the non-federal share. The non-federal share is comprised of local tax revenue. Ohio utilizes a Certified Public Expenditure (CPE) arrangement for the non-federal share when county boards are the providers. The non-federal share for CPE arrangements is also from local tax revenue.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

The rate setting methodology does not include any factors that represent costs associated with room and board.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

Nominal deductible

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: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	86371.96	12104.72	98476.68	146306.65	6575.37	152882.02	54405.34
2	86616.22	12504.97	99121.19	149964.32	6772.63	156736.95	57615.76
3	86628.35	12880.12	99508.47	153713.43	6975.81	160689.24	61180.77
4	86872.93	13305.89	100178.82	157556.27	7185.08	164741.35	64562.53
5	86885.39	13705.07	100590.46	161495.18	7400.63	168895.81	68305.35

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	30500	30500
Year 2	30500	30500
Year 3	30500	30500
Year 4	30500	30500
Year 5	30500	30500

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

Ohio estimated the average number of days on the IO waiver based on historical waiver eligibility data from SFY 2020 to SFY 2022. Ohio estimates approximately 1,644 disenrollments per year for each year of the waiver renewal while maintaining a consistent unduplicated participant count of 30,500. The impact of enrollment patterns results in a slight change in the average length of stay (ALOS) over the 5-year waiver renewal period.
Ohio estimates the average number of days each person is served as follows:
Waiver Year 1: 336
Waiver Year 2: 337
Waiver Year 3: 337
Waiver Year 4: 338
Waiver Year 5: 338

Ohio will accrue total person-days of service based on multiplying the ALOS by the unduplicated participant count of 30,500:
Waiver Year 1: 10,248,000
Waiver Year 2: 10,278,500
Waiver Year 3: 10,278,500
Waiver Year 4: 10,309,000
Waiver Year 5: 10,309,000

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:*

Development of the Factor D estimates for the Individual Options (IO) waiver program is based on historical experience for the covered services and adjusted for projected future enrollment. We reviewed historical experience for the covered services from the IO waiver year (WY) 3 372 report to ensure that historical experience aligned with projected future experience. Factor D estimates for the new 5-year waiver period for the renewal (July 1, 2024 through June 30, 2029) were developed in the following manner:

- *Base number of users was estimated by determining the allocated number of users from the historical data experience along with assumptions regarding future expectations. For the IO waiver services, the expected percentage of members identified as using a service was derived by summarizing utilization during SFY 2022 (July 1, 2021 through June 30, 2022). For services with no experience in the historical data, the percentage of utilization from the historically filed experience was used. The projected number of users for WY 1 of the waiver renewal represents the expected percentage of utilization multiplied by the projected unduplicated participant count for WY 1. We have not reflected increases in the projected number of users from WY 1 to WY 5 of the renewal period based on maintaining the same projected numbers of unduplicated participants (30,500) over the course of the 5-year renewal period. Due to requirements by CMS to avoid an MOE violation, the total number of unduplicated participants is being held at or above the level listed in WY 5 of the current waiver (30,500).*
- *Baseline average units per user was calculated by adjusting the historically filed experience of average units per user by projected growth in the Average Length of Stay (ALOS). Therefore, a projected average units per user was developed based on projected WY 5 experience from the currently approved waiver period multiplied by the change in ALOS from WY 5 from the currently approved waiver period to WY 1 of the waiver renewal. Changes 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 from WY5 of the currently approved waiver to WY1 of the renewal period.*

- *The average cost per unit varies for services affected by and not affected by the budgetary changes effective January 1, 2024 contained in Chapter 5123-9 of the Administrative Code. For services affected by the January 1, 2024 amendment the cost per unit is set to the historically filed WY5 cost. Over the future 5 years of the waiver, the average cost per unit for these services is held constant. For all other services we applied an annual trend of 3% starting with the historically filed WY5 cost. Over the 5-year renewal period, the cost per unit for these services continues to trend at the same annual rate. Services that receive the 3% annual trend include all three Assistive Technology services and the Interpreter service.*
- *New Services: Users for Adult Day Quality Payments is set equal to the user count for the Job Development and Individual Employment Support services, respectfully. We projected one unit per user during the waiver period and the average cost per unit is set to the Tier C rate of $730 or $650 for the respective service. For this service, the trend throughout the waiver years aligns with the methodology explained above.*

The increases observed in the Factor D costs on a year over year basis were due to the following changes reflected in Appendix J-2-d over the course of the waiver renewal period:

- *Unit cost trend applied to a limited set of services (Assistive Technology and Interpreter Services)*
- *Increase in Average Length of Stay (ALOS) from WY 1 to WY 2 as well as between WY 3 and WY 4 which results in additional units per user for certain services*

January 2025

Users for the Health Assessment Service are projected to start at 3,000 in WY1 of the renewal and increase by 500 for each subsequent waiver year. We projected 12 units per user for all waiver years in the renewal period assuming the service occurs once per month for each user. Average unit cost is set to $34.50 and held constant for all 5 years in the waiver renewal period. Users of the Competitive Integrated Employment (CIE) non-medical transportation to be reimbursed under a special service rate are projected to be 1,236 annually for the entirety of the waiver period. The average unit cost of $58.59 is based on the special service rate fee schedule and assumes 80% of providers are employed by an agency, 75% of vehicles are not modified, and the distribution of trip distance for the 0-15, 16-30, and 31+ mile is 60:20:20. We projected 6 units per user on average for all waiver years in the renewal period based on based on these assumptions, an assumption that 20% of non-medical transportation utilization will be furnished by a provider eligible for the CIE rate.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Base Year data reflects state plan costs identified for IO waiver members in the historical data during SFY 2022 (July 1, 2021 through June 30, 2022). Costs are adjusted for the change in ALOS between SFY 2022 and the projected waiver years of the renewal.

Factor D' was trended at a rate of 3.0% per year based on historical experience and budget forecast trends.

iii. ***Factor G Derivation.*** *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Base Year data reflects historical Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) costs in the Ohio Medicaid data during SFY 2022 (July 1, 2021 through June 30, 2022). This population excludes DODD waiver members and only includes member months with a claim at an ICF/IID. This serves as the proxy population for the ICF/IID level of care costs represented by Factor G in this waiver.

Factor G costs were trended at a rate of 2.5% per year based on historical experience and budget forecast trends.

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:*

Factor G' Derivation
Base Year data reflects historical state plan service costs for members with Intellectual Disabilities residing in an Intermediate Care Facility in the Ohio Medicaid data during SFY 2022 (July 1, 2021 through June 30, 2022). This population excludes DODD waiver members and only includes member months with a claim at an ICF/IID. This serves as the proxy population for the ICF/IID level of care costs represented by Factor G in this waiver.

Factor G' costs were trended at a rate of 3.0% per year based on historical experience and budget forecast trends.

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	
Community Respite	
Habilitation - Adult Day Support	
Homemaker/Personal Care	
Specialized Medical Equipment and Supplies	
Assistive Technology	
Career Planning	
Community Transition Service	
Environmental Accessibility Adaptations	
Group Employment Support	
Habilitation - Vocational Habilitation	
Health Care Assessment	
Home Delivered Meals	
Homemaker/Personal Care - Daily Billing Unit	
Individual Employment Support	
Interpreter	
Money Management	
Non-Medical Transportation	

Waiver Services	
Nutrition	
Participant-Directed Homemaker/Personal Care	
Remote Supports	
Residential Respite	
Shared Living	
Social Work	
Transportation	
Waiver Nursing Delegation	
Waiver Nursing	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Respite Total:						852338.40
Community Respite	Day	524	60.00	27.11	852338.40	
Habilitation - Adult Day Support Total:						202515586.90
Habilitation-Adult Day Support Day	Day	12235	150.00	100.21	183910402.50	
Habilitation-Adult Day Support Hour	Hour	10226	110.00	16.54	18605184.40	
Homemaker/Personal Care Total:						836819972.80
Homemaker/Personal Care	Hour	13628	2144.00	26.15	764061996.80	
On Site/On Call	Hour	3398	1325.00	16.16	72757976.00	
Specialized Medical Equipment and Supplies Total:						5964401.04
Specialized Medical Equipment and Supplies	Item	1768	1.00	3373.53	5964401.04	
Assistive Technology Total:						5267697.24
Assistive Technology Consultation	Item	2498	1.00	141.56	353616.88	
GRAND TOTAL:						2634344738.22
Total Estimated Unduplicated Participants:						30500
Factor D (Divide total by number of participants):						86371.96
Average Length of Stay on the Waiver:						336

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Technology Supports	Hour	5	10.00	22.45	1122.50	
Assistive Technology Equipment	Item	2082	1.00	2359.73	4912957.86	
Career Planning Total:						1335988.26
Job Development	Hour	112	100.00	64.81	725872.00	
Benefits Education and Analysis	Item	52	1.00	434.19	22577.88	
Employment/Self-Employment Plan	Item	1	1.00	972.53	972.53	
Self-Employment Launch	Hour	34	6.00	64.81	13221.24	
Career Discovery	Item	29	1.00	1782.96	51705.84	
Worksite Accessibility	Hour	27	6.00	64.81	10499.22	
Career Exploration	Hour	61	100.00	64.81	395341.00	
Situational Observation and Assessment	Item	35	1.00	972.53	34038.55	
Adult Day Quality Payment- Job Development	Item	112	1.00	730.00	81760.00	
Community Transition Service Total:						158000.00
Community Transition Service	Item	79	1.00	2000.00	158000.00	
Environmental Accessibility Adaptations Total:						5044320.00
Environmental Accessibility Adaptations	Item	1130	1.00	4464.00	5044320.00	
Group Employment Support Total:						4107618.16
Group Employment Support-Hour	Hour	708	678.00	6.62	3177758.88	
Group Employment Support-Day	Day	658	28.00	50.47	929859.28	
Habilitation - Vocational Habilitation Total:						48158714.10
Habilitation-Vocational Habilitation-Hour	Hour	5286	75.00	13.19	5229175.50	
Habilitation-Vocational Habilitation	Day	5772	95.00	78.29	42929538.60	
GRAND TOTAL:						2634344738.22
Total Estimated Unduplicated Participants:						30500
Factor D (Divide total by number of participants):						86371.96
Average Length of Stay on the Waiver:						336

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Health Care Assessment Total:						1242000.00
Health Care Assessment Service	Month	3000	12.00	34.50	1242000.00	
Home Delivered Meals Total:						2450520.70
Home Delivered Meals	1 meal	983	257.00	9.70	2450520.70	
Homemaker/Personal Care - Daily Billing Unit Total:						1029625198.80
Homemaker/Personal Care - Daily Billing Unit	Day	11919	319.00	270.80	1029625198.80	
Individual Employment Support Total:						3861676.00
Individual Employment Support	Hour	1442	40.00	50.70	2924376.00	
Adult Day Quality Payment- Individual Employment Support	Item	1442	1.00	650.00	937300.00	
Interpreter Total:						12085.58
Interpreter	Hour	23	13.00	40.42	12085.58	
Money Management Total:						2560163.76
Money Management	Hour	2932	33.00	26.46	2560163.76	
Non-Medical Transportation Total:						143036036.82
Non-medical transportation	Trip	17711	369.00	21.82	142601533.38	
Competitive integrated employment transportation	Trip	1236	6.00	58.59	434503.44	
Nutrition Total:						78650.88
Nutrition	Hour	112	12.00	58.52	78650.88	
Participant-Directed Homemaker/Personal Care Total:						1185078.25
Participant-Directed Homemaker/Personal Care	Hour	25	1867.00	25.39	1185078.25	
Remote Supports Total:						22912722.72
Remote Supports	Hour	1181	1944.00	9.98	22912722.72	
Residential Respite Total:						1677282.36
GRAND TOTAL:						2634344738.22
Total Estimated Unduplicated Participants:						30500
Factor D (Divide total by number of participants):						86371.96
Average Length of Stay on the Waiver:						336

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Respite	Day	130	29.00	327.50	1234675.00	
Residential Respite	Hour	268	52.00	31.76	442607.36	
Shared Living Total:						233120606.42
Shared Living	Day	4987	299.00	156.34	233120606.42	
Social Work Total:						247866.63
Social Work	Hour	289	69.00	12.43	247866.63	
Transportation Total:						68202501.36
Transportation	Mile	18298	2094.00	1.78	68202501.36	
Waiver Nursing Delegation Total:						1651040.16
Waiver Nursing Delegation Assessment	Per assessment	341	6.00	45.16	92397.36	
Waiver Nursing Delegation Consultation	Hour	341	120.00	38.09	1558642.80	
Waiver Nursing Total:						12256670.88
Waiver Nursing	Hour	521	558.00	42.16	12256670.88	
GRAND TOTAL:						2634344738.22
Total Estimated Unduplicated Participants:						30500
Factor D (Divide total by number of participants):						86371.96
Average Length of Stay on the Waiver:						336

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Respite Total:						852338.40
Community Respite	Day	524	60.00	27.11	852338.40	
GRAND TOTAL:						2641794590.67
Total Estimated Unduplicated Participants:						30500
Factor D (Divide total by number of participants):						86616.22
Average Length of Stay on the Waiver:						337

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Habilitation - Adult Day Support Total:						202515586.90
Habilitation-Adult Day Support Day	Day	12235	150.00	100.21	183910402.50	
Habilitation-Adult Day Support Hour	Hour	10226	110.00	16.54	18605184.40	
Homemaker/Personal Care Total:						839177852.72
Homemaker/Personal Care	Hour	13628	2150.00	26.15	766200230.00	
On Site/On Call	Hour	3398	1329.00	16.16	72977622.72	
Specialized Medical Equipment and Supplies Total:						5964401.04
Specialized Medical Equipment and Supplies	Item	1768	1.00	3373.53	5964401.04	
Assistive Technology Total:						5425732.02
Assistive Technology Consultation	Item	2498	1.00	145.81	364233.38	
Assistive Technology Supports	Hour	5	10.00	23.12	1156.00	
Assistive Technology Equipment	Item	2082	1.00	2430.52	5060342.64	
Career Planning Total:						1335988.26
Job Development	Hour	112	100.00	64.81	725872.00	
Benefits Education and Analysis	Item	52	1.00	434.19	22577.88	
Employment/Self-Employment Plan	Item	1	1.00	972.53	972.53	
Self-Employment Launch	Hour	34	6.00	64.81	13221.24	
Career Discovery	Item	29	1.00	1782.96	51705.84	
Worksite Accessibility	Hour	27	6.00	64.81	10499.22	
Career Exploration	Hour	61	100.00	64.81	395341.00	
Situational Observation and Assessment	Item	35	1.00	972.53	34038.55	
Adult Day Quality Payment- Job Development	Item	112	1.00	730.00	81760.00	
Community Transition Service Total:						158000.00

GRAND TOTAL:	2641794590.67
Total Estimated Unduplicated Participants:	30500
Factor D (Divide total by number of participants):	86616.22
Average Length of Stay on the Waiver:	337

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Transition Service	Item	79	1.00	2000.00	158000.00	
Environmental Accessibility Adaptations Total:						5044320.00
Environmental Accessibility Adaptations	Item	1130	1.00	4464.00	5044320.00	
Group Employment Support Total:						4116992.08
Group Employment Support-Hour	Hour	708	680.00	6.62	3187132.80	
Group Employment Support-Day	Day	658	28.00	50.47	929859.28	
Habilitation - Vocational Habilitation Total:						48158714.10
Habilitation-Vocational Habilitation-Hour	Hour	5286	75.00	13.19	5229175.50	
Habilitation-Vocational Habilitation	Day	5772	95.00	78.29	42929538.60	
Health Care Assessment Total:						1449000.00
Health Care Assessment Service	Month	3500	12.00	34.50	1449000.00	
Home Delivered Meals Total:						2460055.80
Home Delivered Meals	1 meal	983	258.00	9.70	2460055.80	
Homemaker/Personal Care - Daily Billing Unit Total:						1032852864.00
Homemaker/Personal Care - Daily Billing Unit	Day	11919	320.00	270.80	1032852864.00	
Individual Employment Support Total:						3861676.00
Individual Employment Support	Hour	1442	40.00	50.70	2924376.00	
Adult Day Quality Payment- Individual Employment Support	Item	1442	1.00	650.00	937300.00	
Interpreter Total:						12447.37
Interpreter	Hour	23	13.00	41.63	12447.37	
Money Management Total:						2560163.76
Money Management	Hour	2932	33.00	26.46	2560163.76	
Non-Medical						143422490.84

GRAND TOTAL:	2641794590.67
Total Estimated Unduplicated Participants:	30500
Factor D (Divide total by number of participants):	86616.22
Average Length of Stay on the Waiver:	337

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation Total:						
Non-medical transportation	Trip	17711	370.00	21.82	142987987.40	
Competitive integrated employment transportation	Trip	1236	6.00	58.59	434503.44	
Nutrition Total:						78650.88
Nutrition	Hour	112	12.00	58.52	78650.88	
Participant-Directed Homemaker/Personal Care Total:						1188886.75
Participant-Directed Homemaker/Personal Care	Hour	25	1873.00	25.39	1188886.75	
Remote Supports Total:						22983441.00
Remote Supports	Hour	1181	1950.00	9.98	22983441.00	
Residential Respite Total:						1677282.36
Residential Respite	Day	130	29.00	327.50	1234675.00	
Residential Respite	Hour	268	52.00	31.76	442607.36	
Shared Living Total:						233900274.00
Shared Living	Day	4987	300.00	156.34	233900274.00	
Social Work Total:						247866.63
Social Work	Hour	289	69.00	12.43	247866.63	
Transportation Total:						68397924.00
Transportation	Mile	18298	2100.00	1.78	68397924.00	
Waiver Nursing Delegation Total:						1651040.16
Waiver Nursing Delegation Assessment	Per assessment	341	6.00	45.16	92397.36	
Waiver Nursing Delegation Consultation	Hour	341	120.00	38.09	1558642.80	
Waiver Nursing Total:						12300601.60
Waiver Nursing	Hour	521	560.00	42.16	12300601.60	
GRAND TOTAL:						2641794590.67
Total Estimated Unduplicated Participants:						30500
Factor D (Divide total by number of participants):						86616.22
Average Length of Stay on the Waiver:						337

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Respite Total:						852338.40
Community Respite	Day	524	60.00	27.11	852338.40	
Habilitation - Adult Day Support Total:						202515586.90
Habilitation-Adult Day Support Day	Day	12235	150.00	100.21	183910402.50	
Habilitation-Adult Day Support Hour	Hour	10226	110.00	16.54	18605184.40	
Homemaker/Personal Care Total:						839177852.72
Homemaker/Personal Care	Hour	13628	2150.00	26.15	766200230.00	
On Site/On Call	Hour	3398	1329.00	16.16	72977622.72	
Specialized Medical Equipment and Supplies Total:						5964401.04
Specialized Medical Equipment and Supplies	Item	1768	1.00	3373.53	5964401.04	
Assistive Technology Total:						5588502.22
Assistive Technology Consultation	Item	2498	1.00	150.18	375149.64	
Assistive Technology Supports	Hour	5	10.00	23.81	1190.50	
Assistive Technology Equipment	Item	2082	1.00	2503.44	5212162.08	
Career Planning Total:						1335988.26
Job Development	Hour	112	100.00	64.81	725872.00	
Benefits Education and Analysis	Item	52	1.00	434.19	22577.88	
Employment/Self-Employment Plan	Item	1	1.00	972.53	972.53	
Self-Employment					13221.24	
GRAND TOTAL:						2642164734.62
Total Estimated Unduplicated Participants:						30500
Factor D (Divide total by number of participants):						86628.35
Average Length of Stay on the Waiver:						337

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Launch	Hour	34	6.00	64.81		
Career Discovery	Item	29	1.00	1782.96	51705.84	
Worksite Accessibility	Hour	27	6.00	64.81	10499.22	
Career Exploration	Hour	61	100.00	64.81	395341.00	
Situational Observation and Assessment	Item	35	1.00	972.53	34038.55	
Adult Day Quality Payment- Job Development	Item	112	1.00	730.00	81760.00	
Community Transition Service Total:						158000.00
Community Transition Service	Item	79	1.00	2000.00	158000.00	
Environmental Accessibility Adaptations Total:						5044320.00
Environmental Accessibility Adaptations	Item	1130	1.00	4464.00	5044320.00	
Group Employment Support Total:						4116992.08
Group Employment Support-Hour	Hour	708	680.00	6.62	3187132.80	
Group Employment Support-Day	Day	658	28.00	50.47	929859.28	
Habilitation - Vocational Habilitation Total:						48158714.10
Habilitation- Vocational Habilitation-Hour	Hour	5286	75.00	13.19	5229175.50	
Habilitation- Vocational Habilitation	Day	5772	95.00	78.29	42929538.60	
Health Care Assessment Total:						1656000.00
Health Care Assessment Service	Month	4000	12.00	34.50	1656000.00	
Home Delivered Meals Total:						2460055.80
Home Delivered Meals	1 meal	983	258.00	9.70	2460055.80	
Homemaker/Personal Care - Daily Billing Unit Total:						1032852864.00
Homemaker/Personal Care - Daily Billing Unit	Day	11919	320.00	270.80	1032852864.00	
			GRAND TOTAL:			2642164734.62
			Total Estimated Unduplicated Participants:			30500
			Factor D (Divide total by number of participants):			86628.35
			Average Length of Stay on the Waiver:			337

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Employment Support Total:						3861676.00
Individual Employment Support	Hour	1442	40.00	50.70	2924376.00	
Adult Day Quality Payment- Individual Employment Support	Item	1442	1.00	650.00	937300.00	
Interpreter Total:						12821.12
Interpreter	Hour	23	13.00	42.88	12821.12	
Money Management Total:						2560163.76
Money Management	Hour	2932	33.00	26.46	2560163.76	
Non-Medical Transportation Total:						143422490.84
Non-medical transportation	Trip	17711	370.00	21.82	142987987.40	
Competitive integrated employment transportation	Trip	1236	6.00	58.59	434503.44	
Nutrition Total:						78650.88
Nutrition	Hour	112	12.00	58.52	78650.88	
Participant-Directed Homemaker/Personal Care Total:						1188886.75
Participant-Directed Homemaker/Personal Care	Hour	25	1873.00	25.39	1188886.75	
Remote Supports Total:						22983441.00
Remote Supports	Hour	1181	1950.00	9.98	22983441.00	
Residential Respite Total:						1677282.36
Residential Respite	Day	130	29.00	327.50	1234675.00	
Residential Respite	Hour	268	52.00	31.76	442607.36	
Shared Living Total:						233900274.00
Shared Living	Day	4987	300.00	156.34	233900274.00	
Social Work Total:						247866.63
Social Work	Hour	289	69.00	12.43	247866.63	
Transportation Total:						68397924.00

GRAND TOTAL:	2642164734.62
Total Estimated Unduplicated Participants:	30500
Factor D (Divide total by number of participants):	86628.35
Average Length of Stay on the Waiver:	337

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation	Mile	18298	2100.00	1.78	68397924.00	
Waiver Nursing Delegation Total:						1651040.16
Waiver Nursing Delegation Assessment	Per assessment	341	6.00	45.16	92397.36	
Waiver Nursing Delegation Consultation	Hour	341	120.00	38.09	1558642.80	
Waiver Nursing Total:						12300601.60
Waiver Nursing	Hour	521	560.00	42.16	12300601.60	
GRAND TOTAL:						2642164734.62
Total Estimated Unduplicated Participants:						30500
Factor D (Divide total by number of participants):						86628.35
Average Length of Stay on the Waiver:						337

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Respite Total:						852338.40
Community Respite	Day	524	60.00	27.11	852338.40	
Habilitation - Adult Day Support Total:						202515586.90
Habilitation-Adult Day Support Day	Day	12235	150.00	100.21	183910402.50	
Habilitation-Adult Day Support Hour	Hour	10226	110.00	16.54	18605184.40	
Homemaker/Personal Care Total:						841535732.64
Homemaker/Personal Care	Hour	13628	2156.00	26.15	768338463.20	
On Site/On Call	Hour	3398	1333.00	16.16	73197269.44	
Specialized Medical Equipment and Supplies						5964401.04
GRAND TOTAL:						2649624235.89
Total Estimated Unduplicated Participants:						30500
Factor D (Divide total by number of participants):						86872.93
Average Length of Stay on the Waiver:						338

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:						
Specialized Medical Equipment and Supplies	Item	1768	1.00	3373.53	5964401.04	
Assistive Technology Total:						5756161.90
Assistive Technology Consultation	Item	2498	1.00	154.69	386415.62	
Assistive Technology Supports	Hour	5	10.00	24.52	1226.00	
Assistive Technology Equipment	Item	2082	1.00	2578.54	5368520.28	
Career Planning Total:						1335988.26
Job Development	Hour	112	100.00	64.81	725872.00	
Benefits Education and Analysis	Item	52	1.00	434.19	22577.88	
Employment/Self-Employment Plan	Item	1	1.00	972.53	972.53	
Self-Employment Launch	Hour	34	6.00	64.81	13221.24	
Career Discovery	Item	29	1.00	1782.96	51705.84	
Worksite Accessibility	Hour	27	6.00	64.81	10499.22	
Career Exploration	Hour	61	100.00	64.81	395341.00	
Situational Observation and Assessment	Item	35	1.00	972.53	34038.55	
Adult Day Quality Payment- Job Development	Item	112	1.00	730.00	81760.00	
Community Transition Service Total:						158000.00
Community Transition Service	Item	79	1.00	2000.00	158000.00	
Environmental Accessibility Adaptations Total:						5044320.00
Environmental Accessibility Adaptations	Item	1130	1.00	4464.00	5044320.00	
Group Employment Support Total:						4126366.00
Group Employment Support-Hour	Hour	708	682.00	6.62	3196506.72	
Group Employment Support-Day	Day	658	28.00	50.47	929859.28	
GRAND TOTAL:						2649624235.89
Total Estimated Unduplicated Participants:						30500
Factor D (Divide total by number of participants):						86872.93
Average Length of Stay on the Waiver:						338

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Habilitation - Vocational Habilitation Total:						48158714.10
Habilitation-Vocational Habilitation-Hour	Hour	5286	75.00	13.19	5229175.50	
Habilitation-Vocational Habilitation	Day	5772	95.00	78.29	42929538.60	
Health Care Assessment Total:						1863000.00
Health Care Assessment Service	Month	4500	12.00	34.50	1863000.00	
Home Delivered Meals Total:						2469590.90
Home Delivered Meals	1 meal	983	259.00	9.70	2469590.90	
Homemaker/Personal Care - Daily Billing Unit Total:						1036080529.20
Homemaker/Personal Care - Daily Billing Unit	Day	11919	321.00	270.80	1036080529.20	
Individual Employment Support Total:						3861676.00
Individual Employment Support	Hour	1442	40.00	50.70	2924376.00	
Adult Day Quality Payment- Individual Employment Support	Item	1442	1.00	650.00	937300.00	
Interpreter Total:						13206.83
Interpreter	Hour	23	13.00	44.17	13206.83	
Money Management Total:						2560163.76
Money Management	Hour	2932	33.00	26.46	2560163.76	
Non-Medical Transportation Total:						143808944.86
Non-medical transportation	Trip	17711	371.00	21.82	143374441.42	
Competitive integrated employment transportation	Trip	1236	6.00	58.59	434503.44	
Nutrition Total:						78650.88
Nutrition	Hour	112	12.00	58.52	78650.88	
Participant-Directed Homemaker/Personal Care Total:						1192695.25
Participant-Directed					1192695.25	
GRAND TOTAL:						2649624235.89
Total Estimated Unduplicated Participants:						30500
Factor D (Divide total by number of participants):						86872.93
Average Length of Stay on the Waiver:						338

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Homemaker/Personal Care	Hour	25	1879.00	25.39		
Remote Supports Total:						23054159.28
Remote Supports	Hour	1181	1956.00	9.98	23054159.28	
Residential Respite Total:						1677282.36
Residential Respite	Day	130	29.00	327.50	1234675.00	
Residential Respite	Hour	268	52.00	31.76	442607.36	
Shared Living Total:						234679941.58
Shared Living	Day	4987	301.00	156.34	234679941.58	
Social Work Total:						247866.63
Social Work	Hour	289	69.00	12.43	247866.63	
Transportation Total:						68593346.64
Transportation	Mile	18298	2106.00	1.78	68593346.64	
Waiver Nursing Delegation Total:						1651040.16
Waiver Nursing Delegation Assessment	Per assessment	341	6.00	45.16	92397.36	
Waiver Nursing Delegation Consultation	Hour	341	120.00	38.09	1558642.80	
Waiver Nursing Total:						12344532.32
Waiver Nursing	Hour	521	562.00	42.16	12344532.32	
GRAND TOTAL:						2649624235.89
Total Estimated Unduplicated Participants:						30500
Factor D (Divide total by number of participants):						86872.93
Average Length of Stay on the Waiver:						338

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Respite Total:						852338.40
Community Respite	Day	524	60.00	27.11	852338.40	
Habilitation - Adult Day Support Total:						202515586.90
Habilitation-Adult Day Support Day	Day	12235	150.00	100.21	183910402.50	
Habilitation-Adult Day Support Hour	Hour	10226	110.00	16.54	18605184.40	
Homemaker/Personal Care Total:						841535732.64
Homemaker/Personal Care	Hour	13628	2156.00	26.15	768338463.20	
On Site/On Call	Hour	3398	1333.00	16.16	73197269.44	
Specialized Medical Equipment and Supplies Total:						5964401.04
Specialized Medical Equipment and Supplies	Item	1768	1.00	3373.53	5964401.04	
Assistive Technology Total:						5928868.14
Assistive Technology Consultation	Item	2498	1.00	159.33	398006.34	
Assistive Technology Supports	Hour	5	10.00	25.56	1278.00	
Assistive Technology Equipment	Item	2082	1.00	2655.90	5529583.80	
Career Planning Total:						1335988.26
Job Development	Hour	112	100.00	64.81	725872.00	
Benefits Education and Analysis	Item	52	1.00	434.19	22577.88	
Employment/Self-Employment Plan	Item	1	1.00	972.53	972.53	
Self-Employment Launch	Hour	34	6.00	64.81	13221.24	
Career Discovery	Item	29	1.00	1782.96	51705.84	
Worksite Accessibility	Hour	27	6.00	64.81	10499.22	
Career Exploration	Hour	61	100.00	64.81	395341.00	
Situational Observation and Assessment	Item	35	1.00	972.53	34038.55	
GRAND TOTAL:						2650004339.80
Total Estimated Unduplicated Participants:						30500
Factor D (Divide total by number of participants):						86885.39
Average Length of Stay on the Waiver:						338

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Quality Payment- Job Development	Item	112	1.00	730.00	81760.00	
Community Transition Service Total:						158000.00
Community Transition Service	Item	79	1.00	2000.00	158000.00	
Environmental Accessibility Adaptations Total:						5044320.00
Environmental Accessibility Adaptations	Item	1130	1.00	4464.00	5044320.00	
Group Employment Support Total:						4126366.00
Group Employment Support-Hour	Hour	708	682.00	6.62	3196506.72	
Group Employment Support-Day	Day	658	28.00	50.47	929859.28	
Habilitation - Vocational Habilitation Total:						48158714.10
Habilitation-Vocational Habilitation-Hour	Hour	5286	75.00	13.19	5229175.50	
Habilitation-Vocational Habilitation	Day	5772	95.00	78.29	42929538.60	
Health Care Assessment Total:						2070000.00
Health Care Assessment Service	Month	5000	12.00	34.50	2070000.00	
Home Delivered Meals Total:						2469590.90
Home Delivered Meals	1 meal	983	259.00	9.70	2469590.90	
Homemaker/Personal Care - Daily Billing Unit Total:						1036080529.20
Homemaker/Personal Care - Daily Billing Unit	Day	11919	321.00	270.80	1036080529.20	
Individual Employment Support Total:						3861676.00
Individual Employment Support	Hour	1442	40.00	50.70	2924376.00	
Adult Day Quality Payment- Individual Employment Support	Item	1442	1.00	650.00	937300.00	
Interpreter Total:						13604.50
Interpreter	Hour	23	13.00	45.50	13604.50	
GRAND TOTAL:						2650004339.80
Total Estimated Unduplicated Participants:						30500
Factor D (Divide total by number of participants):						86885.39
Average Length of Stay on the Waiver:						338

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Money Management Total:						2560163.76
Money Management	Hour	2932	33.00	26.46	2560163.76	
Non-Medical Transportation Total:						143808944.86
Non-medical transportation	Trip	17711	371.00	21.82	143374441.42	
Competitive integrated employment transportation	Trip	1236	6.00	58.59	434503.44	
Nutrition Total:						78650.88
Nutrition	Hour	112	12.00	58.52	78650.88	
Participant-Directed Homemaker/Personal Care Total:						1192695.25
Participant-Directed Homemaker/Personal Care	Hour	25	1879.00	25.39	1192695.25	
Remote Supports Total:						23054159.28
Remote Supports	Hour	1181	1956.00	9.98	23054159.28	
Residential Respite Total:						1677282.36
Residential Respite	Day	130	29.00	327.50	1234675.00	
Residential Respite	Hour	268	52.00	31.76	442607.36	
Shared Living Total:						234679941.58
Shared Living	Day	4987	301.00	156.34	234679941.58	
Social Work Total:						247866.63
Social Work	Unit	289	69.00	12.43	247866.63	
Transportation Total:						68593346.64
Transportation	Mile	18298	2106.00	1.78	68593346.64	
Waiver Nursing Delegation Total:						1651040.16
Waiver Nursing Delegation Assessment	Per assessment	341	6.00	45.16	92397.36	
Waiver Nursing Delegation Consultation	Hour	341	120.00	38.09	1558642.80	
Waiver Nursing Total:						12344532.32
GRAND TOTAL:						2650004339.80
Total Estimated Unduplicated Participants:						30500
Factor D (Divide total by number of participants):						86885.39
Average Length of Stay on the Waiver:						338

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Waiver Nursing	Hour	521	562.00	42.16	12344532.32	
GRAND TOTAL:						2650004339.80
Total Estimated Unduplicated Participants:						30500
Factor D (Divide total by number of participants):						86885.39
Average Length of Stay on the Waiver:						338