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

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in section 1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The state has broad discretion to design its waiver program to address the needs of the waiverï¿½s 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:
Ohio Home Care Waiver July 2025 Amendment

C. Waiver Number:OH.0337
Original Base Waiver Number: OH.0337.90.R1

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
07/01/25
Approved Effective Date of Waiver being Amended: 07/01/21

2. Purpose(s) of Amendment

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

The following changes are being proposed to the Ohio Home Care waiver program to be effective July 1, 2025:

General
Updated references to Ohio Administrative Code, ODM system names, and OHCW services

Main
Attachment Transition Plan: removed reference to PHE and updated disenrollment timeline that an individual will be disenrolled from the waiver no later than one hundred and twenty calendar days following their sixtieth birthday

Appendix A Waiver Administration and Operation
A-3: updated contract entity functions

Appendix B Participant Access and Eligibility
B-1-c: updated disenrollment timeline that an individual will be disenrolled from the waiver no later than one hundred and twenty calendar days following their sixtieth birthday
B-2-c: added self-directed goods and services and vehicle modifications to list of other waiver services that have a service specific limitation
B-6-d, B-6-e, B-6-f: updated language to reference one assessment tool to determine level of care eligibility
B-6-f: updated timeline that a level of care assessment must be completed within 14 calendar days from date of referral assignment

Appendix C Participant Services
C-1-a Summary of Services Covered
-The following services specifications were modified:
-Structured Family Caregiving: updated to include provider who have an accreditation from an organization recognized by

Centers for Medicare and Medicaid Services or the United States Department of Health and Human Services
-Supplemental Adaptive & Assistive Device: removed reference to vehicle modification
-The following service was added:
-Vehicle Modification
C-2-b: added process of ensuring continuity of care for an individual when a provider is added to the abuse registry
C-1-c (New Requirement): added training requirements for HCBS settings and person-centered plan development
C-4-a: updated additional limits on the amount of waiver services to reflect new vehicle modification service and amended supplemental adaptive and assistive device service
C-5 HCBS Settings (New sections 1-3): provided information to address HCBS settings requirements in the new waiver application format

Appendix D Participant Centered Service Planning and Delivery
D-1-a (New Requirement): added training requirements for HCBS settings and person-centered plan development
D-1-d-ii. (New section): identified HCBS settings requirements in the service plan.
D-1-g (New Requirement): added sample size reviews are representative of the demographic make-up of the OHCW population.
D-2-a: updated new enrollee contact schedule

Appendix F Participant Rights
F-3-b: updated that ODM is responsible for the OHCW grievance/complaint system

Appendix G Participant Safeguard
G-1-b, G-1-d: updated language references and terms to align with ODM incident management rule 5160-44-05

Appendix I Financial Accountability
I-2-a: updated rate methodology for vehicle modification service

Appendix J Cost-Neutrality Demonstration
J-2-c-i: added language that waiver remains cost neutral with addition of vehicle modification service
J-2-d-i: updated WY5 slot and service projections for Supplemental Adaptive and Assistive Device and Vehicle Modification services

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☒ **Waiver Application**	Main-2, Main A. Attachment
☒ **Appendix A ? Waiver Administration and Operation**	A-3
☒ **Appendix B ? Participant Access and Eligibility**	B-1-c, B-2-c, B-3-f, B-4-b, B-6-d, B-6-e, B-6-f, B-7-b
☒ **Appendix C ? Participant Services**	C-1-a, C-1-c, C-2-a, C-2-b, C-2-f, C-4-a, C-5-1, C-5-2, C-5-3
☒ **Appendix D ? Participant Centered Service Planning and Delivery**	D-1-a, D-1-d-i, D-1-d-ii, D-1-g, D-1-I, D-2-a
☐ **Appendix E ? Participant Direction of Services**	
☒ **Appendix F ? Participant Rights**	F-1, F-3-b, F-3-c
☒ **Appendix G ? Participant Safeguards**	G-1-b, G-1-d, G-2-a-ii
☐ **Appendix H**	
☒ **Appendix I ? Financial Accountability**	Quality Improvement-b-i, I-2-a, I-2-b, I-2-d
☒ **Appendix J ? Cost-Neutrality Demonstration**	J-2-c-i, J-2-d-i

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

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☒ **Add/delete services**

☒ **Revise service specifications**

☒ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☐ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☐ **Other**

Specify:

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

1. Request Information (1 of 3)

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

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

Ohio Home Care Waiver July 2025 Amendment

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: OH.0337
Draft ID: OH.002.05.05

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/21
Approved Effective Date of Waiver being Amended: 07/01/21

PRA Disclosure Statement

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

☒ **Hospital**
Select applicable level of care

◉ **Hospital as defined in 42 CFR § 440.10**

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

Not applicable.

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

☒ **Nursing Facility**

Select applicable level of care

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

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

Not applicable.

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

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

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

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

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

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

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

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

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

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

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

☐ **A program authorized under section 1115 of the Act.**
Specify the program:

H. Dual 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 Ohio Home Care Waiver offers home and community-based services (HCBS) to people with chronic disabilities and/or medical conditions who would otherwise be eligible for Medicaid in a hospital or nursing facility.

The goals of the waiver include identifying and addressing individual's unique needs, increasing choice and control of home and community-based services, including providers, and maintaining cost neutrality.
. The objectives of the waiver include:
(1) serving individuals age 0 through 59 with either an intermediate (nursing facility) level of care or a skilled (hospital) level of care; and
(2) assigning funding amounts based on a case management agency's (CMA) assessment. Individuals enrolled on the Ohio Home Care Waiver must reside in and/or receive HCBS in a private residence or another setting that meets the home and community-based setting requirements set forth in 42 CFR 441.530. Additionally, they shall participate in a person-centered service planning process that is consistent with the requirements of 42 CFR 441.301.

Ohio is reserving capacity for waiver eligible individuals who are also participating in the HOME Choice (Money Follows the Person) Program. To be eligible for enrollment on the Ohio Home Care Waiver via a reserve capacity waiver slot, individuals must:

* Be determined by the Ohio Department of Medicaid (ODM) to be eligible for the HOME Choice Program; and
* Meet the eligibility criteria for the Ohio Home Care Waiver.

Organizationally, ODM, the State Medicaid agency, is responsible for administration and oversight of the Ohio Home Care Waiver. ODM contracts with multiple Case Management Agencies (CMA) to provide assessment and case management services. ODM also contracts with a single entity to perform provider management functions. The CMAs operate statewide and are responsible for interfacing with individuals at the local level to assure access to services. CMA staff perform level of care assessments and reassessments, work with each individual to develop/update person-centered service plans (plan of care) tailored to meet specific service needs, monitor health and welfare, and provide ongoing case management and support. The CMAs and their subcontractors are not permitted to provide direct home health or waiver program services to individuals enrolled on the Ohio Home Care Waiver. During the first year of an individual's waiver eligibility, the case managers who render ongoing case management services cannot be the same case managers who determined initial eligibility.

The provider oversight contractor reviews provider applications. It also conducts onsite visits, including HCBS settings compliance, when applicable. The contractor also monitors provider compliance with the HCBS waiver program, assures health and welfare and conducts provider oversight and critical incident investigations.

The CMAs and the provider oversight contractor must adhere to their agreements with ODM and must comply with ODM administrative rules, regulations and policies. ODM requires criminal record checks for all contractors and providers and oversees incident reporting. ODM monitors CMA and provider oversight contractor performance through quality reviews. The State monitors the entire waiver in accordance with a quality management plan based on CMS' waiver assurances.

The renewal incorporates traditional service delivery methods and continues to focus on participant direction practices that afford opportunities for individual choice and control in accordance with Ohio Administrative Code rules. Individuals have access to agency providers that are Medicare-certified, are accredited by ACHC, CHAP or the Joint Commission, or are other approved ODM-administered waiver service providers. In addition, individuals can choose non-agency providers who may include RNs/LPNs, neighbors and friends, and non-legally responsible family members, including legal guardians of adult children.

A broad range of services continues to be included in the Ohio Home Care Waiver in order to provide a viable home and community-based alternative to institutional care. Services include adult day health center, community integration, community transition, home care attendant, home delivered meals, home maintenance and chore, home modifications, out-of-home respite, personal care aide, personal emergency response systems, self-directed goods and services, supplemental adaptive and assistive devices, supplemental transportation, vehicle modifications, and waiver nursing services.

3. Components of the Waiver Request

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

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

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

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

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

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

- ◉ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ○ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

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

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

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

4. Waiver(s) Requested

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

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

- ◉ **Not Applicable**
- ○ **No**
- ○ **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in section 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 section 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

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

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

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

1. Informed of any feasible alternatives under the waiver; and,

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

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

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

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would

receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR § 441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR § 441.301(b)(1)(ii), waiver services are not furnished to individuals who are 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 section 1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR Part 433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. If a provider certifies that a particular legally liable third-party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR Part 431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR § 431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and

improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the quality improvement strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

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

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

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

Electronic Methods: Ohio posts a public notice, summary of the draft waiver and the draft waiver on the ODM website. The case management agencies (CMAs) and provider oversight contractor post the public notices on their websites, which link to the ODM website and also include information about how to obtain a non-electronic copy of the proposed waiver. ODM also shares the link via email with its stakeholders.

The specific link used for public comment for the Ohio Home Care Waiver was: https://medicaid.ohio.gov/about-us/notices

Non-electronic Methods: The local County Department of Job and Family Services offices post a copy of the Public Notice and Request for Comment announcement, which includes information about how to obtain a non-electronic copy of the proposed waiver renewal or amendments. ODM also informs stakeholders on the various workgroups it maintains or participates on.

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

E-mail - Ohio has established a dedicated e-mail box: OHCWfeedback@medicaid.ohio.gov.
Written comments - Ohio also provides a U.S. Postal Service address, which is Ohio Department of Medicaid, ATTN: Ohio Home Care Waiver, P.O. Box 182709, Columbus, OH 43218.
Fax - Ohio provided a fax number, which was (614) 466-6945.
Toll-free phone number - Ohio provides a toll-free number, 1 (800) 438-8603, with a recorded message advising callers they have five minutes in which to leave to provide input.
Courier or in-person submission to: Attn: BLTSS, Lazarus Building, 50 West Town Street, Columbus OH 43218.

Public Notification and Public Input Process for the HCBS Statewide Transition Plan
For each required public comment period, Ohio uses all the above methods to notify the public of the opportunity to review and comment on the HCBS Statewide Transition Plan and/or to request a non-electronic copy of the plan. In addition, remittance advice notifications are used to reach the provider community. ODM places a notice on provider “remittance advices” advising providers of the draft transition plan and listing the website at which they could read the plan and submit comments. Home health agencies, personal care aides and home care attendants, and waiver services organizations are among the provider types notified.

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

Ohio Olmstead Task Force
ODM meets periodically with the Ohio Olmstead Task Force to share information and solicit input. The committee is an important conduit for direct communication and involvement of individuals, caregivers and key stakeholders in the development of the structure, function, training components, oversight and administrative policies and procedures related to the Ohio Home Care Waiver.

ODM-administered HCBS Waiver Rules Workgroup/Mailing List
This workgroup/mailing list consists of individuals, caregivers, providers, provider organizations, representatives from Medicaid- serving agencies and other key advocates. Its focus is to review and recommend administrative rule changes governing HCBS waivers.

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

feedback.

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

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

7. Contact Person(s)

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

Last Name: Sly

First Name: ShaRhonda

Title: Section Chief, Home and Community Based Services Policy

Agency: Ohio Department of Medicaid

Address: 50 West Town Street, Fifth Floor, P.O. Box 182709

Address 2:

City: Columbus

State: **Ohio**

Zip: 43218

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

Fax: (614) 466-6945

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:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Ohio**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Ohio**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

☐ **Replacing an approved waiver with this waiver.**

☐ **Combining waivers.**

☐ **Splitting one waiver into two waivers.**

☐ **Eliminating a service.**

☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**

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

☐ **Reducing the unduplicated count of participants (Factor C).**

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

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

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

Specify the transition plan for the waiver:

Ohio Home Care Waiver to PASSPORT:

When an individual enrolled on the Ohio Home Care Waiver turns 60 years old, they will transition to the PASSPORT Waiver no later than one hundred and twenty calendar days following their sixtieth birthday. The waiver case manager will support the individual through this transition. The case manager's responsibility includes discharge planning with the PASSPORT Administrative Agency for individuals leaving the Ohio Home Care Waiver. This level of assistance involving both waiver case management entities continue to be provided to individuals for a seamless transition to the PASSPORT waiver.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Carryover from Appendix I-2-a (Rates, Billing and Claims: Rate Determination Methods)

Rates for the Ohio Home Care Waiver were first established in 1998 when the waiver was first approved. Waiver nursing and personal care aide services were established using a loaded first hour and subsequent 15 minute unit rates. Other waiver services were, and have continued to be paid, at different rates according to installment fees, monthly, half- day, per item, per mile, or per diem units. Over the years, all the waiver service rates have been subject to both percentage increases and decreases pursuant to actions by the Governor and the Ohio Legislature.

Home Maintenance and Chore
The State uses the negotiated market rate model of rate setting for this service. The service is reimbursed on a per job basis. The selected provider submits a bid for the provision of the service; the bid represents all the items/supports identified in the person-centered services plan. The accepted bid is authorized in the services plan. The maximum ceiling for the service is based on the historical utilization trends of the Minor Home Modification, Maintenance and Repair, Chore, and Pest Control services in the PASSPORT, and MyCare waivers.

Supplemental Transportation
The reimbursement rate methodology for Supplemental Transportation services considers the cost of providing the service. The methodology includes review of Ohio Medicaid claims and enrollment data. The state utilized claims and enrollment data from the Ohio Home Care waiver historical experience (SFY 2019) to establish Supplemental Transportation reimbursement on a per mile (S0215) basis. The reimbursement for this service is set via a fee schedule.

Adult Day Health Center Services
The reimbursement rate methodology for Adult Day Health Center Services considers the cost of providing the service, which includes review of Ohio Medicaid claims and enrollment data. The state utilized claims and enrollment data from the Ohio Home Care waiver historical experience (SFY 2019) to establish Adult Day Health Center Services reimbursement on both a per half-day (S5101) and per day (S5102) basis. These reimbursement rates are set via a fee schedule. The full-day rate is utilized when 5 or more hours are provided to an individual in a day and reimbursed at a per half-day rate when less than 5 hours are billed.

July 2023
As a result of Ohio's House Bill 33, the Ohio Department of Medicaid (ODM) biennial budget incorporates billing maximum rate increases Ohio's HCBS waiver programs. The increase in funding allotted results in an increase to anticipated expenditures for the Ohio Home Care program. The purpose of this amendment is to incorporate the appropriated service reimbursement increase, impacting personal care, adult day, home delivered meals, supplemental transportation and waiver nursing. J-2 has been updated with this information.

September 2024
The average cost per unit for the Structured Family Caregiving service was developed to ensure the per diem rate for this service was lower than the equivalent of 4 hours of the current agency Personal Care rate (the observed average length of a visit for personal care), and projecting the additional service to be budget neutral to the waiver as an individual is not permitted to have Personal Care and Structured Family Caregiving services on the same day. In addition, we compared the resulting per diem rate to the provider reimbursement rates for similar services in five other states to ensure the rate would be sufficient for providers to render this service. The average cost per unit for Self-Directed Goods and Services was developed as an average of the cost per unit rates utilized in development of the SELF and Level One 1915(c) waiver applications effective 1/1/2024

The following relates to the addition of self-direct within Appendix E.

*personal care, unit rate (current provider managed service maximum rate billable established 2024). unit rate negotiated between the provider and the
individual within the bounds of minimum wage, the individual's service budget and the established maximum for the service.

*waiver nursing, unit rate unit rate provider managed (current maximum rate billable established 2024), unit rate negotiated between the provider and the

individual within the bounds of minimum wage, the individual's service budget and the established maximum for the service.

*home care attendant, unit rate provider managed (current maximum rate billable established 2024), unit rate negotiated between the provider and the
individual within the bounds of minimum wage, the individual's service budget and the established maximum for the service.

July 2025
Vehicle Modification Service: The State uses the negotiated market rate model of rate setting for this service. The service is reimbursed on a per job basis. The selected provider submits a bid for the provision of the service; the bid represents all the items/supports identified in the person- centered services plan. The accepted bid is authorized in the services plan. The maximum ceiling of $10,000 for the service is based on the not to exceed rate listed for the Supplemental Adaptive and Assistive Device service where vehicle modification was previously included.

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:

Bureau of Long-Term Services and Supports

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

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

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the state. Thus, this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

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

ODM competitively bids a contract with one or more case management agencies (CMA) to perform certain program and case management functions as described in Appendix A-7. The CMAs and their subcontractors are not permitted to provide direct home health or waiver program services to any individuals enrolled on the Ohio Home Care Waiver. The case managers who render ongoing case management services cannot be the same case managers who determined initial eligibility. ODM, ODM oversight entities, or it's approved vendor will conduct audits as it determines necessary or appropriate, to determine the CMA's compliance. Audits may be conducted in-person or desk review. The CMA must work with ODM to provide all requested information and if found non-compliant, remediation will be required.

ODM also contracts with a single entity to review provider applications, complete initial provider enrollment screening. conduct onsite visits, monitor provider compliance with the HCBS waiver program, complete annual structural reviews of providers, make referrals to ODM when compliance actions must be taken, and conduct provider oversight and incident investigations. This contract is competitively bid.

○ **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:

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

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

Appendix A: Waiver Administration and Operation

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

ODM is responsible for the monitoring and oversight of all the contractors described in Appendix A-3.

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:

ODM continually monitors the quality of its contractors' performance. The frequency of the State's monitoring activities varies depending upon the item/activity. For each of the waiver operational and administrative functions identified in Appendix A-7, ODM oversees contracted entity functions in the following manner: ODM uses data analysis as the method of oversight for participant waiver enrollment, waiver expenditures managed against approved funding amounts, prior authorization of waiver services, utilization management, and quality assurance and quality improvement activities. ODM conducts case file reviews to oversee level of care evaluation and review of participant service plans. A variety of monitoring and oversight methods are utilized, including, but are not limited to:

* Review of contract deliverables (reviewed monthly/quarterly)
* Reviews of contractors' compliance with contract terms
* Ongoing reviews
* Performance standards (reviewed semi-annually during quality reviews/briefings)
* Onsite observation (as needed)
* Complaint monitoring (reviewed quarterly)

In accordance with the terms of their contract and the policies set forth in OAC rule 5160-45-06, when a contractor fails to meet federal or state program requirements, contract deliverables or performance standards for work requirements, ODM notifies the contractor of performance deficiencies via a Notice of Noncompliance or a Notice of Operational Deficiency. In response to the notification, the contractor is required to submit a plan of correction to ODM describing actions that will be taken to correct deficiencies, including dates for actions to be completed. Notifications may result in the imposition of progressive corrective measures that may include, but are not limited to:

• Meeting with ODM to identify problems and develop a program of additional training and technical assistance in order to meet the specific program requirement, contract deliverable, or performance standard.
• Referral to any regulatory agency charged with investigating specific complaints and/or situations.
• Withholding part or all a contractor's fees until a program requirement, contract deliverable, or performance standard is met. This may occur along with other corrective measures.
• Assigning part or all a contractor's caseload to ODM staff or another available ODM contractor until a program requirement, contract deliverable, or performance standard is met. This may occur along with other corrective measures.
• Imposing actual or liquid damages. The State has the option of collecting actual direct or liquid damages from a contractor for any default. For each instance of default, the State provides the contractor with estimates of the actual direct damages sustained due to the default. If the actual direct damages cannot be determined due to the nature of the default, the State may determine liquid damages. Liquid damages shall not exceed 10 percent of the cost of the contract for the fiscal year in which the default occurs. Events of default include, but are not limited to, the following:

** Failure by a CMA to adhere to the terms and conditions of their contract, including but not limited to clinical management functions described in their Scope of Work, and completion within specified timeframes.
** Failure by the provider oversight contractor to adhere to the terms and conditions of its contract, including but not limited to the oversight functions described in their Scope of Work, and completion within specified timeframes.
** Failure by a contractor to produce and comply with the Quality Management Plan, quarterly management reports, and/or monthly performance reports described in the contract deliverables, including submittal within specified timeframes.
** Failure by a contractor to adhere to all state and federal rules and program requirements. Progressive corrective measures may ultimately lead to termination of a contract.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR § 431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care

is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☒	☒
Waiver enrollment managed against approved limits	☒	☐
Waiver expenditures managed against approved levels	☒	☒
Level of care waiver eligibility evaluation	☒	☒
Review of Participant service plans	☒	☒
Prior authorization of waiver services	☒	☒
Utilization management	☒	☒
Qualified provider enrollment	☒	☒
Execution of Medicaid provider agreements	☒	☐
Establishment of a statewide rate methodology	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☐
Quality assurance and quality improvement activities	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
A-5: Number and percentage of complaints filed that were resolved within 15 calendar days. N= Number of complaints filed that were resolved within 15 calendar days. D= Total number of complaints filed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ODM-approved assessment and case management system

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

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

Performance Measure:
A-6: Number and percent of structural reviews for non-agency personal care aides that were completed timely by the provider oversight contractor. N= Number of structural reviews for non-agency personal care aides that were completed timely by the provider oversight contractor. D= Total number of structural reviews for non-agency aides due in the quarter.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
A-1-a: Number and percent of quality briefings conducted timely between Ohio Department of Medicaid and contracted Case Management Agencies (CMAs) to review CMA 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**
	☐ **Continuously and Ongoing**
	☐ **Other**

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

Performance Measure:
A-1-b: Number and percent of quality briefings conducted timely between Ohio Department of Medicaid and the Provider Oversight Contractor (POC) to review POC contractual reporting requirements and 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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A-1-c: Number and percent of quality briefings conducted timely between Ohio Department of Medicaid and the contracted Financial Management Services (FMS) entity to review FMS entity contractual reporting requirements and performance data as specified in the waiver application. N:Number of quality briefings conducted timely. D: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**
	☐ **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 the contracted Financial Management Services entity on time and in the approved format. N: Number of quarterly performance measure reports submitted timely and in the approved format. D: 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: Financial Management Services entity	☐ **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-3-a: Number and percent of quality improvement plans required by Ohio Department of Medicaid (ODM) that were submitted on time by contracted Case Management Agencies (CMAs) and accepted by ODM. N: Number of quality improvement plans required by ODM that were submitted on time by contracted CMAs and accepted by ODM. D: 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: Case Management Agencies	☐ **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-3-b: Number and percent of quality improvement plans required by Ohio Department of Medicaid (ODM) that were submitted on time by the Provider Oversight Contractor (POC) and accepted by ODM. Numerator: Number of quality improvement plans required by ODM that were submitted on time by the POC 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: Provider Oversight Contractor	☐ **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-3-c: Number and percent of quality improvement plans required by Ohio Department of Medicaid (ODM) that were submitted on time by the Financial Management Services (FMS) entity and accepted by ODM. N: Number of quality improvement plans required by ODM that were submitted on time by the FMS entity and accepted by ODM. D: 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: Financial Management Services entity	☐ **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**

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-4: Number and percent of annual quality monitoring and improvement reports submitted to Ohio Department of Medicaid (ODM) by the contracted Case Management Agencies on time and in the correct format. Numerator: Number of reports submitted on time and in the correct format. Denominator: Number of reports submitted on time and in the correct format.

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: Case Management Agencies	☒ **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.

The Ongoing Review process gathers data to measure compliance and performance regarding specific waiver assurances and other contract measures. This process includes record reviews and in-person interviews with individuals enrolled on the waiver. ODM selects a random sample of waiver participants, conducts the reviews, and compiles the data for reporting and analysis. Through this process, ODM conducts enough reviews to produce waiver- specific findings that can be reported with 95% confidence of being within a margin of error of +/- 5%.

b. Methods for Remediation/Fixing Individual Problems

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

ODM has operational responsibility for the Ohio Home Care Waiver. ODM delegates certain functions to CMAs and the provider oversight contractor. Contracts between ODM and these entities include language authorizing ODM to perform oversight activities that help to establish the program's compliance with federal and state laws and regulations, as well as auditing and fiscal compliance. In the Ohio Home Care Waiver, Ohio integrates the State's Medicaid quality strategy into HCBS waivers by aligning ODM's waiver quality processes with that work. ODM employs a multi-faceted monitoring and oversight process that includes the following:

Monthly and Quarterly Reporting – Case management agencies and the provider oversight contractor are monitored through data reports specified in their contract. These reports are generated by either the contractor or ODM directly and enable ODM to monitor operational output and quality performance data.

Ongoing Review – Every year, ODM conducts interviews with approximately 400 randomly selected waiver participants to measure compliance with performance regarding 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.

Targeted Review – ODM conducts targeted reviews of individuals enrolled on HCBS waivers across populations. These reviews are performed on a subset of individuals enrolled on all of the State's HCBS waivers. Ohio uses claims data and other criteria to identify a target group based on, for example, diagnosis, service utilization (over or under), medications and care management. The goal is to locate "hot spots" within the program and identify at-risk individuals who, with the assistance of our partners, the State can help to avoid or mitigate negative health outcomes.

Contractor Reviews – ODM conducts a review of each CMA and the provider oversight contractor in order to ensure compliance with all contract terms. The review includes a desk review and an on-site visit. ODM issues a review report and the CMAs and the provider oversight contractor are required to develop and submit a plan of correction related to all identified deficiencies. ODM continues to monitor compliance with the plan of correction.

Quality Briefings – ODM meets with each contracted agency quarterly to dialogue about data generated through their respective quality processes. In these meetings, ODM reviews performance data generated through targeted reviews and discusses remediation and/or corrective action. These briefings are also informed by data presented by ODM on the oversight activities conducted by the agency, including but not limited to, problems detected, corrective measures taken and how such measures are/were verified. The quality briefings also serve as the forum for ODM and contractors to share and review performance metrics.

The Quality Steering Committee provides administrative oversight for Ohio' 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.

Health, Safety and Welfare Oversight Committee - 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.

Case-Specific Resolution - ODM assures case-specific resolution through multiple interventions including the Health, Safety, and Welfare committee oversight process and interdisciplinary case review meetings conducted with internal staff of varying disciplines.

Unmet Needs - An Unmet Need is defined as any health and safety risk for the individual, grievance, and/or concerns with case management performance identified during a field review/survey. When staff encounter a situation in which a waiver recipient's health or welfare may be at risk, or when CM deficiencies are identified, staff follow a protocol to report unmet needs. 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 CMs, 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.

Fiscal Reviews – ODM staff perform regular desk reviews of administrative costs, with A-133 Audits being performed every 1-3 years based on risk. Additional detail about Ohio's practice for maintaining fiscal oversight of the Ohio Home Care Waiver can be found in Appendix I.

Open lines of Communications – ODM regularly communicates with case management agencies and the provider oversight contractor about case-specific matters and other issues related to program operations, provides technical assistance and responds to inquiries. Topics include, but are not limited to, individual health and welfare, program administration, budgeting, enrollment, providers and provider enrollment, provider reimbursement, issues pertaining to Medicaid state plan services, pending legislation, statutory and rule changes, etc.

ODM also conducts monthly "one-on-one" meetings with each contractor.

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 Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

served in each subgroup:

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☒	**Disabled (Physical)**	0	59	
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

*Individuals 0 through 59 years of age who require an intermediate (nursing facility) level of care or a skilled (hospital) level of care.

Also, within a reserved capacity that has been established for the waiver, the state targets individuals determined by ODM to be eligible for the HOME Choice (Money Follows the Person) Program, and who meet the eligibility criteria for the Ohio Home Care Waiver.

ODM will be permitted to enroll individuals disenrolling from another NF-LOC waiver, who meet the eligibility criteria for the Ohio Home Care Waiver. These individuals will retain their LOC determination for the period it would have been effective in the waiver from which they disenrolled, absent a change of condition.

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:

ODM will disenroll individuals from the Ohio Home Care Waiver no later than one hundred and twenty calendar days following their sixtieth birthday. The case manager's discharge planning responsibilities include assisting the individual with enrollment on another appropriate NF-LOC waiver. Individuals will retain their LOC determination for the period it would have been effective in the Ohio Home Care Waiver, absent a change of condition.

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:

    At the time of enrollment on the Ohio Home Care Waiver, no individual's waiver service costs shall exceed $14,700 per month.

    Individuals are assigned a monthly cost limit based on their service needs as identified in the planning process. The cost limit is based on the monthly cost of services as identified in the person-centered service plan. Cost limits are adjusted when service needs change. When person-centered service plans result in waiver service cost increases of $1000 or more per month, or contract-specified services exceed $14,000 per month, the CMA must obtain prior authorization from ODM in accordance with the process described in Appendix C-4-a.

- ○ **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)

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:

After entrance onto the waiver, at any time the individual's waiver service needs are determined to exceed $14,700 per month, the CMA must obtain prior authorization from ODM in accordance with the process described in Appendix C-4-a.

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:

Monthly Cost Cap Limitation: Each CMA has an interdisciplinary clinical review committee comprised of a minimum of two licensed clinical staff members. The team is responsible for conducting case reviews to inform service planning for high risk individuals and for recommending to ODM the approval of the person-centered service plan authorizations when the monthly cost of services exceeds $14,700.

Service Specific Limitation: The interdisciplinary clinical review committee process is also used to inform service planning for high risk individuals and for recommending to ODM the approval of the person-centered service plan authorizations in excess of the limitation established in Appendix C for the following services: home maintenance and chore, home modification, self-directed goods and services, supplemental adaptive and device, and vehicle modification.

The individual retains hearing rights in the event when additional services are not approved in excess of the individual cost limit.

☒ **Other safeguard(s)**

Specify:

In the event additional waiver services are not authorized in excess of the $14,700 per month cost limit, referrals to other community services, including institutional services, are provided to the individual. The individual retains hearing rights in the event that ODM does not approve the additional services in excess of the individual cost limit.

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	10212
Year 2	10968
Year 3	11724
Year 4	12480
Year 5	13236

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

◉ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

○ **The state limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

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

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

○ **Not applicable. The state does not reserve capacity.**

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

Purpose(s) the state reserves capacity for:

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

Appendix B: Participant Access and Eligibility

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

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

Reserved Capacity for HOME Choice Participants

Purpose *(describe):*

Establishment of a reserved capacity of waiver slots in order to support the implementation of a Money Follows the Person Demonstration Grant the State received from CMS. Known as the HOME Choice (Helping Ohioans Move, Expanding Choice) Program, it transitions qualifying participants currently residing in nursing facilities, ICFs-IID, and hospitals into their own homes or other community settings. The HOME Choice Program provides additional services to enhance existing Medicaid State Plan and HCBS that will enable them to safely and successfully integrate into community life. Participants are entitled to receive HOME Choice Program services for 30 days beginning on the day they move from an institutional setting into the community. All individuals enrolled on the Ohio Home Care Waiver, including those participating in the HOME Choice Program, have comparable access to all services offered in the waiver.

Describe how the amount of reserved capacity was determined:

Reserve capacity for the Ohio Home Care Waiver was projected at 150 per waiver year based on a review/analysis of past years' enrollment of HOME Choice participants into the Ohio Home Care Waiver, as well as a review and analysis of HOME Choice Program utilization of waivers in general.

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

Waiver Year	Capacity Reserved
Year 1	150
Year 2	150
Year 3	150
Year 4	150
Year 5	150

Appendix B: Participant Access and Eligibility

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

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

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

Purpose *(describe):*

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

Describe how the amount of reserved capacity was determined:

Reserved capacity for the Ohio Home Care Waiver is projected at 25 per waiver year as no actual data is available at this time. The State will monitor such enrollments and modify the projection as appropriate.

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

Waiver Year	Capacity Reserved
Year 1	25
Year 2	25
Year 3	25
Year 4	25
Year 5	25

Appendix B: Participant Access and Eligibility

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

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

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

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

e. Allocation of Waiver Capacity.

Select one:

◉ **Waiver capacity is allocated/managed on a statewide basis.**

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

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

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

In general, waiver applicants are considered on a first come-first serve basis according to the signature date on their HCBS waiver referral. However, priority is given to the following persons applying for enrollment on the Ohio Home Care Waiver:

*Children who are from birth up to, but not including, age 21 who:

* Were residing in an inpatient hospital setting at the time of, and at least fourteen consecutive days prior to, application for the Ohio Home Care Waiver; or

* Have had three or more inpatient hospital stays during the twelve months prior to application for the Ohio Home Care Waiver.

*Individuals between the ages of 21 and 59 who resided in an inpatient hospital setting for 14 consecutive days prior to application for the Ohio Home Care Waiver.

*Individuals from birth through age 59 living in the community living who are at imminent risk of institutionalization due to the documented loss of a primary caregiver.

*Individuals from birth through age 59 who, at the time of application for the Ohio Home Care Waiver, were receiving private duty nursing services for at least 12 consecutive months.

*Individuals from birth through age 59 who are residents of a Medicaid-funded nursing facility at the time of application.

*Within a reserved capacity established by this waiver, individuals between the ages of 18-59 who are residing in an institutional setting, and who have been determined by ODM to be eligible for the HOME Choice (Money Follows the Person) Program.

* Within a reserved capacity established by this waiver, 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 home and community-based waiver services in another state.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- (●) **Section 1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.

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

- ( ) **No**
- (●) **Yes**

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

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

- [x] **Parents and Other Caretaker Relatives (42 CFR § 435.110)**
- [x] **Pregnant Women (42 CFR § 435.116)**
- [x] **Infants and Children under Age 19 (42 CFR § 435.118)**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR § 435.121**
- [ ] **Optional state supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - ( ) **100% of the Federal poverty level (FPL)**
  - ( ) **% of FPL, which is lower than 100% of FPL.**

    Specify percentage: [ ]

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in section 1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 1902(a)(10)(A)(ii)(XV) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in section 1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in section 1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR § 435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR § 435.320, § 435.322 and § 435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

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

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

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

Specify percentage: [ ]

○ **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

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

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

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

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

☒ **Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under section 1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time period after September 30, 2027 (or other date as required by law).

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

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

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

◉ **Use spousal post-eligibility rules under section 1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR § 435.726 (Section 1634 State/SSI Criteria State) or under § 435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under section 1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

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

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

- ○ **The following standard included under the state plan**

  Select one:

  - ○ **SSI standard**
  - ○ **Optional state supplement standard**
  - ○ **Medically needy income standard**
  - ○ **The special income level for institutionalized persons**

    (*select one*):

    - ○ **300% of the SSI Federal Benefit Rate (FBR)**
    - ○ **A percentage of the FBR, which is less than 300%**

      Specify the percentage:
    - ○ **A dollar amount which is less than 300%.**

      Specify dollar amount:
  - ○ **A percentage of the Federal poverty level**

    Specify percentage:
  - ○ **Other standard included under the state plan**

    Specify:

- ○ **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.
- ◉ **The following formula is used to determine the needs allowance:**

  Specify:

  65% of 300% of the Supplemental Security Income Federal Benefit Rate (SSI/FBR)
- ○ **Other**

  Specify:

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

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

Specify:

Specify the amount of the allowance (*select one*):

- ( ) **SSI standard**
- ( ) **Optional state supplement standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

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

- ( ) **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

- ( ) **Not Applicable (see instructions)**
- (●) **AFDC need standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

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

- ( ) **The amount is determined using the following formula:**

Specify:

- ( ) **Other**

Specify:

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

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

Select one:

- ○ **Not Applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The state does not establish reasonable limits.**
- ○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **The following dollar amount:**

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

◉ **The following formula is used to determine the needs allowance:**

Specify formula:

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

○ **Other**

Specify:

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

Select one:

◉ **Allowance is the same**

○ **Allowance is different.**

Explanation of difference:

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

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

Select one:

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

◉ **The state does not establish reasonable limits.**

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

Appendix B: Participant Access and Eligibility

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

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

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State – January 1, 2014 through

September 30, 2027 (or other date as required by law).

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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

- ○ **The provision of waiver services at least monthly**
- ◉ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

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

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

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

- ○ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ◉ **By an entity under contract with the Medicaid agency.**

Specify the entity:

The contracted case management agencies (CMAs).

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

- ○ **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:

Registered Nurses (RN), Licensed Practical Nurses (LPN) and Social Workers (Licensed Social Worker Trainee (SWT), Licensed Social Worker (LSW), or Licensed Independent Social Worker (LISW)) licensed to practice in the State of Ohio complete the initial level of care evaluation for waiver applicants. All registered nurses are licensed by the Ohio Board of Nursing and all social workers are licensed by the Counselor, Social Worker, Marriage and Family Therapists Board to practice in Ohio. The CMAs verify the current licensure status of applicants during the hiring process.

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

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

As a condition of waiver eligibility, applicants must meet either the intermediate level of care (ILOC) or skilled level of care (SLOC) criteria set forth in OAC rule 5160-3-08.

The level of care for an individual seeking ODM-administered nursing facility-based waiver services is determined through an assessment tool that is consistent with the criteria set forth in OAC 5160-3-08 and is integrated in the ODM-approved assessment and case management system.

The ILOC criteria for individuals are met when long-term services and supports needs exceed the criteria for the protective level of care. The ILOC criteria includes skilled nursing service needs, skilled rehabilitation service needs, activities of daily living (ADL) assistance needs, assistance with medication self-administration, and the need for 24 hour support in order to prevent harm due to a cognitive impairment and can be met in one of the following ways:

- Assistance with a minimum of at least two ADLs.
- Assistance with a minimum of at least one ADL and assistance with medication self-administration.
- A minimum of at least one skilled nursing service or skilled rehabilitation service.
- Twenty-four (24) hour support in order to prevent harm due to a cognitive impairment.

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

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

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

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

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

There is one assessment tool used in determining level of care eligibility in the Ohio Home Care Waiver. The tool is integrated in the ODM-approved assessment and case management system. The tool identifies the medical, developmental, behavioral, and ADL/instrumental activities of daily living (IADL) needs of the individual.

The assessment tool is a comprehensive case management tool that is used in nursing facility-based level of care waiver administration, consistent with the criteria set forth in OAC 5160-3-08. The assessment includes an evaluation of the individual's living arrangements, family circumstances, caregiver needs, and formal/informal supports.

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 ODM-approved assessment and case management system will notify a case management agency (CMA) that a waiver application has been received and assigned to the CMA. Per its contract with ODM, each CMA is required to complete the assessment within 14 calendar days. The individual can include other parties of their choosing in the assessment.

An RN, LPN, LSW, LISW, or SWT evaluates whether the applicant meets the SLOC or ILOC criteria set forth in Ohio Administrative Code (OAC) rule 5160-3-08. The individual is also assessed for Ohio Home Care Waiver eligibility pursuant to OAC rule 5160-46-02. The assessment is documented on the assessment tool in the ODM-approved assessment and case management system, and the individual is informed of fair hearing/appeal rights in accordance with OAC Division 5101:6.

The process for reevaluation of level of care is the same.

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

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  Specify the other schedule:

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

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**

  Specify the qualifications:

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

Tracking of level of care due dates occurs at the CMA level, resulting in the timely scheduling and performance of reevaluations. ODM will provide quarterly performance reports that include timeliness data to the CMAs. ODM reviews these reports with the CMAs and if there are problems, may require corrective action.

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

Documentation of all level of care evaluations and reevaluations is maintained in the ODM-approved assessment and case management system in accordance with state and federal regulations.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
B-1: Number and percent of initial assessments completed for applicants who requested long term care services. N= Number of applicants who had an initial assessment. D= Total number of applicants who were referred to an ODM-contracted case management agency for initial assessment.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ODM-approved assessment and case management system

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

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

Data Aggregation and Analysis:

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

Performance Measure:
B-4: Number and percent of priority and non-priority level of care assessments completed timely by the contracted CMAs. Numerator: Number of priority and non-priority level of care assessments completed timely by the contracted CMAs. Denominator: Total number of priority and non-priority level of care assessments assigned to the contracted CMAs in the quarter.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ODM-approved assessment and case management system

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

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: The 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 redeterminations completed within 12 months of the previous Level of Care determination. N= Number of level of care redeterminations completed within 12 months of the previous level of care determination. D= Total number of waiver individuals with redeterminations needed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ODM-approved assessment and case management system

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

		Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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 waiver individuals with initial Level of Care determinations reviewed that were completed using the process required by the approved waiver. N= Number of waiver individuals w/initial Level of Care determinations reviewed that were completed using the process required by the approved waiver. D= Total number of waiver individuals with initial Level of Care determinations

Data Source (Select one):
Other
If 'Other' is selected, specify:
ODM-approved assessment and case management system

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

ODM relies on data gathered through the Ongoing Review, and quarterly reports of output and quality performance data by the CMAs as a means to identify systems compliance and performance issues associated with LOC determinations. ODM employs the Ongoing Review process to validate the CMAs are accurately and consistently applying the level of care rules.

To address systems issues: 1) ODM compiles data showing evidence of the problem; 2) ODM presents the data to the CMAs in a Quality Briefing or monthly meeting; 3) ODM may conduct, or require the CMAs to conduct further analysis to verify the finding and determine cause; 4) for verified findings, the CMAs are required to develop a plan for improvement; 5) ODM approves the plan for improvement; and 6) the CMAs implement the plan for improvement; 7) in a subsequent monthly meeting or Quality Briefing, ODM follows up on implementation of the plan for improvement with the CMAs; 8) ODM monitors data from subsequent reviews to verify improvement; 9) if the compliance or performance issues remain, ODM works with the CMAs to identify other solutions; this may result in a new or altered plan for improvement; and 10) if the improvement plan requires a substantive change in operations, ODM may alter the Quality Management Improvement Plan in order to formalize or clarify ODM expectations for the CMAs.

Individual assessment and level of care determination-related issues that are discovered are directed by ODM to the case management agencies for follow up and remediation at the individual level.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

At the time of initial assessment and reassessment, the CMA case managers are responsible for providing written materials and explaining information to individuals about feasible alternatives, and for informing individuals about their freedom of choice between waiver and institutional services.

Individuals enrolling on the Ohio Home Care Waiver receive a handbook at the time of enrollment. They also receive a copy of the handbook at the time of annual reassessment. The handbook details feasible alternatives that are available, including free choice of providers and the option to receive waiver services or institutional care. It also informs individuals of their rights and responsibilities while enrolled on the waiver. Among other things, those rights include the right to request a state hearing. Individuals sign an agreement documenting their choice of waiver services in lieu of institutional services. A copy of the agreement can be made available to CMS upon request.

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

Documentation of Freedom of Choice forms is maintained within the ODM-approved assessment and case management system in accordance with state and federal regulations.

Appendix B: Participant Access and Eligibility

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

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

Individuals with limited English proficiency have access to a variety of resources at the county, state and CMA levels at the time of application and after enrollment.

CDJFS
CDJFSs make translators available to individuals who need interpretation services as early as at the time of application. They also utilize a variety of State forms that have been translated into other languages including Spanish and Somali.

CMAs and the Provider Oversight Contractor
Each contractor has policies and procedures in place to ensure that individuals enrolled on the Ohio Home Care Waiver who have communication barriers such as limited English proficiency (LEP) or a speech and/or hearing impairment are able to communicate effectively. They make use of the language skills of their own staff, and will arrange for approved translation/interpreter services in a multitude of languages, including American Sign Language. Contractors will translate written materials upon request, and most are able to convert their websites into other languages by changing internet settings or using online translators.

ODM
Pursuant to Title VI of the Civil Rights Act of 1964, no person shall be discriminated based on race, color or national origin. Title VI has been interpreted by the US Department of Justice to prohibit discrimination against individuals who with limited English proficiency. To ensure compliance with Title VI, ODM has strategies in place to ensure all programs, support services and administrative offices have access to translation services and qualified interpreters. ODM encourages the use of interpretation and translation services when assisting individuals with limited English language proficiency, visual and/or hearing impairment.

To ensure persons with limited English proficiency have access to all benefits/services, ODM provides interpreters when needed and translates documents into certain languages as required by CMS. Vital documents such as applications, etc., that are necessary for individuals to receive services, are translated into different languages. The HCBS Waiver Guide is available in Spanish, as are the Medicaid Consumer Guide, information about Healthy Start, Healthchek, and Food Stamps, and state hearing rights forms. The Request for Cash, Food Stamp and Medical Assistance has also been translated into Somali.

The Office of Employee Relations provides technical assistance to ODM staff, over the telephone interpreting services is provided to ODM offices as requested, and language line services is provided to all program areas in the department. "Near-instant interpretation services" are provided through a contract with ODM. As a result, telephone access to interpreters in more than 110 languages is offered. Other interpretation services are offered, as well.

ODM monitors access to services by persons with limited English proficiency as part of its ongoing monitoring activities described in this waiver.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Adult Day Health Center Services**		
Statutory Service	**Personal Care Aide Services**		
Other Service	**Community Integration Services**		
Other Service	**Community Transition Services**		
Other Service	**Home Care Attendant Services**		
Other Service	**Home Delivered Meal Services**		
Other Service	**Home Maintenance and Chore Services**		
Other Service	**Home Modification Services**		
Other Service	**Out-of-Home Respite Services**		
Other Service	**Personal Emergency Response Systems**		
Other Service	**Self-directed goods and services**		

Service Type	Service		
Other Service	Structured Family Caregiving Services		
Other Service	Supplemental Adaptive and Assistive Device Services		
Other Service	Supplemental Transportation Services		
Other Service	Vehicle Modification		
Other Service	Waiver Nursing Services		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Health Center Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

Adult Day Health Center Services (ADHCS) are regularly scheduled services delivered at an adult day health center to individuals age eighteen or older. A qualifying adult day health center must be a freestanding building or a space within another building that is not be used for other purposes during the provision of ADHCS. The services that the adult day health center must provide are waiver nursing or personal care aide services, recreational and educational activities, and at least one meal, but no more than two meals, per day that meet the individual's dietary requirements. The services the adult day health center may also make available are skilled therapy services, and transportation of the individual to and from ADHCS.

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

*ADHCS are reimbursable at a full-day rate when five or more hours are provided to an individual in a day.
*ADHCS are reimbursable at a half-day rate when less than five hours are provided to an individual in a day.
*None of the services provided by the adult day health center are reimbursable separately.
*ADHCS and the provider of such services must be identified on the person-centered service plan.
*ADHCS do not include services performed in excess of what is approved pursuant to the person-centered service plan.
*ADHCS do not duplicate coverage provided under the State plan and EPSDT services are not duplicated.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicare-certified HHA; ACHC-, CHAP- or Joint Commission-accredited agency; adult day health centers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health Center Services

Provider Category:

Agency

Provider Type:

Medicare-certified HHA; ACHC-, CHAP- or Joint Commission-accredited agency; adult day health centers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM/Provider Oversight Contractor

Frequency of Verification:

Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigation of Provider Occurrences). Provider qualifications are verified at the time of initial enrollment and at five-year provider agreement revalidation.

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):

Personal Care Aide Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

Personal Care Aide Services are services provided to an individual pursuant to his or her person-centered service plan that assist the individual with activities of daily living (ADL) and instrumental activities of daily living (IADL) needs. Personal Care Aide Services consist of the following:

*Bathing, dressing, grooming, nail care, hair care, oral hygiene, shaving, deodorant application, skin care, foot care, feeding, toileting, assisting with ambulation, positioning in bed, transferring, range of motion exercises, and monitoring intake and output;
*General homemaking activities including, but not limited to: meal preparation and cleanup, laundry, bed-making, dusting, vacuuming, washing floors and waste disposal;
*Paying bills and assisting with personal correspondence as directed by the individual; and
*Accompanying or transporting the individual to Ohio Home Care Waiver services, medical appointments, other community services, or running errands on behalf of the individual.

Personal Care Aide Services provide needed personal care aide services up to the individual's approved individual budget that are not otherwise available. It is different than state plan home health because its provider pool is not limited to Medicare-certified home health agencies and the scope of tasks that can be provided is much broader.

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

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

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

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

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

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

- ☒ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Self-directed caregiver
Agency	Medicare-certified home health agency; ACHC-, CHAP- or Joint Commission-accredited agency
Individual	Non-agency employed personal care aide

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care Aide Services

Provider Category:

Individual

Provider Type:

Self-directed caregiver

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

FMS enrolled self-directed caregiver.

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

As designated by the member-employee and agreed to by the self-directed caregiver, qualifications include:

1. Certificate of completion within the last 24 months for either a competency evaluation program or training and competency evaluation program approved or conducted by the Ohio Department of Health in accordance with section 3721.31 of the Revised Code; or

2. the Medicare competency evaluation program for HHAs as specified in 42 CFR 484.80; or

3. another equivalent training program that includes training in the following areas:
*Personal Care Aide Services;
*Basic home safety; and
*Universal precautions for the prevention of disease transmission, including hand-washing and proper disposal of bodily waste and medical
instruments that are sharp or may produce sharp pieces if broken.
*First aid certification; or

4. other training as designated by the individual employer and documented on the written agreement in accordance with rule 5160-45-03.2. If the only training received is individual-specific, the self-directed caregiver must be trained by each individual who chooses them as a caregiver.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care Aide Services

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM/Provider Oversight Contractor

Frequency of Verification:

Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigation of Provider Occurrences). Provider qualifications are verified at the time of initial enrollment and at five-year provider agreement revalidation.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care Aide Services

Provider Category:

Individual

Provider Type:

Non-agency employed personal care aide

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certificate of completion within the last 24 months for either a competency evaluation program, or training and competency evaluation program approved or conducted by the Ohio Department of Health in accordance with section 3721.31 of the Revised Code; or the Medicare competency evaluation program for HHAs as specified in 42 CFR 484.80; or another equivalent training program that includes training in the following areas:

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

First aid certification.

Other Standard *(specify):*

Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM/Provider Oversight Contractor

Frequency of Verification:

Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigation of Provider Occurrences). Provider qualifications are verified at the time of initial enrollment and at five-year provider agreement revalidation.

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

Service Title:

Community Integration Services

HCBS Taxonomy:

Category 1: | **Sub-Category 1:**

17 Other Services | 17990 other

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

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

Service Definition *(Scope):*

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

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

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

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

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

No limitations on amount, frequency or duration.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Social Workers; Nurses; Homemakers; Individual Workers
Agency	Home Health Agency; Social Service Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Integration Services

Provider Category:

Individual

Provider Type:

Social Workers; Nurses; Homemakers; Individual Workers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM/Provider Oversight Contractor

Frequency of Verification:

Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigation of Provider Occurrences). Provider qualifications are verified at the time of enrollment and at five-year provider agreement revalidation.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Integration Services

Provider Category:

Agency

Provider Type:

Home Health Agency; Social Service Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM/Provider Oversight Contractor

Frequency of Verification:

Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigation of Provider Occurrences). Provider qualifications are verified at the time of initial enrollment and at five-year provider agreement revalidation.

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

Service Title:

Community Transition Services

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

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

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

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

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

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

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

The total cost of the service may not exceed $2000

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Social Workers; Healthcare Professionals; Community-based Social Service Providers
Agency	Human Service Agencies; Social Service Agencies; Senior Centers; Community Action Organizations; Home Health Agencies; ODM-contracted Transition Coordination Organizations

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:
Individual
Provider Type:

Social Workers; Healthcare Professionals; Community-based Social Service Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM/Provider Oversight Contractor

Frequency of Verification:

Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigation of Provider Occurrences). Provider qualifications are verified at the time of initial enrollment and at five-year provider agreement revalidation.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Transition Services

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM/Provider Oversight Contractor

Frequency of Verification:

Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigation of Provider Occurrences). Provider qualifications are verified at the time of initial enrollment and at five-year provider agreement revalidation.

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

Service Title:

Home Care Attendant Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

* Assistance with the self-administration of medications in accordance with OAC rule 5160-44-27;
* The performance of certain nursing tasks in accordance with OAC rule 5160-44-27; and
* Personal care aide tasks as set forth in OAC rule 5160-46-04.

While this service includes personal care aide tasks, it is more involved because of the provision of assistance with self-administration of medication and the performance of certain nursing tasks - tasks that have, until the passage of RC 5166.30-5166.3010, and the addition of this service, had to be performed by an RN, or licensed practical nurse at the direction of an RN, as waiver nursing, private duty nursing or home health nursing services.

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

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

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

In accordance with OAC rule 5160-45-03, all ODM-administered waiver individuals and their authorized representatives are empowered to have choice and control over the arrangement and provision of the services they receive, and free choice of provider. For the purposes of the Ohio Home Care Waiver, such services include home care attendant services. The individual must be determined through the assessment and service planning processes to have nursing needs that can be safely met through home care attendant services. Adult individuals may designate an authorized representative to act on their behalf. Individuals who are minors must have an authorized representative. The authorized representative must be present and awake during the provision of home care attendant services.

Home care attendant services must be authorized by an authorizing health care professional. ODM must receive an ODM 2389 "Home Care Attendant Medication Authorization Form" and/or an ODM 2390 "Home Care Attendant Skilled Task Authorization Form" that bear the signatures of the individual or authorized representative, home care attendant and the authorizing health care professional. These forms identify the following:

* The individual's choice of home care attendant and written consent from the individual or authorized representative allowing the attendant to provide the specific home care attendant services identified during the assessment and service planning processes.

* Written assurance from the individual's authorizing health care professional attesting that the individual or authorized representative possesses the skills necessary to:

+ Actively choose the home care attendant service (over skilled nursing services);
+ Actively choose their home care attendant; and
+ Participate in the implementation of the service itself.

* Written assurance from the authorizing health care professional that the attendant has demonstrated the ability to

furnish the individual-specific home care attendant service to the individual.

* A description of the specific nursing task or self-administration of medication that the home care attendant will assist the individual with, and instructions the attendant must following when assisting the individual.

The home care attendant is required to secure the services of an RN, in agreement with the individual or authorized representative, and participate in a face-to-face visit every ninety days with the individual, authorized representative, and the RN for the purpose of monitoring the individual's health and welfare. The first RN visit shall occur upon the initiation of home care attendant services and the case manager must be present at that time. During the face-to-face visit, the RN shall serve as a resource for the purpose of answering any questions the home care attendant, individual and/or authorized representative have about individual care needs, medications and other medical issues. The home care attendant and the RN are required to document the activities of the visit in the individual's clinical record, and the home care attendant must discuss the results of the face-to-face visit with the case manager and the individual and/or authorized representative. The individual or authorized representative may contact the authorizing health care professional at any time. RNs may include, but are not limited to, the individual's authorizing health care professional, or a private physician's office or clinic nurse, etc. It is the provider's responsibility to secure the services of the nurse.

Medication must be maintained in its original container and the attached label must match the dosage and means of administration set forth on the ODM 2389 "Home Care Attendant Medication Authorization Form." In addition, schedule drugs must have warning labels on them, and the attendant is required to count, and recount at least monthly, the medication in the individual's or authorized representative's presence and record the count on a log located in the individual's record. The attendant is required to notify the authorizing health care professional within 24 hours if any medication is missing, or the count cannot be reconciled. Schedule drugs must be stored separately from all other medications, and must be secured and locked at all times when not being administered to the individual in order to prevent access by unauthorized individuals.

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

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

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

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

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

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

- ☒ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Self-directed caregiver
Individual	Non-agency Home Care Attendant

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Care Attendant Services

Provider Category:

Individual

Provider Type:

Self-directed caregiver

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

1. Self-directed home care attendant caregivers either meets the personnel qualifications specified in 42 CFR 484.4 for home health aides, or has successfully completed at least one of the following:
a. A competency evaluation program, or training and competency evaluation program approved or conducted by the Ohio Department of Health under section
3721.31 of the Revised Code; or

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

c. Training and instruction about how to deliver the specific home care attendant services authorized by the individual's authorizing health care
professional, and/or the individual or the authorized representative in cooperation with the individual's licensed health care professional.

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Care Attendant Services

Provider Category:

Individual

Provider Type:

Non-agency Home Care Attendant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

See other standard (below).

Other Standard *(specify):*

ORC Sections 5166.30-5166.3010 and OAC Rule 5160-44-27. Specifically, the provider must supply ODM with evidence to its satisfaction of all of the following:

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

* A competency evaluation program, or training and competency evaluation program approved or conducted by the Ohio Department of Health under section 3721.31 of the Revised Code;
* A certified vocational program in a health care field, and written testing and skills testing by return demonstration;
* A training program approved by ODM that includes training in at least all of the following and provides training equivalent to that approved or conducted by the Ohio Department of Health under section 3721.31 of the Revised Code or that meets the requirements of 42 CFR 484.4, basic home safety, universal precautions for the prevention of disease transmission, individual-specific personal care aide services and the labeling, counting and storage requirements for schedule medications;

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

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

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

5) The home care attendant has obtained a certificate of completion of a course in CPR from a class that is not provided solely through the Internet, and that includes hands-on training by a certified CPR instructor and a successful return demonstration.

6) The home care attendant must secure the services of an RN, in agreement with the individual or authorized representative, and participate in a face-to-face visit every 90 days with the individual, authorized representative, and the RN for the purpose of monitoring the individual's health and welfare. During the face-to-face visit, the RN shall serve as a resource for the purpose of answering any questions the home care attendant, individual and/or authorized representative have about individual care needs, medications and other issues. The home care attendant and the RN shall document the activities of the visit in the individual's clinical record. The home care attendant shall also discuss the results of the face-to-face visit with the case manager, and the individual or authorized representative.

7)The home care attendant shall complete at least 12 hours of in-service continuing education regarding home care attendant services annually. Continuing education topics include, but are not limited to, individual health and welfare, CPR, patient rights, emergency preparedness, communication skills, aging sensitivity, developmental stages, nutrition, transfer techniques, disease-specific trainings and mental health issues.

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

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

* Written consent from the individual's authorizing health care professional indicating that the home

care attendant has demonstrated the ability to furnish the individual-specific home care attendant service to the individual. The consent must include the individual's name and address; a description of the specific nursing task or self-administration of medication that the attendant will assist with (including name, dosage and route of administration of any medications); the times/intervals when the attendant is to assist the individual; the dates on which the attendant is to begin and cease providing assistance; a list of severe adverse reactions that the attendant must report to the individual's health care professional; at least one telephone number at which the attendant can reach the individual's health care professional in an emergency for consultation after contacting emergency personnel; at least one fax number at which the attendant can reach the individual's authorizing health care professional when the schedule drugs are missing or cannot be reconciled; and instructions the attendant must follow when assisting the individual (including instructions for maintaining sterile conditions and for the storage of task-related equipment and supplies).

Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM/Provider Oversight Contractor

Frequency of Verification:

Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigation of Provider Occurrences). Provider qualifications are verified at the time of initial enrollment and at five-year provider agreement revalidation.

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

Service Title:

Home Delivered Meal Services

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:**

Service Definition *(Scope):*

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

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

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

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

- The service includes no more than two meals per day.
- Planned multiple meal delivery shall not exceed 14 meals that are compliant with food storage and safety requirements.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Non-agency employed provider
Agency	Agency, e.g., Meals on Wheels, a food vendor, etc.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meal Services

Provider Category:

Individual

Provider Type:

Non-agency employed provider

Provider Qualifications

License *(specify):*

Current, valid license or certificate from the local health department

Certificate *(specify):*

Other Standard *(specify):*

Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46

A provider of home delivered meals shall provide and maintain evidence of:
(a) A current, valid food operations or other applicable license or certificate as required by licensing or regulatory agencies where the meal is produced.
(b) Good standing with all applicable federal, state and local regulatory agencies; and
(c) Meeting licensing requirements for safety, storage, sanitation and other applicable provisions for food service.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM/Provider Oversight Contractor

Frequency of Verification:

Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigation of Provider Occurrences). Provider qualifications are verified at the time of initial enrollment and at five-year provider agreement revalidation.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meal Services

Provider Category:

Agency

Provider Type:

Agency, e.g., Meals on Wheels, a food vendor, etc.

Provider Qualifications

License *(specify):*

Current, valid license or certificate from the local health department.

Certificate *(specify):*

Other Standard *(specify):*

Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46

A provider of home delivered meals shall provide and maintain evidence of:
(a) A current, valid food operations or other applicable license or certificate as required by licensing or regulatory agencies where the meal is produced.
(b) Good standing with all applicable federal, state and local regulatory agencies; and
(c) Meeting licensing requirements for safety, storage, sanitation and other applicable provisions for food service.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM/Provider Oversight Contractor

Frequency of Verification:

Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigation of Provider Occurrences). Provider qualifications are verified at the time of initial enrollment and at five-year provider agreement revalidation.

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

Service Title:

Home Maintenance and Chore Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

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

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

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

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

Home Maintenance and Chore Services are limited to $10,000 per twelve-month calendar year and are outside of the individual funding amount.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Contractor; Independent General Contractor; Handyman; House Cleaner; Maid; Home Repair Worker; Exterminator
Agency	Home Improvement Company; Builder; Neighborhood Organization; Community Action Agency; Social Service Agency; Home Health Agency; and Extermination Company

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Independent Contractor; Independent General Contractor; Handyman; House Cleaner; Maid; Home Repair Worker; Exterminator

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM/Provider Oversight Contractor

Frequency of Verification:

Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigations of Provider Occurrences). Provider qualifications are verified at the time of initial enrollment and at five-year provider agreement revalidation.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home Improvement Company; Builder; Neighborhood Organization; Community Action Agency; Social Service Agency; Home Health Agency; and Extermination Company

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM/Provider Oversight Contractor

Frequency of Verification:

Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigation of Provider Occurrences). Provider qualifications are verified at the time of initial enrollment and at five-year provider agreement revalidation.

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

Service Title:

Home Modification Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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

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

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

• Home modifications do not include new, replacement, or repair of a previously approved home modification that has been damaged as a result of apparent misuse, abuse or negligence.
• Home modification services are limited to $10,000 per twelve-month calendar year and are outside of the individual funding amount.
• Home modification services do not duplicate coverage provided under the State plan and EPSDT.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Non-agency employed providers, e.g., independent contractors
Agency	Agency, e.g., home improvement companies and general contractors, etc.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modification Services

Provider Category:

Individual

Provider Type:

Non-agency employed providers, e.g., independent contractors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM/Provider Oversight Contractor

Frequency of Verification:

Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigation of Provider Occurrences). Provider qualifications are verified at the time of initial enrollment and at five-year provider agreement revalidation.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modification Services

Provider Category:

Agency

Provider Type:

Agency, e.g., home improvement companies and general contractors, etc.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM/Provider Oversight Contractor

Frequency of Verification:

Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigation of Provider Occurrences). Provider qualifications are verified at the time of initial enrollment and at five-year provider agreement revalidation.

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

Service Title:

Out-of-Home Respite Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

Out-of-Home Respite Services are services delivered to consumers in an out-of-home setting in order to allow respite for caregivers normally providing care. The service must include an overnight stay.

The services the out-of-home respite provider must make available are:
*Waiver nursing
*Personal care aide services
*Three meals per day that meet the individual's dietary requirements.

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

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

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	ICF-IID , NF, or another licensed setting approved by ODM or certified by the Ohio Department of Aging or the Ohio Department of Developmental Disabilities

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

ICF-IID , NF, or another licensed setting approved by ODM or certified by the Ohio Department of Aging or the Ohio Department of Developmental Disabilities

Provider Qualifications

License *(specify):*

ICF-IID that has an active Medicaid provider agreement in accordance with Sections 5124.06 and 5124.07 of the Revised Code, or NF per OAC rules 5160-3-02 and 5160-3-02.3

Certificate *(specify):*

Provider certification by the Ohio Department of Aging or the Ohio Department of Developmental Disabilities

Other Standard *(specify):*

Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM/Provider Oversight Contractor

Frequency of Verification:

Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigation of Provider Occurrences). Provider qualifications are verified at the time of initial enrollment and at five-year provider agreement revalidation.

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

Service Title:

Personal Emergency Response Systems

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14010 personal emergency response system (PERS)

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

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

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

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

*Wearable waterproof activation devices; and

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

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

PERS does not include the following:

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

*In-home communication connection systems used to supplant routine supervision of individuals under the age of eighteen.

*Remote monitoring services.

*New equipment or repair of previously-approved equipment that has been damaged as a result of apparent misuse, abuse or negligence.
*Personal Emergency Response Systems do not duplicate coverage provided under the State plan and EPSDT services are not duplicated.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicare-certified HHA; ACHC-, CHAP- or Joint Commission-accredited agencies, Other ERS agencies

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Medicare-certified HHA; ACHC-, CHAP- or Joint Commission-accredited agencies, Other ERS agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM/Provider Oversight Contractor

Frequency of Verification:

Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigation of Provider Occurrences). Provider qualifications are verified at the time of initial enrollment and at five-year provider agreement revalidation.

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

Service Title:

Self-directed goods and services

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

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

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

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

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

Self-directed goods and services are individualized; therefore an exhaustive list cannot be developed. Goods and services include any needed equipment, supplies or services not covered by medicaid or another approved HCBS waiver service. This may include but is not limited to:

(a) community classes, memberships, training or coaching; and

(b) household related items or devices; and

(c) camps; and

(d) art, music, or other alternative therapies.

Goods and services purchased under this coverage may not circumvent other restrictions on the claiming of FFP for waiver services, including the prohibition against claiming for the costs of room and board. Each of the specific goods and services that are purchased under this coverage must be documented in the service plan.

Self-Directed Goods and Services are purchased from the self-directed budget up to two-thousand-five hundred dollars ($2,500) every 365 days. Any service needs that cannot be met within the annual self-directed goods and services limit must be brought to ODM's attention for further review. Self-directed goods and services purchased must be clearly linked to an individual's assessed need that is established in the service plan.

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

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

- Experimental treatments; or
- Items used solely for entertainment or recreational purposes; or
- Monthly rent, utilities or internet service: or
- Items that are illegal or otherwise prohibited by federal or state regulations.

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

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

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

☐ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Financial Management Services Entity

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Financial Management Services Entity

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

See additional information provided in Appendix E.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Ohio Department of Medicaid

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Structured Family Caregiving Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

Structured Family Caregiving (SFC), described in Ohio Administrative Code 5160-44-33, is a service for individuals who are at least 18 years of age and resides with a caregiver who provides assistance to the individual with daily personal care and household support, and assistance with activities needs to promote independence and integration into the community.

Providers of SFC are agency-only. The individual may choose any willing and able SFC provider, meeting the program provider specifications. The agency provides coaching and support services to caregivers.

SFC providers may not perform health-related elements of the service (skilled care, nursing, medication administration) that, by state law, only licensed medical professionals can deliver. The individualized service plan will describe how routine health related tasks will be met through the use of agency-based providers.

The service is intended to complement, not replace, similar services available under the Medicaid state plan. The waiver service shall not be used in lieu of the Medicaid state plan home health benefits when it has been determined the individual meets the eligibility criteria as described in chapter 5160-12 of the Ohio Revised Code.

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.

The SFC service does not cover costs associated with room and board.

The maximum allowable payment rates and procedure codes for SFC are found here: https://codes.ohio.gov/ohio-administrative-code/rule-5160-1-06.1

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

~SFC will not be authorized for individuals who are medically unstable or medically complex as a substitute for skilled care provided by an RN, LPN, licensed nurse, or other licensed health care professional.

~SFC will not be provided on the same calendar day as out-of-home respite as described in rules 5160-44-17 and 173-39-02.03 of the Administrative Code.

~SFC services will not be provided on the same calendar day when more than two hours of the following services, or combination of, are authorized on the individual's person-centered service plan:

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

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

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

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

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

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**
☐ **Remote/via Telehealth**

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

☒ **Legally Responsible Person**
☒ **Relative**
☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicare-certified home health agency, otherwise-accredited agency, or hold an accreditation from an organization recognized by CMS or the United States Department of HHS.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Medicare-certified home health agency, otherwise-accredited agency, or hold an accreditation from an organization recognized by CMS or the United States Department of HHS.

Provider Qualifications

License *(specify):*

Rule 5160-44-33 outlines requirements.

Certificate *(specify):*

Medicare-certified home health agency, otherwise-accredited agency, or hold an accreditation from an organization recognized by Centers for Medicare and Medicaid Services (CMS) or the United States Department of Health and Human Services (HHS), and operate in accordance with Chapter 5160-45 of the Administrative Code.

Other Standard *(specify):*

For medicare-certified home health agencies, the caregiver will successfully meet trainings specified in 42 C.F.R. 484.80 (as in effect on October 1, 2023), or for otherwise-accredited agencies or hold an accreditation from an organization recognized by Centers for Medicare and Medicaid Services (CMS) or the United States Department of Health and Human Services (HHS), the caregiver will successfully complete at least eight hours of initial training that the individual determines the provider needs to meet the individual's specific needs by the deadline the individual establishes. The provider will ensure the caregiver receives structured training tailored to support the caregiver to meet the individual's assessed needs.

The provider’s coaching and support professional staff will include:

*a registered nurse (RN), in accordance with Chapter 4723. of the Revised Code,

*a licensed practical nurse (LPN), at the direction of an RN, in accordance with Chapter 4723. of the Revised Code,

*a licensed social worker (LSW), in accordance with Chapter 4757. of the Revised Code. or

*a licensed independent social worker (LISW), in accordance with Chapter 4757. of the Revised Code.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM/Provider Oversight Contractor

Frequency of Verification:

Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigation of Provider Occurrences). Provider qualifications are verified at the time of initial enrollment and at five-year provider agreement revalidation.

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

Service Title:

Supplemental Adaptive and Assistive Device Services

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14031 equipment and technology

Category 2:

14 Equipment, Technology, and Modifications

Sub-Category 2:

14032 supplies

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Supplemental Adaptive and Assistive Device Services are medical equipment, supplies and devices that are not otherwise available through any other funding source and that are suitable to enable the individual to function with greater independence, avoid institutionalization, and reduce the need for human assistance.

The need for certain items, particularly mobility devices or items where seating is involved, may require evaluation by an occupational therapist pursuant to section 4755.08 of the Revised Code, or a physical therapist pursuant to section 4755.44 of the Revised Code. The cost of the assessment may be included in the cost of the supplemental adaptive and assistive device. Additionally, some adaptive/assistive devices may be provided prior to an individual's discharge from an institution into the community. In such instances, the adaptive/assistive device can be initiated up to 180 days prior to discharge, and the date of service for allowable expenses shall be the date on which the individual leaves the institution and enrolls on the waiver.

Supplemental adaptive and assistive device services include repairs of previous equipment, including parts and labor, unless the repair is required as a result of apparent misuse, abuse or negligence.

Supplemental Adaptive and Assistive Device Services must be prior-approved, and the provider of such services must be identified on the person-centered service plan.

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

* ODM or its designee shall only approve the lowest cost alternative that meets the individual's needs as determined during the assessment process.

*Reimbursement for medical equipment and supplies shall not exceed a combined total of $10,000 within a calendar year per individual, and is outside of the individual's individual funding amount. ODM will not approve the same type of medical equipment, supplies and devices for the same individual during the same calendar year, unless there is a documented need for ongoing medical equipment, supplies or devices as documented by a licensed health care professional, or a documented change in the individual's medical and/or physical condition requiring the replacement.

Supplemental Adaptive and Assistive Device Services do not include:

*Items considered by the federal Food and Drug Administration as experimental or investigational.
*Funding of down payments toward the purchase or lease of any supplemental adaptive and assistive device services.
*Service animals.
*Equipment, supplies or services furnished in excess of what is approved pursuant to, and as specified on the individual's person-centered service plan.
*New equipment or supplies or repair of previously approved equipment or supplies that have been damaged as a result of apparent misuse, abuse or negligence.
*Routine care and maintenance of devices.

*Services performed in excess of what is approved pursuant to, and specified on, the individual's person-centered service plan.

*Supplemental Adaptive and Assistive Device Services do not duplicate coverage provided under the State plan and EPSDT services are not duplicated.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency, e.g., DME providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supplemental Adaptive and Assistive Device Services

Provider Category:

Agency

Provider Type:

Agency, e.g., DME providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM/Provider Oversight Contractor

Frequency of Verification:

Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigation of Provider Occurrences). Provider qualifications are verified at the time of initial enrollment and at five-year provider agreement revalidation.

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

Service Title:

Supplemental Transportation Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

Supplemental Transportation Services are transportation services that are not otherwise available through any other resource that enable an individual to access waiver services and other community resources specified on the individual's person-centered service plan. Supplemental Transportation Services include, but are not limited to, assistance in transferring the consumer from the point of pick-up to the vehicle and from the vehicle to the destination point.

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

Supplemental Transportation Services and the provider of such services must be identified on the person-centered service plan. Supplemental Transportation Services do not include services performed in excess of what is approved pursuant to, and specified on, the individual's person-centered service plan.

*Supplemental Transportation Services do not duplicate coverage provided under the State plan and EPSDT services are not duplicated.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency, e.g., ambulette companies, senior centers, and community action organizations. etc.
Individual	Non-agency employed provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supplemental Transportation Services

Provider Category:

Agency

Provider Type:

Agency, e.g., ambulette companies, senior centers, and community action organizations. etc.

Provider Qualifications

License *(specify):*

Motor Vehicle

Certificate *(specify):*

Other Standard *(specify):*

Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM/Provider Oversight Contractor

Frequency of Verification:

Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigation of Provider Occurrences). Provider qualifications are verified at the time of initial enrollment and at five-year provider agreement revalidation.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supplemental Transportation Services

Provider Category:

Individual

Provider Type:

Non-agency employed provider

Provider Qualifications

License *(specify):*

Motor vehicle

Certificate *(specify):*

Other Standard *(specify):*

Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM/Provider Oversight Contractor

Frequency of Verification:

Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigation of Provider Occurrences). Provider qualifications are verified at the time of initial enrollment and at five-year provider agreement revalidation.

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

Service Title:

Vehicle Modification

HCBS Taxonomy:

Category 1:	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):*

Vehicle modification services are adaptations or alterations to a vehicle that are not otherwise available through any other source and that are suitable to enable the individual to function with greater independence and integrate more fully into the community and to ensure the health, welfare and safety of the individual.

Vehicle modification services must be prior-approved, and the provider of such services must be identified on the person-centered service plan.

Vehicle modification services may only be made to a vehicle owned by the individual enrolled in the program, a relative of the individual who provides primary long-term support whether paid or non-paid, or a non-relative who provides primary long-term support to the individual and is not a paid provider.

Reimbursable vehicle modifications include but are not limited to:
-External handling devices and carriers
-Operating aids, such as assistive equipment and technologies
-Raised and lowered floors or roofs, raised doors
-Scooter/wheelchair hoists, hitches, or tie downs
-Lifts
-Maintenance, repair, or replacement of a previous vehicle modification funded by the individual's waiver
-Transfers of adaptable equipment from one vehicle to another for use by the same individual.
-Vehicle modifications may also include factory-installed adaptations when documented on a separate, itemized invoice associated with the purchase of a new vehicle not pre-owned or pre-leased. Such modifications are payable upon proof of transfer of vehicle ownership from the dealer into the name of allowable owners of the vehicle described in this rule.

For structural vehicle modifications, an evaluation may be required by an occupational therapist or physical therapist pursuant co Chapter 4755 of the Revised Code or a certified driver rehabilitation specialist (CDRS) or a driver rehabilitation specialist (DRS) under the supervision of a CDRS. The cost of the assessment may be included in the cost of the vehicle modification service. Non-structural minor modifications may be exempt from formal evaluations performed by a qualified professional.

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

*ODM or its designee shall only approve the lowest cost alternative that meets the individual's needs as determined during the assessment process.

*Reimbursement for vehicle modifications shall not exceed a total of $10,000 within a calendar year per individual and is outside of the individual's individual funding amount. ODM will not approve the same type of vehicle modification for the same individual during the calendar year, unless there is a documented need for or change in the individual's medical and/or physical condition requiring replacement.

*Vehicle modification services do not include services performed in excess of what is approved pursuant to, and specified on, the individual's person-centered service plan.

*Vehicle modification services are not allowed for vehicles owned by independent paid providers, business entities, and provider agencies.

Vehicle Modification Service does not include:
-Modifications that are available through another funding source.
-Routine auto care and maintenance of general utility unrelated to the vehicle modification.
-Replacement or repair of previously approved vehicle modifications damaged because of apparent misuse, abuse or negligence.
-Payment for the purchase of a vehicle except as set forth in paragraph (B)(9) of this rule.
-Permanent modifications to leased vehicles.
-Vehicle insurance costs.
-Removal of a modification except in instances of transfers of adaptable equipment from one vehicle to another for use by the same individual
-Repairs needed to a vehicle before a modification can be installed.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Provider of Vehicle Modifications

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modification

Provider Category:

Agency

Provider Type:

Agency Provider of Vehicle Modifications

Provider Qualifications

License *(specify):*

Licensed as an adaptive mobility dealer in accordance with section 4517.01 of the Ohio Revised Code

Certificate *(specify):*

Other Standard *(specify):*

Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM/Provider Oversight Contractor

Frequency of Verification:

Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigation of Provider Occurrences). Provider qualifications are verified at the time of initial enrollment and at five-year provider agreement revalidation.

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

Service Title:

Waiver Nursing Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

Waiver nursing are part-time, intermittent and/or continuous nursing services provided to individuals who require the skills of a registered nurse (RN) or licensed practical nurse (LPN) at the direction of an RN. Waiver nursing services are furnished within the nurse's scope of practice as set forth in Chapter 4723 of the Revised Code (Ohio's Nurse Practice Act) and Administrative Code rules adopted thereunder.

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

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

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

- ☒ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Waiver Nursing Services

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

RN/LPN

Certificate *(specify):*

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

Other Standard *(specify):*

Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM/Provider Oversight Contractor

Frequency of Verification:

Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigation of Provider Occurrences). Provider qualifications are verified at the time of initial enrollment and at five-year provider agreement revalidation.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Waiver Nursing Services

Provider Category:

Individual

Provider Type:

Self-directed caregiver

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

FMS-enrolled self-directed caregiver

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Waiver Nursing Services

Provider Category:

Individual

Provider Type:

Non-agency employed RN; non-agency employed LPN

Provider Qualifications

License *(specify):*

RN/LPN

Certificate *(specify):*

Other Standard *(specify):*

Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46

Verification of Provider Qualifications

Entity Responsible for Verification:

ODM/Provider Oversight Contractor

Frequency of Verification:

Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigation of Provider Occurrences). Provider qualifications are verified at the time of initial enrollment and at five-year provider agreement revalidation.

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☒ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

ODM contracts with multiple CMA to perform certain program and case management functions around the state. These contracts are competitively bid. The CMAs are responsible for interfacing with individuals at the local level to assure they have access to services. They perform level of care assessments, recommend waiver program eligibility, work with individuals to develop a person-centered service plan (plan of care) that is tailored to meet their service needs, monitor health and welfare, and provide ongoing case management and support. The CMAs must adhere to all administrative rules, regulations and policies established by ODM.

To ensure proper training for PCSP development, the State has published three training modules, geared toward care coordination responsibilities within the nursing facility-based waiver programs. These include HCBS Settings Overview, HCBS Settings Criteria and Modifications and Care Coordination Role in HCBS Settings. The training modules are located here: https://medicaid.ohio.gov/families-and-individuals/citizen-programs-and-initiatives/hcbs/hcbs-transition.

The CMAs and their subcontractors cannot provide direct home health or waiver program services to any individuals enrolled on the Ohio Home Care Waiver through the entire term of their CMA contracts. During the first year of an individual's waiver eligibility, the case managers who render ongoing case management services cannot be the same case managers who determined initial eligibility.

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

Service
Adult Day Health Center Services
Personal Care Aide Services
Community Integration Services
Community Transition Services
Home Care Attendant Services
Home Delivered Meal Services
Home Maintenance and Chore Services
Home Modification Services
Out-of-Home Respite Services
Personal Emergency Response Systems
Self-directed goods and services
Structured Family Caregiving Services
Supplemental Adaptive and Assistive Device Services
Supplemental Transportation Services
Vehicle Modification
Waiver Nursing Services

1. Will any in-person visits be required?

- ○ **Yes.**
- ○ **No.**

2. *By checking each box below, the state assures that it will address the following when delivering the service remotely/via telehealth.*

☐ **The remote service will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc.** ***Explain:***

☐ **How the telehealth service delivery will facilitate community integration.** ***Explain:***

☐ **How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service can be rendered without someone who is physically present or is separated from the individual.** ***Explain:***

☐ **How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service.** ***Explain:***

☐ **How the telehealth will ensure the health and safety of an individual.** ***Explain:***

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):

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

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

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

The processes for background checks differ between agency and non-agency providers furnishing Ohio Home Care Waiver services.

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

Process for Agency Employees: Prior to hiring a new employee, the waiver agency must screen the potential employee against a list of databases (see C-2-b) for disqualifying information. If the potential employee meets certain criteria based on the results of his or her registry screening, he or she will not be permitted to furnish HCBS to individuals enrolled on the Ohio Home Care Waiver and a criminal record check will not be necessary.

Potential employees who clear the screening are required to furnish a set of fingerprint impressions and submit to a criminal record check with BCI. If the person fails to provide the agency with fingerprint impressions upon request, he or she cannot be employed by the agency to provide HCBS to individuals on the Ohio Home Care Waiver. The agency can conditionally employ the person on a time-limited basis pending the results of the criminal record check, however, the person is only permitted to provide services under supervision. The agency applies the results of the criminal record check against the tiered exclusionary periods. If the results indicate the person has been convicted of, or pleaded guilty to, a disqualifying offense, then employment must be terminated. The waiver agency is responsible for ensuring that employees are subject to the database screening and criminal records recheck procedures every five years. The agency maintains documentation of the screening and records recheck for all employees. ODH reviews the records of agencies providing Medicare services and who are Joint Commission- accredited. ODM reviews agency records of agencies that do not provide Medicare services and that are not Joint Commission-accredited according to a pre-determined monitoring schedule.

Process for Self-Directed Caregivers: For self-directed caregivers who are not currently enrolled waiver providers with ODM, criminal records are verified by the FMS at hiring and at least every five years thereafter. Criminal record checks are conducted in accordance with rule 5160-1-17.8 of the Administrative Code. Self-Directed caregivers may begin rendering services while criminal record checks are pending for up to 60 days under conditional employment.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ○ **No. The state does not conduct abuse registry screening.**
- ◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

In accordance with the Affordable Care Act, and the time of enrollment and re-enrollment, ODM conducts screenings of all providers based on assigned risk levels and in accordance with 42 CFR 455 Subpart e. These include, but are not limited to, on-site visits, criminal record checks and exception list verifications. Additionally, pursuant to section 5164.342 of the Ohio Revised Code, Ohio requires registry screens of provider agency applicants or employees prior to the background check being performed. They must also be performed on non-agency providers/applicants as part of the provider enrollment process in accordance with section 5164.341 of the Ohio Revised Code. If a prospective provider, or existing agency or non-agency provider meets certain criteria based on the results of their registry screen, the person will not be permitted to furnish services to individuals enrolled on the Ohio Home Care Waiver. As needed, the CMA is notified so providers can be removed from individual's person-centered service plans and to authorize a new provider to fulfill the services that may have been affected. Also, the CMA must ensure the individual's health, safety, and welfare. These databases include, but are not limited to the following:

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

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

(3) The DODD abuser registry;

(4) Ohio's state nurse aide registry;

(5) Any other database, if any, specified in rules adopted by ODM.

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

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

For self-directed caregivers who are not currently enrolled waiver providers with ODM, abuse registry screening is conducted by the FMS at hiring and at least every five years. Abuse registry screening is conducted at the limited level in accordance with rule 5160-1-17.8 of the Administrative Code.

Appendix C: Participant Services

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

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *Select one*:

- ○ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ◉ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is ***"extraordinary care"***, exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

Requirements are outlined 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 personal care aide and waiver nursing services, as described below. Spouses may serve as a direct care worker for structured family caregiving service, while employed through an agency, as described below.

Through assessment and care planning activities, the case manager 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 a spouse are determined to meet extraordinary care requirements, as determined through Ohio’s Extraordinary Care Instrument (ODM Form 10372).

Limitations:

*The parent of a minor child or spouse must be employed through an agency.
*Service is not authorized for respite purposes.
*The maximum number of hours a spouse may be authorized is forty hours, unless ODA, ODM or their designee determines additional hours are necessary to meet the health and safety needs of the individual.

Service payments: Routine agency billing procedures apply.

Routine strategies outlined throughout the waiver application are employed to ensure permitting a legally responsible to serve as a direct care worker is in the best interest of the participant. This includes increased care coordination oversight activities when this allowance is implemented.

The state ensures payments are made only for services rendered through care coordination oversight and authorization, person-centered planning and routine provider oversight activities described throughout this waiver application.

A parent or spouse serving as a direct care worker are required to meet provider certification requirements for the service provided.

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ◉ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Requirements are outlined 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 personal care, structured family caregiving service, or waiver nursing, 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 personal care, structured family caregiving service, or waiver nursing, through agency employment:

*authorized representative
*declaration for mental health treatment
*general power of attorney
*healthcare (medical) power of attorney
*appointment of legal custody of a minor
*guardianship pursuant to a court order, if granted court authority to serve as a direct care worker for the individual.

The direct care worker is required to meet provider requirements for the service provided.

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

Relatives with designated legal decision-making authority may be authorized the number of hours necessary, up to a maximum of forty hours, to meet the needs determined by their person-centered plan and authorized by ODM or their designee. Additional hours may be authorized by ODM or their designee if it is determined it is 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 individual to serve as a direct care worker is in the best interest of the participant. This includes increased care coordination and oversight activities when this allowance is implemented.

The state ensures payments are made only for services rendered through care coordination oversight and authorization, person-centered planning and routine provider oversight activities described throughout this waiver application. Service payments through routine agency billing procedures apply.

Relatives without legal decision-making authority as described in 5160-44-32 may receive payment for providing waiver services, in accordance with chapters 5160-40, 5160-45 and 5160-46 of the Ohio administrative code.

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR § 431.51:

Any person or agency that wants to provide Ohio Home Care Waiver program services must complete the waiver service provider enrollment process set forth in OAC rule 5160-45-04 and meet the provider requirements and specifications set forth in OAC Chapters 5160-44, 5160-45 and 5160-46. If an individual prefers a person who is not an approved Medicaid waiver provider, they are encouraged to communicate this information to their CMA. The CMA will direct them to the provider oversight contractor's website for information about how to apply through ODM's provider network management system and initiate the provider enrollment process. New providers must successfully complete ODM-mandated new provider training within 90 days after a new provider's Ohio Medicaid enrollment date.

All prospective and approved providers can access information that links them to program rules and available training opportunities on both the ODM website and the provider oversight contractor's website.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one*:

- ○ **No, the state does not choose the option to provide HCBS in acute care hospitals.**
- ○ **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*
  - ☐ **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**
  - ☐ **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**
  - ☐ **The HCBS must be identified in the individual's person-centered service plan; and**
  - ☐ **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

And specify: **(a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;(b) How the 1915(c) HCBS will assist the individual in returning to the community; and(c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.**

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

Performance Measure:
C-1: Number and percent of new non-agency providers that meet initial licensure requirements prior to providing waiver services and/or adhere to other state standards. N= Number of new non-agency providers that meet initial licensure requirements prior to providing waiver services and/or adhere to other state standards. D= Total number of new non-agency providers enrolled.

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

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 providers that continue to meet enrollment requirements at reenrollment. N= Number of providers that continue to meet enrollment requirements at reenrollment. D= Total number of providers due for reenrollment.

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

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-3: Number and percent of new agency providers that meet initial certification requirements prior to providing waiver services. N= Number of new agency providers that meet initial certification requirements prior to providing waiver services. D= Total number of new agency providers enrolled.

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

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-6: Number and percent of new self-directed caregivers enrolled through a Financial Management Services (FMS) entity who met initial enrollment requirements prior to providing waiver services. N: Number of enrolled self-directed caregivers who met initial enrollment requirements prior to providing waiver services. D: Total number of self-directed caregivers enrolled through an FMS entity.

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: Financial Management Services entity	☐ **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: Financial Management Services entity	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. ***Sub-Assurance: The state 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:
C-4: Number and percent of non-agency personal care aide and home care attendant providers who continue to meet waiver enrollment requirements. N= Number of non-agency personal care aide and home care attendant providers reviewed who continue to meet waiver enrollment requirements. D= Total number of non-agency personal care aide and home care attendant providers reviewed.

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

Provider Oversight Contractor		
	☐ **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 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-5: Number and percent of non-agency personal care aides (PCA) and home care attendants (HCA) for whom training was conducted in accordance w/state requirements and the approved waiver. N= # of non-agency PCAs & HCAs who received training in accordance with state requirements & the approved waiver. D= # of non-agency PCAs & HCAs for whom a structural review was held in the quarter.

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

ODM believes that education is an important part of remediation for provider issues. As part of the remediation process, ODM assures that the opportunity is exercised to educate providers about the rules, and about the importance of implementing practices that assure compliance with the rules. ODM and the CMAs and the provider oversight contractor work closely to provide ongoing education to providers, and to send them alerts in order to help providers avoid and remedy problems.

When a provider is found to be non-compliant with a rule during a structural review, incident investigation, or an investigation of a provider occurrence, the provider oversight contractor sends the provider written correspondence to inform the provider that they must correct the violation.

Non-compliance identified during a Structural Review is issued in a Findings Report - Issued after the Structural Review exit conference has occurred; the Findings Report summarizes the overall outcome of the review. If there has been a finding of noncompliance, the report specifies the Administrative Code rules that are the basis for which noncompliance has been determined and outlines the specific issues or findings of noncompliance the provider must address in a plan of correction.

Depending on the nature and severity of the violation, the provider is required to submit a plan of correction. After the provider oversight contractor reviews and accepts the plan of correction, the violation is closed, and a communication is sent to the provider confirming acceptance of the plan of correction. The provider oversight contractor monitors the provider's compliance with the plan of correction. If a plan of correction is not submitted, or not found acceptable by the provider oversight contractor, the provider oversight contractor refers the finding to ODM and ODM sends the provider a Notice of Operational Deficiency. A Notice of Operational Deficiency can also be issued when ODM or the provider oversight contractor substantiates critical incidents and provider occurrences such as allegations of provider billing violations, substandard provider performance such as sleeping on the job, provider theft, etc., and serious and immediate threats to the health and welfare of the individual.

A Notice of Operational Deficiency requires the provider to submit a plan of correction in accordance with the policies set forth in OAC rule 5160-45-06. If the provider submits a plan of correction that ODM finds acceptable, the violation is closed, and a communication is sent to the provider confirming acceptance. The provider oversight contractor monitors the provider's compliance with the plan of correction. If the provider does not respond, or does not submit an acceptable plan of correction, sanctions are imposed. Sanctioning may include termination of the provider’s Medicaid Agreement.

ODM and the provider oversight contractor use an electronic database to document when a provider receives a Notice of Operational Deficiency, and/or findings letter resulting from a structural review. The database allows the State to document when a formal communication has been issued and why, and when the provider responds with a plan of correction (including if it is accepted).

The State and the provider oversight contractor then monitor providers to assure that providers correct rule violations in several ways:

1) ODM and the provider oversight contractor continue to monitor the provider via the electronic database to determine if the provider continues to violate the same or similar rule(s). If a provider continues to be in violation, the State may issue the provider a Notice of Operational Deficiency or issue progressive sanctions, including but not limited to terminating the provider.

2) A prevention plan is created to assist in keeping the individual safe .. The provider participates in the development of the plan. The plan is monitored by the provider oversight contractor and is specified on the person-centered service plan.

3) ODM and the provider oversight contractor also have the discretion to conduct announced and unannounced visits with any provider, at any time, to investigate provider occurrences or individual incidents, and may conduct a in person visit with providers during the course of an investigation of a provider occurrences or critical incident.

4) ODM monitors provider performance directly during the Ongoing Review by interviewing the individual about provider quality, interactions and performance, and assuring provider documentation is maintained to support the amount, scope, and frequency of service delivery, as well as Medicaid claims.

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: Provider Oversight Contractor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

◉ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect

when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☒ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

(a) Waiver services to which the limit applies:

*Community Transition Services are limited to $2,000 per individual per waiver enrollment.
*Self-directed goods and services are limited to $2,500 per individual within 365 days.
*Home Maintenance and Chore Services are limited to $10,000 per twelve-month calendar year.
*Home Modification Services are limited to $10,000 per twelve-month calendar year unless there are additional funds available through a self-directed budget as described in Appendix E.
* Under Supplemental Adaptive and Assistive Device Services, reimbursement for medical equipment, and supplies shall not exceed $10,000 within a calendar year per individual. ODM will not approve the same type of medical equipment, supplies and devices for the same individual during the same calendar year unless there is a documented need for ongoing medical supplies or devices as documented by a licensed health care professional, or a documented change in the individual's medical and/or physical condition requiring the replacement.
*Vehicle Modification Services are limited to $10,000 per twelve-month calendar year.

(b) Basis of limit: The limits that are being established for these services are set forth in OAC Chapters 5160-44, 5160-45 and 5160-46 and are identified in (a) above.

(c) Adjustment of the limit: Home maintenance and chore services, home modifications, supplemental adaptive and assistive devices, and vehicle modifications must be prior-approved. Home maintenance and chore services in excess of the limit can be approved by ODM when there is a documented need for such services. Supplemental adaptive and assistive devices in excess of the limit can be approved by ODM when there is a documented need for ongoing medical supplies, or a documented change in the individual's medical and/or physical condition requiring replacement. Any self-directed goods and services needs that cannot be met within the annual self-directed goods and services limit must be brought to ODM’s attention for further review.

(d) Provision of exceptions: Any exceptions to home maintenance and chore, self-directed goods and services, vehicle modifications and/or supplemental adaptive and assistive device services must be brought to ODM's attention for review and prior approval.

(e) Safeguards: Case managers are responsible for monitoring the adequacy of services provided to individuals through a schedule of contacts based on the individual's case management level as described in Appendix D-2. Individuals can request home maintenance and chore, home modifications, supplemental adaptive and assistive device, and/or vehicle modification services from their case manager at any time. Self-directed goods and services are addressed by the case manager when the individual chooses to self-direct their services.

The need for home modification services may require the completion of an in-home evaluation by an occupational therapist or physical therapist as licensed pursuant to Chapter 4755 of the Revised Code. The evaluation shall determine the individual’s capacity to utilize the requested service. It may also require the completion of an in-home evaluation by an appropriately qualified professional to determine the suitability of the immediate environment where the modification will be installed and the viability of the completion of the modification to improve independence.

An occupational or physical therapist may also be consulted to evaluate and recommend the most appropriate adaptive and assistive device to meet the individual's identified needs.

An in-home evaluation by an appropriately qualified professional may be required to determine the suitability of the immediate environment where a home maintenance and chore service will be performed and the viability of the completion of the service to improve independence and/or facilitate a healthy and safe environment.

The need for structural vehicle modification services may require the completion of an evaluation by an occupational therapist or physical therapist as licensed pursuant to Chapter 4744 of the Revised Code or a certified driver rehabilitation specialist (CDRS) or a driver rehabilitation specialist (DRS) under the supervision of a CDRS. The evaluation includes the appropriate vehicle modification and capacity of the person meant to use the modification and the suitability of the vehicle. Non-structural minor modifications may be exempt from formal evaluations performed by a qualified professional.

(f) Notification of amount: Case managers must notify the individual of the approval of the request for and amount of home maintenance and chore, home modification, adaptive and assistive device, and/or vehicle modification services and must update the person-centered service plan accordingly. Self-directed goods and services are addressed through the self-directed budgeting process and included in person-centered services plans when authorized.

(g) Hearing rights: Case managers must also notify individuals of their right to request a hearing subsequent to a denial of the individual's request for initial or subsequent community transition, home maintenance and chore, self-directed goods and services, home modification, supplemental adaptive and assistive device, and/or vehicle modification services.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☒ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

Individual limits are determined at the time of entry onto the waiver, with modifications occurring subsequent to changes in the individual's condition or circumstances. Individuals are assigned a monthly cost limit by the CMAs based on their service needs as identified in the assessment and person-centered service planning processes. The cost limit, or cap, is based on the monthly cost of services as identified in the person-centered service plan. The person-centered service plan contains all authorized services, including the cost of services. The cost limit excludes community transition, home maintenance and chore, home modification, self-directed goods and services, supplemental adaptive and assistive device, and vehicle modification services.

Cost limits are adjusted when service needs change. The CMA must have a process in place in which Person-centered service plans are subject to review by an internal clinical review team. This team must be established to review utilization management including the ongoing review of services exceeding $14,000 per month or other prior authorization conditions as described below for necessity prior to submitting request to ODM.

The CMA clinical review committee must be comprised of a minimum of two licensed clinical staff members. The team is responsible for conducting case reviews to inform service planning for high risk individuals and for recommending to ODM the approval of the person-centered service plan authorizations when the monthly cost of services exceeds $14,000. Quarterly, the Contractor must describe how it is managing cost growth in the Ohio Home Care Waiver program.

Conditions under which prior authorization is required include, but are not limited to:

- An increase in monthly service authorization amounting to $1000 over the reset baseline.

- An increase in service authorization amounting to $1000 over the previously authorized amount of private duty nursing (PDN) or, if applicable, a combination of PDN and home health services for individuals who are newly enrolled on the Ohio Home Care Waiver.

- Any service authorization of $14,000 or more in a month.

- Person-centered service plans that include more than 112 paid hours per week of personal care aide services, nursing or home care attendant services, adult day health, or any combination of these or other like services, regardless of funding source, authorized for more than four weeks.

As an additional safeguard to assure individuals have access to needed services in the event of an emergency, the previous description of prior authorization will not delay an individual’s access to urgently needed services. The CMAs can approve temporary increases in services up to $12,000 for no more than 21 calendar days. Emergency increases over $12,000 must be prior-authorized by ODM. The CMAs submit reports of all emergency authorizations to ODM quarterly, of which ODM reviews a random sample.

Individuals receive a revised copy of the person-centered service plan anytime changes are made, and they request a copy of their
current person-centered service plan at any time from their case manager.

Individuals are notified by the CMAs in writing of their hearing rights related to service changes which affect their cost limits. Hearing rights are also generated after denial of an individual's request for a change or increase in their funding amount.

The methodology for determining individuals' budget limits, based on level of support, is open for public inspection.

ODM does not provide special reimbursement based on an individual's geographic location, etc. The same waiver service rates are paid statewide for the same service. However, adjustments to the individual's approved services and cost limit can be made based on the individual's specific needs and circumstances using the process described above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 §§ CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings in which 1915(c) HCBS are recieved. *(Specify and describe the types of settings in which waiver services are received.)*

Settings for the OHCW program are fully described in Ohio Administrative Code 5160-44-01 Nursing facility-based level of care home and community-based services programs: home and community-based settings

The following is identified in the rule:
(1) A private residence is presumed to be a home and community-based setting provided it meets the requirements set below. For the purposes of this rule, provider owned or controlled settings are not private residences.
(a) The private residence is integrated in and supports the individual's full access to the greater community.
(b) The private residence is selected by the individual from among setting options.
(c) The private residence ensures an individual's right to privacy, dignity, and respect as well as freedom from coercion and restraint.
(d) The private residence optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices.
(e) The private residence facilitates individual choice regarding services and supports, and who provides them.

(2) A provider-owned or controlled residential setting, in addition to the requirements above (1a-1e), the following additional conditions will be met, consistent with the individual's person-centered services plan.
(a) The individual's unit or dwelling is a specific physical place that can be rented or occupied under either:
(i) A legally enforceable agreement between the individual receiving services, and the owner of the dwelling pursuant to Chapter 5321. of the Revised Code
(ii) For settings in which Chapter 5321. of the Revised Code does not apply, a lease, residency agreement or other legally enforceable agreement in effect for the individual which provides protections that address eviction processes and appeals comparable to those provided under Chapter 5321. and Chapter 1923. of the Revised Code
(b)The individual has privacy in their sleeping or living unit including all of the following:
(i) The unit has entrance doors lockable by the individual, with only appropriate staff having keys; and
(ii) An individual sharing a unit has a choice of roommates in that setting.
(c)The individual has the freedom to furnish and decorate their sleeping or living unit within the lease or legally enforceable agreement.
(d)The individual has the freedom and support to control their own schedule and activities, and has access to food at any time.
(e) The individual is able to have visitors of their choosing at any time.
(f) The setting is physically accessible to the individual

Home and community-based settings do not include the following:
-A nursing facility;
-An institution for mental diseases;
-An intermediate care facility for individuals with intellectual disabilities;
-A hospital;
-A psychiatric residential treatment facility; or
-Any other locations as determined by the ODM or its designee

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring*

across residential and non-residential settings in which waiver HCBS are received.)

Initial Compliance
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.

Ongoing HCBS Setting Compliance Monitoring
Ongoing monitoring of HCBS settings are monitored through scheduled provider compliance reviews and ongoing reviews completed by entities responsible for program care coordination and service authorization activities. Event-based reviews continue to be conducted upon receipt of complaints from individuals/guardians, community members, or others.

In the event a setting that previously demonstrated evidence of compliance cannot (or does not) subsequently produce acceptable evidence of compliance, the State's established relocation team, led by the State Long-Term Care Ombudsman and/or entities responsible for program care coordination, will work with individuals to transition them to a setting of their choice that meets the HCBS characteristics.

New Residential and non-residential HCBS service setting applicants:
An initial on-site assessment is conducted for all new settings that provide residential and non-residential HCBS.
•For all settings applying to serve individuals in an Ohio HCBS program, the assessment is conducted prior to the entity being issued a
Medicaid provider agreement to furnish HCBS waiver services.
•For individuals enrolled on an Ohio HCBS program, the entity responsible for care coordination and/or service authorization will ensure
that new settings comply with the HCBS settings standards prior to adding the service to the individual's service plan. If a setting's
non-compliance prevents a service from being added to an individual's plan, the individual will be afforded due process in accordance
with Ohio Revised Code 5101:6-1 through 5101:6-9.

All HCBS service providers newly applying to become a service provider are assessed and verified to meet HCBS settings requirements prior to approval to become a Medicaid waiver service provider. Sites unable to meet HCBS settings requirements are prohibited from becoming new service providers. Providers meeting criteria for Heightened Scrutiny may not receive approval until the outcome of the CMS HS review has been determined and approval is received.

Description of a beneficiary's recourse to notify the state of provider non-compliance (grievance process, notification of case manager, etc.) and how the state will address beneficiary feedback.

Ombudsman
In conjunction with the State Long Term Care Ombudsman Office, the State employed a public education and outreach campaign on the HCBS settings characteristics, including communicating the process for individuals to raise concerns regarding the community nature, or lack thereof, of a specific setting. There also was guidance developed for ombudsman representatives, case managers, and waiver Service coordinators when educating individuals about HCBS settings and person-centered planning. Additional guidance was developed to provide guidance to individuals receiving Assisted Living or Adult Day Services in the Assisted Living, PASSPORT, Ohio Home Care and MyCare Ohio Waivers.

The State recognizes protection and advocacy entities are key partners in ongoing compliance by informing individuals of their right to file a complaint regarding a specific setting and/or to report directly to the State any concerns with a setting's ability to comply. Upon receiving a report by an individual or another entity, the State will initiate a formal review, as appropriate.
Using the existing complaint processes, individuals have the right to file a complaint regarding a specific setting Individuals may report complaints through their care coordination entity, long term state ombudsman and/or to report directly to the State any concerns with a setting's ability to comply. Upon receiving a report by an individual or another entity, the State will initiate a formal review, as appropriate.

Case Manager
The case manager or waiver service coordinator also is an independent resource that the consumer can notify of any ongoing issue whether it is related to the HCBS settings rule or not. The waiver service coordinator serves as an invaluable resource for the HCBS participant to help with authorizing paid supports, locating and informing the HCBS participant about community related resources, acting as support when there are provider related concerns including the HCBS settings rule, and just and a trusted confident to the HCBS participant. The waiver service coordinator is expected to make referrals to the appropriate entity depending on the instance, whether that is the Ombudsman, licensing agency, provider compliance, or protective services. The waiver service coordinator frequently reaches out the HCBS participant for regular assessments and check-ins and is also available by phone, in-person, or electronically as the HCBS participant needs or concerns arise.

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

- ☒ **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.**
- ☒ **The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. *(see Appendix D-1-d-ii)***
- ☒ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**
- ☒ **Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.**
- ☒ **Facilitates individual choice regarding services and supports, and who provides them.**
- ☒ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.**

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings*.)

- ○ **No, the waiver does not include provider-owned or controlled settings.**
- ◉ **Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):
  - ☒ **The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.**
  - ☒ **Each individual has privacy in their sleeping or living unit:**
    - ☒ **Units have entrance doors lockable by the individual.**
    - ☒ **Only appropriate staff have keys to unit entrance doors.**
    - ☒ **Individuals sharing units have a choice of roommates in that setting.**
    - ☒ **Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.**
  - ☒ **Individuals have the freedom and support to control their own schedules and activities.**
  - ☒ **Individuals have access to food at any time.**

☒ **Individuals are able to have visitors of their choosing at any time.**

☒ **The setting is physically accessible to the individual.**

☒ **Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan*(see Appendix D-1-d-ii of this waiver application).***

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person-Centered Services Plan

a. Responsibility for Service Plan Development. Per 42 CFR § 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(Select each that applies):*

☒ **Registered nurse, licensed to practice in the state**

☒ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☒ **Social Worker**
Specify qualifications:

Ohio licensure as a state-tested and Board-certified social worker trainee, independent social worker, or social worker.

☒ **Other**
Specify the individuals and their qualifications:

Staff are required to receive training for PCSP development and 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.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct**

waiver services to the participant.

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.** ***Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☐ **Direct oversight of the process or periodic evaluation by a state agency;**

☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Individuals have choice and control over the provision of waiver services they need as determined during the person-centered service planning process. Individuals also have choice and control over who participates in the person-centered service planning process, as well as over the selection and direction of waiver service providers. Services and supports are planned and implemented in accordance with each individual's unique needs, expressed preferences and decisions concerning his/her life in the community. To that end,

* Individuals and/or their authorized representatives participate in, and wherever possible lead the person-centered planning process, participate in the development of plans of care and/or select and dismiss ODM-administered waiver service providers. The individual's authorized representative may have a participatory role, as needed and as defined by the individual, unless Ohio law confers decision-making authority to a legal representative (e.g., a legal guardian). The person-centered planning process:

- Includes a team of people chosen by the individual.
- Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions.
- Is timely and occurs at times and locations of convenience to the individual.
- Reflects the cultural considerations of the individual. The process is conducted by providing information in plain language and in a manner that is accessible to persons with disabilities and persons who are LEP.
- Includes strategies for solving conflict or disagreement within the process.
- Ensures that providers of Ohio Home Care Waiver services for the individual, or those who have an interest in or are employed by an Ohio Home Care Waiver service provider, shall not provide case management, provider oversight or develop the person-centered service plan.
- Offers informed choices to the individual regarding the services and supports the individual receives and from whom.
- Includes a method for the individual to request updates to the plan as needed. The individual may request a person-centered plan review at any time.
- Records the alternative HCBS settings that were considered by the individual.

Providers include traditional agency providers such as Medicare-certified HHAs, Joint Commission-, ACHC- and CHAP-accredited agencies, and otherwise approved ODM-administered waiver service providers. They also include non-traditional, non-agency providers such as RNs, LPNs at the direction of an RN, non-legally responsible family members, and other non-agency providers approved by ODM.

*If an individual and/or authorized representative elects to receive all or a portion of their waiver services from non-agency providers, the CMA must assure that the individual/representative trains the providers to meet the individual's health care needs and/or specifies additional training the provider must successfully complete prior to furnishing waiver services; establishes a CMA-approved back-up plan to be followed when the provider is unable to furnish services at the scheduled time and location; and approve timesheets after waiver services have been furnished, and prior to the provider's submission of a claim to ODM.

*The CMA must assure the health and welfare of the individual, and the competency of the individual/representative if an individual elects to receive all or a portion of waiver services from non-agency providers. The CMA must verify that the individual/representative can successfully demonstrate the ability to communicate an understanding of their health care needs, advocate on their own behalf, report provider performance issues, complaints and/or problems to the CMA and/or ODM, and understand and implement problem-solving techniques to resolve conflicts with non-agency providers.

*If an individual elects to receive services from a non-agency provider, but the CMA determines the individual/representative cannot successfully demonstrate the skills identified in the preceding paragraph, and the CMA still cannot assure the individual's health and welfare or the individual and/or representative's competency to direct waiver services provided by a non-agency provider, then the CMA may require that the individual only receive services from agency providers.

*Individuals have the right to request a state hearing anytime they disagree with an action that has been taken by a county department of job and family services, a state agency or the CMA.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. i. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Person-Centered Service Planning Process Overview--Person-centered service planning under the Ohio Home Care Waiver is a multi-dimensional, participant-centered function that involves the ongoing coordination of Medicaid and other formal and informal supports and services an individual receives. It includes authorizing and arranging for waiver services that support and enhance, but do not replace what is already furnished by the family and/or informal caregivers. Person-centered service planning addresses the changing circumstances and medical and physical conditions of an individual over time. Inherent in the process is the desired outcome that services and supports are planned and effectively implemented in accordance with each individual's unique needs, expressed preferences and decisions concerning his or her life in the community. The CMAs are designated by ODM as the entity responsible for person-centered service planning and ongoing case management. ODM monitors and oversees the CMA's activities.

The person-centered service plan describes the person-centered goals, objectives and interventions selected by the individual and the team to support him or her in his or her community of choice. The plan addresses the assessed needs of the individual by identifying medically necessary services and supports provided by natural supports, medical and professional staff and community resources. The plan documents all of the services necessary to prevent the individual's institutionalization, regardless of funding source, as well providers, and the frequency and timeframes for service delivery. It also serves as payment authorization for Ohio Home Care Waiver services. It is intended to prevent the provision of unnecessary or inappropriate services and supports to the individual.

The person-centered service plan must:
- Identify the setting in which the individual resides is chosen by the individual.
- Reflect the individual’s strengths and preferences.
- Reflect clinical and support needs as identified through the assessment process.
- Includes the individual’s identified goals and desired outcomes.
- Identify the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports and those services the individual elects to self-direct.
- Address any risk factors and measures in place to minimize them, when needed.
- Include back-up plans that meet the needs of the individual.
- Be distributed to the individual and other people involved in the plan.

The CMAs must also ensure that the person-centered service plan is understandable to the individual, and the people important in supporting him or her. At a minimum, it must be written in a manner that is accessible to persons with disabilities and persons who are limited English proficient. It must identify the person and/or entity responsible for monitoring the plan. It must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all people and providers responsible for its implementation. This serves as acknowledgement of receipt and agreement to furnish the authorized service as documented on the individual’s person-centered services plan. Acceptable signatures include, but are not limited to a handwritten signature, initials, a stamp or mark, or an electronic signature.
Any accommodations to the individual’s or authorized representative’s signature must be documented on the plan. Providers responsible for the plan’s implementation must be given a written copy of the plan when it is developed and updated.

The person-centered service plan is updated at the time of reassessment, or when events dictate the necessity to reassess individual needs and reevaluate the appropriateness of the person-centered service plan, along with the goals and outcomes of the individual. ODM's quality management strategy establishes monitoring measures to track the timeliness of the person-centered service planning process and the thoroughness of the person-centered service plan.

Individuals are informed whenever there is a proposed change in the person-centered service plan. They are given notice using ODM forms and are informed of their right to request a state hearing regarding the changes. Similarly, the CMAs are required to notify providers of changes in the individual's person-centered services plan.

Individuals work with their case manager to make changes to the person-centered service plan. Changes to the plan that result in a decrease in services, or changes that result in an increase in the cost of services within the individual's funding limit are approved by the CMAs. Changes to the plan that result in an increase in the cost of individual's services in excess of their funding limit are approved by ODM. This process of approval of service plans is referred to as the prior authorization process. In addition to monitoring person-centered service plans via the prior authorization

process, ODM monitors person-centered service planning activity through the ongoing review process.

At a minimum, the person-centered service plan must include goals, objectives and outcomes; the name, phone number,

service responsibilities and funding sources of all paid/unpaid providers and caregivers; the scope, frequency and duration of services (including start/stop dates); the total number of approved units of each service and the total projected monthly cost for Ohio Home Care Waiver services and other Medicaid-covered services for a 12-month period; individual-specific emergency back-up plan; medical patient liability; and the signature of the individual or the individual's authorized representative.

Home and Community-Based Setting Requirements --The CMAs must ensure that person-centered service plan documents that any modification of the additional conditions required for provider-owned or controlled home and community-based settings are supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

- Identification of a specific and individualized assessed need.
- Documentation of the positive interventions and supports used prior to any modifications to the plan.
- Documentation of less intrusive methods of meeting the need that have been tried, but did not work.
- A clear description of the condition that is directly proportionate to the specific assessed need.
- A regular collection and review of data to measure the ongoing effectiveness of the modification.
- Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- Informed consent of the individual.
- An assurance that interventions and supports will cause no harm to the individual.

The CMAs must ensure that the setting chosen by the individual is integrated in, and supports the full access of individuals receiving Ohio Home Care Waiver services to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community to the same degree of access as people not receiving Ohio Home Care Waiver services.

Person-Centered Service Planning Process Under the Ohio Home Care Waiver

1) Assessment Process--Assessments are conducted initially as part of the Ohio Home Care Waiver eligibility determination process, annually thereafter, and at any other time if there is a significant change in the individual's life. A significant change is a variation in the health, care or needs of an individual that warrants further evaluation to determine if changes to the type, amount or scope of services are needed. Significant changes include, but are not limited to, differences in health status, caregiver status, residence/location of service delivery, and service delivery that result in the individual not receiving waiver services for thirty days.

A CMA-employed staff person contacts the waiver applicant/individual to schedule an in-person interview. The applicant/individual can include other parties of their choosing in the meeting. Using the ODM-approved assessment and case management system, and the assessment tools described in Appendix B-6-e of this waiver application, an assessment is conducted to establish or maintain program eligibility. The assessment evaluates living arrangements/household composition, medical and acute/long term care history, medical interventions and treatment regimens, medication profile, functional ability, psycho-social status, safety and cognition, environmental situation, current usage of adaptive and assistive equipment, informal supports, caregiver involvement and formal supports, and results in a level of care recommendation. As needed, the assessor contacts health care providers (e.g., physicians, psychiatrist, etc.) for additional supporting information.

2) Informing the Individual about Available Services-- Once eligibility is established, the case manager arranges a visit with the individual and the individual's team of medical and social service professionals, formal/informal caregivers, family members and anyone else the individual identifies as contributing to their ability to remain safely in the home. Information is provided to the individual about the broad range of services available under the Ohio Home Care Waiver, and the service provider options available (i.e., they can receive services through traditional agency providers as well as other non-agency providers including RNs/LPNs, neighbors, friends, and non-legally

responsible family members).

3) Meeting Individual Goals/Needs/Preferences through the Person-Centered Service Plan Development Process--The individual can have as much or as little involvement in the development of his/her person-centered service plan as he/she prefers. The person-centered service plan takes into consideration the individual's strengths, health status and capacities, identified risk factors, needs, and expressed personal preferences, establishes specific goals, objectives and outcomes related to the individual's plan of care, and identifies the specific tasks and activities that are to be carried out by each Medicaid service provider. Person-centered goals, objectives and outcomes must be prepared for each need identified

during the assessment.

The person-centered service plan is also the tool for identifying and documenting the need for additional assessments that may be necessary.

4) Assignment of Responsibilities for Implementing the Person-Centered Service Plan--During the person-centered service planning process, the CMA reviews the individual's existing informal/formal supports and how they might meet the identified goals, objectives and outcomes. The CMA also explores additional informal/formal supports that can be added. Appropriate referrals and linkages will be established to initiate service. Thereafter, the CMA discusses the availability of waiver services to meet the individual's remaining unmet needs. It is the CMA's responsibility to monitor on an ongoing basis the individual's person-centered service plan to assure that all formal/informal, Medicaid and non- Medicaid services are being provided.

5) Identifying and Managing Risk and Back-up Planning--The CMAs are responsible for continually monitoring health and welfare and educating individuals, as appropriate. When significant risk of harm is identified, an assessment of the presenting information must be made to determine the most appropriate intervention. Aspects of that assessment include the individual's cognitive abilities, vulnerability and extent of dependence on others, support system, health and psychological status, the presence of negative and/or positive outcomes, the involvement of other providers or professionals, the request and preferences of the individual, and the degree of risk to self and others. The CMA identifies strategies to reduce risk, including individual education and referral to community resources, and adjustments to the person-centered service plan. They also determine if there are interventions that could contribute to reducing the risk for reoccurrence and maximizing the individual's health, safety and quality of life.

Individual responsibility for back-up planning is explained in the waiver handbook and is supported in ODM's individual rights and responsibilities rule, OAC rule 5160-45-03. Back-up plans must be documented on the individual's person- centered service plan. Specifically, the CMAs work with individuals to assure the existence of back-up plans so as not to jeopardize individual health and welfare if providers do not arrive when expected. Individuals are instructed to immediately call the provider and/or go to their back-up plan. In accordance with the conditions of participation for ODM-administered waiver service providers set forth in OAC rule 5160-44-31, if the provider is employed by an agency, the agency must assure that a back-up plan is in place and staff are available to provide services when the provider's regularly scheduled staff cannot or do not meet their obligation to provide services to the individual. If the individual receives services from a non-agency provider, the individual must be willing to develop a back-up plan for individual provider absences and emergencies. OAC rule 5160-44-31 also requires that the non-agency provider assist the individual, upon initiation of services, in developing a back-up plan in the event the regularly scheduled non-agency provider cannot or does not meet their obligation to provide services.

6) Addressing Participant Health Care Needs--It is the CMA's responsibility to assure that the individual's health care needs are being addressed. Coordination and consultation with the treating physician and other medical providers (e.g., nurses, OTs, dieticians, respiratory therapists, etc.) on the individual's team is necessary to keep the case manager accurately apprised of the individual's health status.

7) Coordination of Waiver, Non-waiver, and Managed Care Services--On an ongoing basis, the CMA works with the individual, providers and team members to assure that the services identified on the person-centered service plan are coordinated and provided in a manner that matches individual need, meet age-appropriate health maintenance requirements and are provided at the lowest possible cost. Individuals are required to use services funded by non-Medicaid home care resources as much as feasible. Medicaid-covered services support, rather than supplant, the

caregiver's role in caring for the individual. Medicaid is the payor of last resort.

8) Monitoring and Oversight of Person-Centered Service Plan Implementation--ODM and the CMAs undertake several monitoring and oversight activities to ensure that the individuals' goals, needs and preferences are included in person- centered service planning/care coordination and are appropriate. The activities are performed in accordance with ODM/CMA quality management plans.

All new enrollees must be contacted at a Level 2 acuity for the first six months of enrollment. An in-person visit supersedes a telephonic contact.

After the first six months of enrollment, an individual's case management acuity level can be changed. The acuity level is determined by the CMA's assessment of the individual's needs, complexity of medical issues, and available informal supports. It is completed at least annually at the time of assessment/reassessment or if there is a significant change. Ongoing individual contact occurs in accordance with the individual's level of case management.

- Level 1 requires a maximum of 90 calendar days between contacts and a maximum of 180 calendar days between in-person visits; and
- Level 2 requires a maximum of 30 calendar days between contacts and a minimum of three in-person visits in six months, with a maximum of 60 calendar days between visits. Additional visits should be made per individual request or based on clinical necessity.

During the contact, an informal review of individual outcomes is conducted. The person-centered service plan is reviewed to determine if services are being rendered as intended, and individual satisfaction and changes in the individual's health, family and environmental situations are discussed.

Case management activities, including assessments, reassessments and person-centered service planning processes are monitored by ODM via the ongoing review process, the prior authorization process and through performance data that is reported by ODM to the CMAs as part of the quality management plan. In addition, ODM conducts retrospective reviews of clinical records to assure that assessments and person-centered service planning documents are complete, accurate and reflect the outcome of the assessment. The reviews also assure that the CMAs are compliant with all OAC relevant rules and policies.

CMA chart audits/clinical practice reviews are conducted to ensure quality case management practices. The program review also addresses the congruence of individual- assessed need, how those needs are being met, and case manager interventions, assurances of health and welfare and clinical documentation skills. Client satisfaction as it relates to the inclusion and decision-making/person-centered service planning processes, and satisfaction with the CMA and the individual case manager are measured as part of the ongoing review process.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

☒ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**

☒ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**

- ☒ **A specific and individualized assessed need for the modification.**
- ☒ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
- ☒ **Less intrusive methods of meeting the need that have been tried but did not work.**
- ☒ **A clear description of the condition that is directly proportionate to the specific assessed need.**
- ☒ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**
- ☒ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**
- ☒ **Informed consent of the individual.**

☒ **An assurance that interventions and supports will cause no harm to the individual.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Participant risk and safety considerations are identified and with the informed involvement of the individual, potential interventions that promote independence and safety are considered. During assessments, reassessments, and anytime thereafter, any known or perceived risk and/or safety considerations are identified and noted on the person-centered service plan and in clinical documentation. Where necessary, the CMAs may initiate risk and safety planning via the implementation of a Health and Safety Action Plan developed by the CMA that identifies situations, circumstances and/or behaviors that without intervention may jeopardize the individual's health and welfare and potentially risk his or her enrollment on the waiver, or explore development of a behavior support plan by appropriate personnel.

Regarding back-up planning, individuals are encouraged to be prepared with service alternatives so as not to jeopardize their health and welfare if providers do not arrive when expected. Individuals are instructed to immediately call the provider and/or go to their back-up plan. If the provider is employed by an agency, the agency must either have back-up available or assist the individual in making other arrangements. If the individual receives services from a non- agency provider, then the individual must be willing to develop a back-up plan for individual provider absences and emergencies and submit it to the case manager. Back-up plans are documented on the person-centered service plan.

Additionally, the CMAs are available to individuals 24 hours-a-day, 365 days-a-year.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The CMAs maintain an electronic listing of all available agency and non-agency Medicaid service providers, by county and by the service they are authorized to provide. That information is shared with individuals at the time of person-centered service planning, electronically and/or via hard copy, and the individual's choice of providers is respected and considered. The CMAs also maintain an active and private listing of individuals who are seeking particular types of providers. If the individual wants to hire a friend, neighbor, or non-legally responsible family member as a non-agency provider, they are encouraged to direct the potential service provider to ODM to help them enroll as a Medicaid provider.

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):

ODM staff approve services on the person-centered services plans through the prior authorization process when projected costs exceed authorized funding amounts, and on an as needed basis, provides instruction to the CMAs regarding service plan modifications.

ODM monitors person-centered planning through the ongoing review process. Ongoing, ODM conducts targeted reviews focusing on both performance measures and participation satisfaction. Reviews are completed with a sample size adequate to report results with 95% confidence of being within a +/- 5% margin of error. The sample size is representative of the demographic make-up of the OHCW population. Topics include service planning, care management satisfaction, free choice of provider, level of care, health and welfare, hearing rights, and validation of service delivery. For performance measures, ODM field reviewers compare assessments to person-centered service plans to determine if an individual's person-centered service plan includes services and supports consistent with the individual's assessed needs. ODM retains the right to review and modify person-centered services plans at any time.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR § 92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☒ **Other**

Specify:

Copies of the person-centered service plans are maintained within the ODM-approved assessment and case management system.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The CMAs are responsible for implementing the person-centered service plans. Among their primary responsibilities are the following:

*To monitor and assure that individuals can exercise free choice of provider;
*To monitor and assure the appropriateness of service delivery and the outcomes identified on the person-centered service plan using ODM' case management protocols and clinical standards that vary by individual need;
*To monitor and assure that services meet the needs of the individual;
*To monitor and assure that back-up plans are effective;
*To assure that methods are in place for prompt follow-up and remediation of identified problems. Case management and corresponding individual contact are divided into two levels.
*New Waiver Individuals
All new enrollees must be contacted at a Level 2 acuity for the first six months of enrollment. Individuals are seen or contacted more frequently as clinically indicated.

* Level 1 is provided to individuals who have been enrolled on the Ohio Home Care Waiver for more than six months and either can safely direct their own care or live with family or friends who are able to direct their care. Additional visits can be made per individual request or based on clinical necessity.

* Level 2 is provided to individuals whose needs are medically complex. The intent for this acuity level is to provide increased contacts and/or visits for individuals who would be isolated from outside resources and have increased risk for health and welfare issues that include, but are not be limited to: living alone; living with a paid provider; not participating in day programs, school or work, receiving services only from family members or non-agency providers; having a restraint, seclusion or restrictive intervention plan, or a Health and Safety Action Plan is in effect; and/or the having been without services for any reason, for more than 30 days. Additional visits can be made per individual request or based on clinical necessity.

Upon discovery of a potentially significant change event, telephone contact must occur by the end of the next full calendar day. If it is determined through this telephone contact that a significant change occurred, an in-person visit must take place by the end of the third full day following discovery. The case manager will complete a reassessment and update the person-centered service plan as needed.

At the state level, ODM monitors that services are furnished in accordance with the person-centered service plan, individuals have access to both waiver and non-waiver services identified on the person-centered service plan, needs identified during the assessment are addressed on the person-centered service plan, back-up plans are in place and effective, the individual is satisfied with service delivery, and there is prompt follow-up when problems are identified. ODM monitors and provides oversight through a variety of processes, including the ongoing review, review of quarterly data (e.g., information about the CMAs' quality management activities), the annual site review and the prior authorization process.

Remediation of problems identified through the State's monitoring of person-centered service planning occurs in a variety of ways, including but not limited to: one-on-one technical assistance provided by ODM clinical staff to CMAs' clinical staff, practice directives issued by ODM to the CMAs, and the complaints process. ODM provides detailed information to the CMAs through the chart audit/clinical review processes. This data is reported to CMAs and is semi-annually reviewed by ODM.

b. Monitoring Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

- ☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**
- ☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**
- ☐ **Direct oversight of the process or periodic evaluation by a state agency;**
- ☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**
- ☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participantsï?½ 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 waiver individuals whose person-centered service plans address their personal goals. N= Number of waiver individuals whose person-centered service plans address their personal goals. D= Total number of waiver individuals' person-centered service plans reviewed.

Data Source (Select one):
Other

If 'Other' is selected, specify:
ODM-approved assessment and case management system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence +/- 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
D-2: Number and percent of waiver individuals whose person-centered service plans reflect services and supports necessary to address their assessed risks. N= Number of waiver individuals whose person-centered service plans reflect services and supports necessary to address their assessed risks. D= Total number of waiver individuals' person-centered service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ODM-approved assessment and case management system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence within MOE +/- 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

Performance Measure:
D-3: Number and percent of waiver individuals whose person-centered service plans include services and supports consistent with their assessed needs. N= Number of waiver individuals whose person-centered service plans include services and supports consistent with their assessed needs. D= Total number of waiver individuals' person-centered service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ODM-approved assessment and case management sysetm

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence within MOE +/- 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.***

Performance Measures

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

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

Performance Measure:
D-4: Number and percent of person-centered service plans that were developed in accordance with the approved waiver and current case management contracts. N= Total number of person-centered service plans that were developed in accordance with the approved waiver and current case management contracts. D= Total number of person-centered service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ODM-approved assessment and case management system

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

		Sample Confidence Interval = 95% confidence within MOE of +/- 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

c. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
D-5: Number and percent of person-centered service plans that were reviewed and updated at least once in the last 12 months. N= Number of person-centered service plans that were reviewed and updated at least once in the last 12 months. D= Total number of individuals enrolled on the waiver with an annual person-centered service plan needed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ODM-approved assessment and case management system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence within MOE of +/- 5%
☐ **Other**	☒ **Annually**	☐ **Stratified**

Specify:		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:
D-6: Number and percent of person-centered service plans reviewed that were updated when the waiver individual's needs changed. N= Number of person-centered service plans reviewed that were updated when the waiver individual's needs changed. D= Total number of waiver individuals reviewed whose needs changed.

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

ODM-approved assessment and case management system

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

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: Participants are afforded choice between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
D-7: Number and percent of waiver individuals reviewed who received services in the type, scope, amount, duration & frequency specified in the person-centered svc plan. N= Number of waiver individuals reviewed who received services in the type, scope, amount, duration & frequency specified in the person-centered svc plan. D= Total number of waiver individuals' person-centered svc plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ODM-approved assessment and case management system

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

		Confidence Interval = 95% confidence within an MOE of +/-5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

e. ***Sub-assurance: The state monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

Performance Measure:
D-8: Number & percent of individuals enrolled on waiver notified at least annually of their right to choose waiver services & providers. N= Number of individuals reviewed who signed "Individual on Waiver - Agreement and Responsibilities" form w/in 12 months prior to review acknowledging they were notified of the right to choose waiver services & providers. D= total number of individuals reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
ODM-approved assessment and case management system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence within MOE of +/- 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

ODM relies on data gathered through Ongoing Review, monthly and quarterly reports of output and quality performance data by the CMAs to identify systems compliance and performance problems associated with care planning. Deficiencies are addressed as part of the remediation process following the Ongoing Review.

ODM's incident management process also includes a requirement to establish prevention plans for substantiated critical incidents. ODM monitors prevention plans to assure individuals' needs are addressed timely and risk factors are mitigated to reduce the risk of reoccurrence.

To address such systems problems: 1) ODM compiles the data showing evidence of the problem; 2) ODM presents the data to the CMAs in a Quality Briefing or monthly meeting; 3) ODM may conduct, or require the CMAs to conduct, further analysis to verify the finding and determine cause; 4) for verified findings, the CMA is required to develop a plan for improvement; 5) ODM approves the plan for improvement; and 6) the CMAs implement the plan for improvement; 7) in a subsequent monthly meeting or Quality Briefing, ODM follows up on implementation of the plan for improvement with the CMAs; 8) ODM monitors data from subsequent reviews to verify improvement; 9) if the compliance or performance issues remain, ODM works with the CMAs to identify other solutions; this may result in a new or altered plan for improvement; and 10) if the improvement plan requires a substantive change in operations, ODM may alter the Quality Management Improvement Plan in order to formalize or clarify ODM expectations for the CMAs.

Individual service planning-related issues that are discovered are directed by ODM to the case management agencies for follow up and remediation at the individual level.

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: Data will be compiled and reviewed at least twice per year

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

A. The nature of the opportunities afforded to participants:

The nature of the employment authority opportunities afforded to individuals enables them to act as the employers of record with the authority to hire, train, direct, and dismiss their self-directed caregivers. Self-directed caregivers may include friends, neighbors, and some relatives. Individuals exercising this authority may have multiple self-directed caregivers.

Individuals can also exercise budget authority when developing their person-centered services plans in conjunction with their case managers and determining the budget amount for self-directed services, including personal care aide, home care attendant, waiver nursing, home modification, and self-directed goods and services.

Individuals identify self-directed caregivers for program enrollment. Individuals evaluate their current person-centered services plans to determine what services they need to safely maintain themselves at home and share these determinations with their case managers.

In this waiver, for self-directed services paid through the FMS, the FMS is responsible for these activities. The FMS contractor tracks and reports self-directed funds, disbursements, and the balance of individual waiver funds.

In addition, the FMS will be responsible for verifying that a self-directed caregiver selected to furnish HCBS meet the necessary qualification established by the state and have the appropriate agreements in place to furnish Medicaid services.

The State will monitor FMS performance against the FMS entity’s contract with the State. The FMS Contractor will be the caregiver enrollment entity and will conduct all eligibility verifications, including criminal record and screening. The FMS contractor will maintain records of all individual employers and self-directed caregiver associations and will provide ODM access to all data necessary to conduct provider oversight and other administrative activities. The FMS Contractor will also collect, process, and verify timesheets of each self-directed caregiver for the authorized services as outlined in the individual’s service plan and individual budget. The FMS Contractor shall verify that the service billed and hours worked are in the approved service plan prior to making payment. The FMS Contractor shall produce twice monthly statements for each individual employer and provide a report accounting for all payments made to self-directed caregivers, as required in the FMS contract. The FMS Contractor shall include in these statements and the report the name and identification number of the employer, the employer’s caregivers’ name and identification number, wages, taxes, and insurances paid for the current period and year-to-date compared to the amount authorized for the current period and year-to-date.

B. How the individuals take advantage of these opportunities:

At each initial assessment and annual reassessment, case managers give individuals an overview of the waiver program that includes a description of the self-direction options available. This includes a discussion of the purpose of self-direction, the differences between provider-managed and self-directed services, and the additional responsibilities of individuals who choose this option. Individuals may choose a representative to support their use of self-direction, but some individuals may need a representative. Individuals and their representatives must be willing and able to direct the services to use the self-directed service delivery method.

Information about the self-directed service option will also be available on ODM's website and on request.

C. The entities that support individuals who direct their service and the supports that they provide:

Case managers provide information and assistance, help individuals gain knowledge of employer responsibilities, and assist with the development and management of their person-centered services plans. When individuals express an interest in using the self-directed option, Waiver case managers provide them with information and guidance on the qualifications of a self-directed caregiver, recruitment, hiring, and training of a qualified caregiver, and employer-related tasks, including working with the FMS. Case managers also work with individuals on budget authority for identified services. If individuals identify representatives to assist with directing their service, the representatives work with the individuals and the waiver case managers to understand the self-directed option. Case managers work with individuals

who need representatives, but have not identified any, to identify their representatives.

The FMS is a vendor that holds a contract with Ohio Department of Administrative Services to provide individuals with administrative functions.

The FMS assists with individual education on becoming an employer by providing individuals with an employer packet. On behalf of individuals, the FMS vendor furnishes self-directed caregivers enrollment packets that include an enrollment form, the individual employer/employee agreement, sample reports, and the necessary Federal and State employment and tax forms, including for the Ohio Bureau of Workers' Compensation.

The FMS assists individuals by reviewing timesheets and processing the self-directed caregiver's payroll. The FMS reports payroll processing issues to individuals, self-directed caregivers, and case managers (when appropriate), and works with them to resolve problems.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☒ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

  Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

When individuals express interest in becoming employers through self-direction, waiver case managers work with them to develop person-centered services plans that include any support needed to assist individuals with the responsibilities of an employer. Waiver case managers provide these individuals with information that explains all of the following employer expectations:

1. Understanding methods for selecting, managing, and dismissing employees.
2. Understanding what services activities are covered.
3. Participating in the development, monitoring, and revision of the person-centered services plan and reliable back-up plans.
4. Understanding corresponding provider requirements, including criminal record checks.
5. Working with the FMS for timely payroll processing, including written approval of provider timesheets.

Waiver case managers also provide individuals who express interest in budget authority through self-direction the following information:

1. Determining wages and establishing billable rates for self-directed caregivers; and
2. Deciding spending for eligible self-directed services.

The case manager will arrange for additional skills development in specific areas as requested by the individual or as deemed necessary by the case manager to assist the individual in the role of the employer. Individuals who cannot meet any of the expectations as employers may elect to use self-direction if case managers determine that their representatives are able to meet those expectations. Individuals who elect to exercise budget authority, they will receive training from their case manager on selecting caregivers and budgeting to ensure their assessed needs are met.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

At each initial assessment and annual reassessments, case managers give individuals an overview of the waiver program that includes the role of the case manager, the person- centered planning process, available services, and a description of the self-direction option. This description includes a discussion of the purpose of self-direction, the differences between the provided-managed and self-directed services, and the additional responsibilities of individuals who choose the self-directed option.

Information about self-directed option will also be available on ODM's website and on request. Waiver case managers will assist individuals with accessing this additional information.

When individuals express interest in self-directed services, waiver case managers provide detailed information about self-direction, including the requirements for hiring, taxes, insurance, and working with the FMS. They will also supply information on the budgeting process.

When individuals elect to proceed with self-direction, waiver case managers provide more information on several components of self-direction, including:

*Identification of the elements of the service to be provided by the self-directed caregiver.
*Qualifications of self-directed caregiver.
*Recruitment, hiring, and training of a qualified self-directed caregiver.
*Employer-related tasks, including working with the FMS.
*Service planning, including development of a back-up plan.
*Budget development, including wage setting and determining billable rates.

The FMS also assists individuals with onboarding their self-directed caregivers. The FMS provides support from the time individuals identify their self-directed caregivers and ongoing as individuals change or add providers. The FMS assigns enrollment specialists to work with individuals, self-directed caregivers, and case managers. The enrollment specialists conduct orientation and assist with onboarding and paperwork through the self-directed caregivers' first paychecks.

Any materials issued by the case management agencies and FMS will be subject to ODM approval or utilize an ODM-supplied template. ODM will provide guidance to the case management agencies and FMS on the requirements for these materials to ensure individuals receive the same information on self-direction regardless of which case management agency the individual selects to manage their services and supports.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**
Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A representative identified to assist an individual with employer or budget authority can be a legally responsible person such as an individual's legal guardian or any other person identified by the individual. If the case manager or individual identifies that the individual would benefit from a representative, the case manager will identify options including other family members, neighbors, community members, etc. This information must be documented within the individual's record and communicated to the FMS.

A representative that is not the individual's legal representative carries out decisions made by the individual but cannot make decisions without the individual's consent.

A representative must:

1. Demonstrate a strong personal commitment to the individual and show knowledge about the individual's references.

2. Be willing and able to fulfill all the employer responsibilities on behalf of the waiver individual when they are using employer authority.

3. Agree to meet with the individual, case manager, and FMS as identified on the person-centered service plan.

A representative may not be paid for this function or be hired by the individual as a self-directed caregiver. As reflected in the care plan, the case manager must assess the individual's satisfaction with the representative's actions. Additional actions taken by the case manager to ensure health and safety include a review of claims, submitted incidents, FMS communications and any other participant concerns during the regularly scheduled contacts. If concerns arise, the case manager must increase the frequency face to face visits and other contacts.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Home Care Attendant Services	☒	☒
Waiver Nursing Services	☒	☒
Home Modification Services	☐	☒
Personal Care Aide Services	☒	☒
Self-directed goods and services	☐	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Entities specializing in FMS for participant-directed programs and payroll services who are approved by the IRS as a Fiscal/Employer Agent (F/EA) may provide this function. The FMS is procured through a Request for Proposal competitively bid contract through Ohio's Department of Administrative Services (DAS). It is a four-way contract with the vendor, DAS, ODM, and the Ohio Department of Aging. Waiver service dollars and the FMS contractual amount will flow through ODM.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The amount of the fee is set by the administrative contract with ODM. The FMS is compensated a per-member per-month (PMPM) rate for each individual enrolled in self-direction.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☒ **Other**

Specify:

The FMS enrolls and maintains timekeeping records for the self-directed caregivers. They will also serve as the enrollment broker for all self-directed caregivers. They will complete the criminal records and other validations to ensure self-directed caregivers who are not also enrolled with ODM as Medicaid providers are eligible to render Medicaid services.

Provides self-directed caregivers information and/or training in the following areas:

Applicable Ohio Administrative Code requirements.
Accurate time reporting;
Correct completion of timesheets;
Incident reporting; and
Medicaid fraud detection and reporting.

The FMS is responsible for payment for goods and services. Payment will be made, based on authorization from the case manager to a pay card issued to the individual. The individual can use the pay card to purchase items in accordance with the authorization. The case manager will obtain receipts or other documentation of purchases to verify that goods and services were delivered in accordance with the standards specified in the waiver. The individual, representative, or caregiver may not be the vendor for any goods and service purchase.

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [x] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [ ] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [ ] **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

ODM oversees of interactions of the FMS with individuals and case management agencies through regularly occurring meetings with the vendor. ODM monitors the effectiveness of the FMS's established protocols for customer service, reporting, self-directed caregiver enrollment, payroll processing, and employer related activities as defined in the FMS contract and operational protocols. The FMS vendor provides monthly and quarterly program reports to the State that are used to assess FMS vendor performance.

The State oversees the employee payroll process of the FMS. The State reviews the FMS invoice prior to payment to ensure the invoice remittance. The State monitors the timeliness and fluidity of FMS process to ensure the best service for individuals and their employees. As described in performance measures Appendix I, ODM receives reports from FMS to verify the integrity of financial transactions through a quarterly review of provider documentation. The FMS will produce routine performance reports, supplies real-time access to their database, and provides weekly data sets of all data maintained to support authorizations, caregiver enrollments, and service claims for ODM data monitoring.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

☐ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Vehicle Modification	☐
Supplemental Adaptive and Assistive Device Services	☐
Home Delivered Meal Services	☐
Home Care Attendant Services	☐
Waiver Nursing Services	☐
Personal Emergency Response Systems	☐
Community Transition Services	☐
Home Modification Services	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Personal Care Aide Services	☐
Adult Day Health Center Services	☐
Self-directed goods and services	☐
Structured Family Caregiving Services	☐
Out-of-Home Respite Services	☐
Home Maintenance and Chore Services	☐
Community Integration Services	☐
Supplemental Transportation Services	☐

☒ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

A. Case managers and the FMS support individuals in exercising their employer and/or budget authority.

B. The information and assistance support are an administrative function of the waiver case manager and the State contracted FMS vendor. The FMS contractor is established through a competitive bidding process that meets the requirements of 45 CFR §74.

C. Before and throughout enrollment, waiver case managers inform individuals of their employer responsibilities including hiring, training, dismissing, and tracking the time sheets of their self-directed caregivers and developing person-centered services plans and associated budgets. Regular in-person home visits are conducted by the waiver case manager with the individual and any others of their choice to review responsibilities and mitigate risk on-going.

The FMS provides payroll functions for individuals including completing federal and state employment and tax forms and tracking time sheets. They also complete self-directed caregiver enrollment and assist the individual and caregiver with onboarding tasks. The FMS supplies individuals exercising budget authority with bi-monthly reports of all payments made for self-directed services.

D. Any issues are reported to the individual, FMS, and ODM. ODM reviews the findings, and directs the remediation, when indicated. ODM has administrative access to the FMS system to view live data at any time. Additionally, ODM receives and reviews monthly performance reports from the FMS, including customer service dashboard and statistics indicating all contacts, top 15 reasons and summary of all call reasons; employer reports including a roster and detailed data with timelines for enrollment; employee reports including a roster and detailed data with dates and timelines for completing enrollment, screening and criminal record checks and the ODM provider agreement. These reports will be compared to invoices to ensure accuracy. The FMS is also required to provide a weekly report of all data gathered for OHCW that ODM will use for ongoing evaluation and research, as well as developing performance measure reports.

E. The oversight of the self-directed service delivery method is the responsibility of ODM.

The individual may designate a representative of their choice to assist with some, or all, their employer and/or budget authority responsibilities. This representative cannot be the self-directed caregiver.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

- ○ **No. Arrangements have not been made for independent advocacy.**
- ◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

The Office of the State Long-Term Care Ombudsman program (ombudsman) is responsible for addressing complaints regarding the health, safety, welfare, and civil rights of long-term care individuals enrolled in the Ohio Home Care Waiver, as well as the rights of nursing homes and residential care facility residents found in Chapter 3721.10 - 3721.17 of the Ohio Revised Code. Further, the ombudsman investigates allegations of the action or inaction of providers of long-term care or representatives of providers of long-term care, government entities, or private social service agencies whose actions may adversely affect the health, safety, welfare, or rights of participants.

Individuals receive ombudsman information from the case manager, including contact information for the state and local programs at enrollment, annually, at reassessment, and as needed. Ohio Administrative Code rule 173-14-16 addresses timeframes for ombudsman responding to inquiries and resolution. Contact with the ombudsman does not influence appeal rights timeframes.

The Department of Job and Family Services Adult Protective Services (APS) is responsible for investigating and evaluating all reports of suspected abuse, neglect, and exploitation of adults aged 60 and over. Case managers, waiver service providers, and all service providers are mandated reporters and mandated to report suspicion of abuse, neglect, and exploitation of an individual to APS. Individuals and their caregivers (if appropriate) receive APS information from the case manager/assessor, including contact information for the state and local programs, at enrollment, annually at reassessment, and as needed.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

When individuals voluntarily terminate self-direction, the waiver case manager must:

1. Identify the contributing factors which led to the voluntary termination.

2. Reassess the individual's current needs to identify alternative services.

3. Authorize provider-managed services.

4. Assist the individual with the provider selection.

5. Coordinate the last day of self-directed service with the first day of provider-managed service or the backup plan if there is a gap between the last day of self-directed service and the first day of provider-managed service.

6. Ensure that the individual, self-directed provider, and the FMS take all necessary actions to terminate the employer-employee relationship.

As with all individual care transitions, case managers are responsible to ensure individual's care needs are met during the transition period. This includes developing a transition of care plan with the individual and onboarding providers as needed. Additionally, back-up plans may be used during any periods of time not covered by the self-directed caregiver or other provider types.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Involuntary termination of self-direction may be necessary under any of the following situations:

1. The individual no longer has an assessed need for the self-directed service(s).

2. The individual or their representative are unable to perform their responsibilities as employers.

3. Self-direction cannot assure the individual's health and welfare.

Case managers will develop plans with individuals to ensure that they receive appropriate services and supports to transition safely to provider-managed services that meet their assessed needs. As with all individual care transitions, case managers are responsible to ensure individual's care needs are met during the transition period. This includes developing a transition of care plan with the individual and onboarding providers as needed. Additionally, back-up plans may be used during any periods of time not covered by the self-directed caregiver or other provider types.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		0
Year 2		0
Year 3		0
Year 4		185
Year 5		197

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law

employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

- ☒ **Recruit staff**
- ☐ **Refer staff to agency for hiring (co-employer)**
- ☒ **Select staff from worker registry**
- ☒ **Hire staff common law employer**
- ☒ **Verify staff qualifications**
- ☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The FMS is responsible for the cost of obtaining a criminal records check. Individuals can request the FMS supply results of any criminal history investigation.

- ☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Individuals may require specific skill training to ensure tasks will be performed in a manner that is responsive to their individual preferences. The individual specific required skill training doesn't change the State's method for conducting criminal record checks. The FMS will conduct screening and criminal record checks for all self-directed caregivers for whom they conduct enrollment activities. This includes criminal record and registry verifications using their contracted background check vendor. ODM will also allow conditional employment for self-directed caregivers to begin employment while the criminal record check is conducted. The conditional employment will be valid for up to 60 calendar days. Self-directed caregivers are also required to disclose any convictions on the consent for criminal record checks. The prohibited offenses outlined in OAC 5160-1-17.8 will be verified and, if identified during the criminal record check, the self-directed caregiver will be terminated. ODM will review all pre-adverse determinations and criminal record checks supplied to determine if the caregiver will receive reconsideration or appeal rights.

- ☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- ☒ **Determine staff wages and benefits subject to state limits**
- ☒ **Schedule staff**
- ☒ **Orient and instruct staff in duties**
- ☒ **Supervise staff**
- ☒ **Evaluate staff performance**
- ☒ **Verify time worked by staff and approve time sheets**
- ☒ **Discharge staff (common law employer)**
- ☐ **Discharge staff from providing services (co-employer)**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☒ **Reallocate funds among services included in the budget**
- ☒ **Determine the amount paid for services within the state's established limits**
- ☒ **Substitute service providers**
- ☒ **Schedule the provision of services**
- ☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☒ **Identify service providers and refer for provider enrollment**
- ☐ **Authorize payment for waiver goods and services**
- ☒ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

At the time of enrollment in the Ohio Home Care waiver, the individual's case manager will review the individual's assessed needs and work with the individual to develop a self-directed service package that will safely maintain the individual at home. The individual and their waiver case manager will set their initial budget for services as if all services will be provider managed. The amount of money that is allocated for the individual to direct the delivery of his or her services is based on the estimated cost of comparable provider managed services. Based on that budgeted amount, the individual, in consultation with the case manager will determine how much of the budget will be used to purchase self-directed services, the number of hours that will be purchased and the number of self-directed caregivers that will be hired to provide the service.

The case manager must adhere to the service planning requirements set forth in Appendix D-1-a of the waiver application when developing the self-directed service package. Individuals may also exercise budget authority over home modification and self-directed goods and services by designing their service plan and prioritizing services according to their preferences. The amount spent may vary by individual, however, the case manager will be responsible for monitoring the implementation of the person-centered service plan to ensure the needs of the individual enrolled on the waiver are consistently being met. Individuals may use any self-directed waiver service funds remaining in the annual budget to cover home modifications above the current service limit described in C-4.

The individual, as the employer, will also establish the pay wage for each self-directed caregiver and any pay differentials (early morning/late night) that will be offered. The individual must pay each caregiver self-directed caregiver no less than the current state minimum wage. The average pay for direct care agency and non-agency staff are shared with the individual to assist them with determining self-directed caregiver wages. The individual is educated about the correlation between wages and the amount of service hours available for purchase based on those wages, including employer related expenses and billable rates.

The content of the individual self-directed budget is supplied in a format prescribed by ODM. The format, along with methodology, will be available through the ODM website. The budget amount available for self-directed goods and services are established in appendix C of this waiver and rule 5160-45-03.5 of the Ohio Administrative Code. The budget amount available for home modifications is as established in appendix C of this waiver and rule 5160-44-13 of the Ohio Administrative Code, except that excess funds in an individual's self-directed budget may be used in addition to the established service limit.

During the orientation process, individuals who elect to direct their services are given wage information to assist them with negotiating a payment rate with their employee. They are also informed of the differences between wages and billable rates to assist them with establishing their budget.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The case manager works with individuals, informing them of the available budget for services, then working with them to develop the self-directed services budget. Budgets are communicated using an ODM-approved budget worksheet that the individual can use to determine wages and amounts available for services.

Individuals may request a reassessment if their current person-centered services plan needs change. A reassessment of need will be conducted and, if appropriate, individuals' person-centered services plans and budgets will be revised. Available budgets are to be updated and made available as the individual's needs change and/or caregiver wages or billable rates, costs of comparable provider managed services, and service authorizations are updated. Individual budgets will be shared at least annually or as updated.

The case manager will inform individuals of their rights to a state hearing and the method of obtaining a state hearing when a change to the person-centered services plan results in a denial, reduction, or termination of services, including available self-directed budget amounts. The case manager informs individuals of the circumstances under which a timely hearing request will result in continued benefits up to the time a decision is rendered on the administrative appeal.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Individuals who self-direct may adjust the provider type and make caregiver schedule changes to meet their individual needs without updates to the person-centered services plan. Adjustments must be within the allotted monthly budget amount and caregivers identified within the person-centered services plan and enrolled with the FMS.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The case manager will, in conjunction with the FMS, monitor the individual's monthly use of personal care aide, home care attendant, waiver nursing, self-directed goods and services, and home modification.

The individual will submit timesheets for self-directed caregivers per pay period. If the individual is in a position to overspend the service budget, the case manager will contact the individual to discuss the service use and, if necessary, reassess the individual's service needs and the person-centered service plan.

If the individual is under utilizing the budget, the case manager will ensure that the individual has adequate access to all services stated in the person-centered service plan. If under utilization continues for a quarter, reassessment of the individual's service needs will be conducted, and the person-centered service plan and individual budget may be revised. The individual will be given fair hearing rights.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR ?431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Individuals receive support and guidance from ODM and the CMAs regarding how to exercise their rights and accept personal responsibility. For example, at the time of their enrollment on the Ohio Home Care Waiver, and annually, thereafter, individuals receive relevant ODM publications and a waiver handbook informing them of their right to freely exercise their constitutional and federal/state statutory rights, including their right to choose HCBS as an alternative to institutional care, and their right to appeal any decision regarding their benefits (e.g., failure to be given a choice of HCBS as an alternative to institutional care, denial of choice of services and/or providers, and/or denial, suspension, reduction of benefits, etc.). Individuals are also informed that if they file appeals in a timely manner (i.e., 15 days after the issuance of the notice) then services will continue during the period of time during which their appeals are under consideration.

Additionally, individuals receive notice regarding proposed adverse benefit determination on the ODJFS 04065 "Prior Notice of Right to a State Hearing," and an explanation of state hearing procedures on the ODJFS 04059 "Explanation of State Hearing Procedures." If they do not agree with the proposed benefit determination outlined in the notice, they have a right to a state hearing within 90 days of the mailing date of the prior notice. If someone other than an individual submits a written hearing request, it must include a written statement signed by the individual authorizing the person to act on the individual's behalf. While the individual has 90 days from the date the notice was mailed to request a hearing, in accordance with OAC Chapter 5101:6, the individual must request a hearing within 15 days of the date the notice was mailed in order to continue benefits during the appeal process.

The Ohio Department of Job and Family Services (ODJFS) Bureau of State Hearings handles state hearings for ODM. It notifies the individual of the date, time and location of their hearing at least ten days in advance. Individuals are entitled to have representation during their hearing as well as access to their case file and any rules being applied to their case. Essential documentation can be subpoenaed, if necessary. Hearing decisions are rendered no later than 30 days after a hearing is held and within 90 days of the hearing request. Individuals whose appeal is overruled are informed about how to ask for an administrative appeal. In all circumstances where the hearing is sustained, ODM must take the action ordered by the decision within 15 days of the date the decision is issued.

ODM or its designee leads all hearings related to disenrollment from the Ohio Home Care Waiver. This includes hearings related to waiver disenrollment due to a change in eligibility criteria including level of care. In addition, ODM or its designee leads hearings related to service denials that are a result of decisions made by ODM as a result of the prior authorization process. The CMAs lead hearings related to eligibility denials and service-level denials, including home modifications and supplemental adaptive and assistive device service requests, proposed decreases in or discontinuation of services, increases in services, or changes in service type, when an individual disagrees, and proposed termination of an individual's option to use non-agency providers. Case management agencies represent ODM in assigned hearings.

All case managers receive training regarding issuing hearing rights and due process procedures during their case management orientation. Case managers' direct role in state hearings is limited, thus preserving their advocacy role with individuals. The CMAs create and maintain a hearing manual that is available to assist case managers and supervisors. In addition, the CMAs have a hearing manager who provides ongoing technical assistance to case management staff as needed.

Hearing rights are specified in OAC division 5101:6. The Ohio Home Care waiver handbook is available upon request.

Notices of adverse benefit determinations and the opportunity to request a fair hearing are maintained in the ODM-approved assessment and case management system.

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:

ODM is responsible for the operation of the Ohio Home Care Waiver grievance/complaint system.

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).

Types of Complaints that Individuals May Register: Individuals are informed by the CMAs of their right to voice dissatisfaction and/or register a complaint any time they feel a Medicaid service provider or the CMA or any of its employees have been unresponsive to their requests, or have been inconsistent in efforts to help the individual reach their home care goals, objectives or desired outcomes. They are also informed that a complaint is not a prerequisite to a fair hearing. This information, including individuals' rights and the process for addressing complaints, is found in the waiver handbook and on the CMAs' websites.

Process and Timelines for Addressing Complaints: Complaints can be made to the Case Management Contractor, Provider Oversight Contractor, or to ODM, and they can originate from a face-to-face conversation, phone call, email, ODM inquiry, or regular mail. If the Case Management Contractor receives a complaint about a provider, the complaint must be forwarded to the provider oversight contractor.

The CMAs must use the following protocol for complaints:

1. Categorize complaints, reference a department, and determine a resolution type.
2. Send a complaint acknowledgment letter to the complainant within one business day of the complaint. A copy of this letter is maintained within the ODM-approved assessment and case management system.
3. Investigate all complaints within three business days of the date of receiving the complaint and maintain a record of all investigatory notes.
4. Submit an action plan to ODM via email within seven days of receiving the complaint
5. Address and attempt to resolve all complaints within 15 calendar days and record the resolution
6. The CMA must send a follow-up letter to each complainant to confirm that resolution has taken place. A copy of this letter is maintained within the ODM-approved assessment and case management system.
7. If a complainant indicates to ODM that a satisfactory resolution was not obtained, and ODM agrees, the complaint will be re-opened and returned to the CMA for further investigation.

In addition, an individual may contact ODM at any time to register a complaint. Individuals also have the ability to contact the ODM Ohio Medicaid Hotline. These calls are referred to the ODM contract managers.

Mechanisms Used to Resolve Complaints: The CMAs have policies, procedures and reporting and tracking mechanisms in place that encourage individuals to express complaints. Data is collected by the CMAs to permit the analysis of patterns by case manager, type of complaint, time taken to resolve the complaint, implementation of corrective action, and region. The CMA Quality Management Team reviews all complaints at monthly meetings. The CMAs also provide ODM with their analysis as part of its monthly performance report.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the

Medicaid agency or the operating agency (if applicable).

The State has an established system for reporting, responding to, investigation and remediation of incidents through Ohio Administrative Code (OAC) 5160-44-05.
Ohio's aligned Nursing Facility Based waiver programs incident management requirements are contained in OAC 5160-44-05.

Incidents that are required to be reported by Ohio's aligned Nursing Facility Based waiver programs are classified into two categories: critical and reportable. The full list and definitions of these incident categories can be found in OAC 5160-44-05, including but not limited to:

Critical Incidents
1) Abuse
2) Neglect
3) Exploitation
4) Misappropriation
5) Unnatural or accidental death
6) Self-harm or suicide attempt resulting in emergency room treatment, in-patient observation, or hospital admission
7) The health and welfare of the individual is at risk due to the individual being lost or missing
8) Any of the following prescribed medication issues:
a. Provider error
b. Prescribed medication issue resulting in emergency medical services (EMS) response, emergency room visit, or hospitalization

Reportable Incidents
1) Natural deaths that are not due to events such as accidents, injuries, homicide, suicide, and overdoses
2) Individual or family member behavior, action, or inaction resulting in the creation of or adjustment to a health and safety action plan
3) The health and welfare of the individual is at risk due to any of the following:
a. Loss of the individual's paid or unpaid caregiver
b. Prescribed medication issue not resulting in EMS response, emergency room visit, or hospitalization
c. Eviction or housing crisis
4) Suicide attempt that does not result in emergency room treatment, in-patient observation, or hospital admission

OAC 5160-44-05 outlines the entities required to report incidents that impact individuals enrolled in Ohio's Nursing Facility Based waiver programs. These parties include:
1) ODM and its designees
2) ODA and its designees
3) Managed care organizations (MCOs)
4) Providers of waiver services
5) Providers of services under the specialized recovery services (SRS) program
6) OhioRISE care management entities
7) Providers serving individuals in the OhioRISE program
8) Providers that furnish services under contract with an MCO

Upon discovering an incident, the reporting entities must do the following, as outlined in OAC 5160-44-05:
1) Take immediate action to ensure the health and welfare of the individual.
2) Report the incident to the waiver case management agency immediately upon discovery but no later than twenty-four hours after discovering the incident. Reports may be made via phone, in-person, or in written form.

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.

Individuals participating in the Ohio Home Care Waiver receive a waiver handbook from their Case Management Agency (CMA) at the time of enrollment and at the time of reassessment. The handbook includes information about individuals' rights, protections against, and how to report alleged incidents. It also contains information about the advocacy agencies that can educate and assist individuals. The CMAs, through the case manager, verbally review the content of the handbook with individuals/family members/caregivers. They sign a form that documents receipt of this information at least annually. The signed form is maintained in the ODM-approved assessment and case management system.

The CMAs provide individual instruction to individuals, caregivers, and authorized representatives about how to notify the authorities in the event health and welfare may be in jeopardy. The CMAs reinforce the training on incidents during each contact and/or in-person visits. The CMAs also assist individuals and/or their informal caregivers with any formal notification necessary. ODM monitors these activities through the course of the ongoing reviews.

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.

All incidents impacting individuals enrolled in Nursing Facility Based waiver programs are reported to the waiver case management agency. The waiver case management agency completes the initial evaluation of a critical incident report. The evaluation includes: ensuring immediate action is taken, as applicable to the nature of the incident, to protect the health and welfare of the individual and any other individuals who may be at risk; issuing notification to any appropriate investigative, protective authority or regulatory, oversight or advocacy entities; and submitting the required reports to ODM.

The waiver case management agency must follow the documentation process described in OAC 5160-44-05. This includes entering incidents into the incident management system as follows:
1) Critical incidents must be entered within one business day of receiving the incident report.
2) Reportable incidents must be entered within three business days of receiving the incident report.

Once an incident has been documented in the incident management system, the investigation may be carried out by either the waiver case management agency or a designated third-party, as described in OAC 5160-44-05. The investigation process includes conducting a review of relevant documents, conducting and documenting interviews, identifying causes and contributing factors, determining whether the incident is substantiated, and documenting all investigative activities in the incident management system.

The steps of the investigation include:
1) The investigation must be initiated within two business days of receiving the incident report.
2) Unless a longer timeframe has been prior approved, the investigation must be concluded no later than forty-five days after receipt of the incident report.

Once the investigation is complete, the waiver case management agency must carry out the closure process described in 5160-44-05. The steps of the closure process include:
1) A summary of the investigative findings and whether the incident was substantiated must be communicated with the individual and their authorized representative or legal guardian unless such action could jeopardize the health and welfare of the individual.
2) For a substantiated critical incident, a prevention plan must be entered into the incident management system and the incident must be closed within seven business days after being notified of the substantiation.
3) For a reportable incident, the incident must be addressed and remediated as determined appropriate, and the incident must be closed within forty-five business days after its submission into the incident management system.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

State Entity Responsible for Overseeing the Operation of the Incident Management System: ODM is responsible for overseeing the operation of the incident management system.

Methods for Overseeing the Operation of the Incident Management System:

Oversight of the incident management system includes regular monitoring of reports generated by the system, as well as any ad hoc review of data to track and trend incidents and reportable events to predict and prevent future occurrences.

Frequency of Oversight Activities:
At least quarterly or more often as necessary.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Restraint is used for behaviors that pose a serious risk of harm to the individual or to others. Such behaviors include, but are not limited to, aggression to others, objects, or self. Allowable restraints include:

- Physical restraint, i.e., the use of any hands-on or physical method that to restrict the movement or function of the individual's head, neck, torso, one or more limbs or the entire body; or
- Chemical restraint, i.e., the use of any sedative psychotropic drug exclusively to manage or control behavior; or
- Mechanical restraint, i.e., the use of any device to restrict an individual's movement or function for any purpose other than positioning and/or alignment.

Less restrictive measures such as verbal redirection/prompting and positive reinforcement are alternative strategies to avoid or reduce the use of restraints. They will always be explored and encouraged by the CMAs and the individual's team.

Restraints may not be used as a routine programmatic intervention, for punitive purposes or for staff convenience. The only restraint that may be used in an emergency is a protective hold which is the application of body pressure to an individual for the purpose of restricting or suppressing the person's movement. Any other use of prone restraints is prohibited.

If it is determined through the assessment and person-centered service planning processes that restraint is being considered by the individual's team, the CMA will work with the team to promote the least restrictive/intrusive, most positive intervention culture needed to keep the individual safe. Restraints must be authorized pursuant to a behavior support plan developed by a physician, licensed psychologist, county board of developmental disabilities, or another behavioral health treatment professional, in conjunction with the person-centered service plan and the individual's team. The behavior support plan is an addendum to the person-centered service plan. The plan will be coordinated to ensure an integrated approach to support individuals with complex behavioral challenges. Staff who are implementing restraints will be trained via a variety of methods including, but not limited to, training directly from the entity that is writing the plan.

When a plan for restraint is being developed, the CMA must assure that the following elements are addressed:

- Agreement from the individual's team that the use of restraint is appropriate.
- Promotion of the least restrictive/intrusive intervention, and the most positive intervention culture needed to keep the individual safe.
- Inclusion and requirement of the use of preventive and/or alternative and non-aversive measures to assure the safety and well-being of the individual.
- Verification of authorization of the use of restraint by the authorizing entity.
- Identification of an oversight entity responsible for ensuring that staff are appropriately trained regarding implementation of the behavior plan, including use of the restraint, as well as for ongoing monitoring of the use of restraint. The oversight entity can include a parent/guardian or authorized representative or a behavioral health provider. However, the person implementing the restraint cannot be the person responsible for monitoring the use of the restraint.
- Existence of a plan to assure, and identification of the party responsible for, training the staff who implement restraint.
- Documentation of the planned use of restraint in the individual's person-centered service plan and communication record.

Any use of an approved restraint must be documented by the provider and reviewed by the case manager during routine visits and team meetings. Any use of a restraint that is not approved or is implemented contrary to the plan must be reported as an incident via the ODM incident managmement system. The provider must contact the CMA and the CMA must contact the individual and his/her legal representative within 24 hours of receiving the incident report. Changes to the person-centered service plan or living situation may be considered to support the person's safety and well-being. Follow-up visits in response to the incident report and to complaints by the individual and his/her legal representative will be conducted and include questions about any actions taken by the service provider that may qualify as unauthorized use or misapplication of physical restraints.

Individuals who are also receiving services through a county board of developmental disabilities are eligible to access services through a behavior support plan. This includes the county board's oversight committees and processes. CMAs are expected to collaborate with county board staff to access this service on behalf of the individual. CMAs should request to be added to the list of those who receive status reports for individuals with an aversive plan, including those plans that include restraints.

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 CMAs report data to ODM on a quarterly basis regarding such things as the number of individuals for whom restraint is used; types of restraint being used; and authorizing entity.

The CMAs will identify any unauthorized or inappropriate use of restraint and report case-specific information through the State's incident management system. Data is analyzed by both the provider oversight contractor and ODM, with appropriate follow-up as needed regarding identified trends and patterns to support improvement strategies. Follow-up includes but is not limited to additional ODM or provider oversight contractor training of CMA or provider staff, and/or changes in protocols and/or rules. Through this analysis, and through both the provider oversight contractor and the incident management system, if case-specific concerns are noted, follow-up will occur with the authorizing entity and the individual's team.

Any significant injuries which result from employment of a restraint must be carefully analyzed and immediately reported to ODM and the CMA in accordance with incident reporting requirements.

In addition, the CMA and an oversight entity (e.g., a parent/guardian or authorized representative or a behavioral health provider) will help to ensure that staff is appropriately trained, and that restraint is used safely and appropriately. ODM must communicate with the case manager and verify documentation of the use of restraints in the person-centered service plan, and communication record.

The CMAs must develop an individual-specific annual report that will be sent to the physician who certified the plan if the physician is the authorizing entity. The report must include identification of the restraints used, frequency of use per month, and information regarding the outcome or response to the use of the restraints. The CMAs must assure the physician reauthorizes the use of the restraints at least annually.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including

restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Restrictive interventions are used for behaviors that pose a serious risk of harm to the individual or to others. Such behaviors include, but are not limited to, aggression to others, objects, or self. Less restrictive measures such as verbal redirection/prompting and positive reinforcement are alternative strategies to avoid or reduce the use of restrictive interventions. They will always be explored and encouraged by the CMA and the individual's team.

Restrictive interventions may be appropriate to address issues such as wandering in unsafe environments, risk of ingesting unsafe or unhealthy items or failing to complete necessary medical/personal care tasks. Interventions may include but are not limited to manipulation of the environment or denying access to a wanted item or activity until completion of a certain task. Restrictive intervention may not be used as a routine programmatic intervention, for punitive purposes or for staff convenience.

Time away is a restrictive intervention during which the individual is directed away from a location or an activity using verbal prompting, only to address a specific behavior. The individual is able to return to the location or activity at his/her choosing. Time away shall never include the use of a physical prompt or an escort. Time away is considered a restrictive intervention as long as the intervention does not meet the definition of seclusion/time-out. The use of any physical prompt or required timeline for re-engaging in an activity shall elevate the restrictive intervention to "seclusion."

If it is determined through the assessment and care planning processes that restrictive intervention is being considered by the individual's team, the CMA will work with the team to promote the least restrictive/intrusive, most positive intervention culture needed to keep the individual safe. Restrictive interventions must be authorized pursuant to a behavior support plan developed by a physician, licensed psychologist, county board of developmental disabilities, or another behavioral health treatment professional, in conjunction with the CMA and the individual's team. The behavior support plan is an addendum to the person-centered service plan. Staff who are implementing restrictive interventions will be trained via a variety of methods including, but not limited to, training directly from the entity that is writing the plan.

When a plan for restrictive intervention is being developed, the CMA must assure that the following elements are addressed:

- Agreement from the individual's team that the use of restrictive interventions is appropriate.
- Promotion of the least restrictive/intrusive intervention, and the most positive intervention culture needed to keep the individual safe.
- Inclusion and requirement of the use of preventive and/or alternative measures to assure the safety and well-being of the individual.
- Verification of authorization of the use of restrictive interventions by the authorizing entity.
- Identification of an oversight entity responsible for ensuring that staff are appropriately trained regarding implementation of the behavior plan, including use of the restrictive interventions, as well as for ongoing monitoring of the use of the restrictive interventions. The oversight entity can include a parent/guardian or authorized representative or a behavioral health provider. However, the person implementing the restrictive interventions cannot be the person responsible for monitoring the use of the restrictive interventions.
- Existence of a plan to assure, and identification of the party responsible for, training the staff who implement the restrictive interventions.
- Documentation of the planned use of restrictive interventions in the individual's person-centered service plan and communication record.

Any use of an approved restrictive intervention must be documented by the provider and reviewed by the case manager during routine visits and team meetings. Any use of a restrictive intervention that is not approved or is implemented contrary to the plan must be reported as an incident via the IMS. The provider must contact the CMA. The CMA must contact the individual and his/her legal representatives within 24 hours of receiving the incident report. Changes to the person-centered service plan or living situation may be considered to support the person's safety and well- being. Follow-up visits in response to the incident report and to complaints by the individual and his/her legal representatives will be conducted and include questions about any actions taken by the service provider that may qualify as unauthorized use or misapplication of a restrictive intervention.

Individuals who are also receiving services through a county board of developmental disabilities are eligible to access services through a behavior support plan. This includes the county board's oversight committees and processes. CMAs are expected to collaborate with county board staff to access this service on behalf of the individual. CMAs should request to be added specifically to the list of those who receive status reports for individuals with an aversive plan, which would include those plans with restrictive intervention.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The CMAs report data to ODM on a quarterly basis regarding such things as the number of individuals for whom restrictive interventions are used; types of restrictive interventions being used; and authorizing entity.

The CMA will identify any unauthorized or inappropriate use of restrictive intervention and report case-specific information through the State's incident management system. Data is analyzed by both the provider oversight contractor and ODM, with appropriate follow-up as needed regarding identified trends and patterns to support improvement strategies. Follow-up includes but is not limited to: additional ODM or provider oversight contractor training of CMA or provider staff, and/or changes in protocols and/or rules. Through this analysis and the incident management system, if case- specific concerns are noted, follow-up will occur with the authorizing entity and the individual's team.

Any significant injuries which result from employment of a restrictive intervention must be carefully analyzed and immediately reported to ODM and the CMA in accordance with critical incident reporting requirements.

In addition, the CMA and an oversight entity (e.g., a parent/guardian or authorized representative or a behavioral health provider) will help to ensure that staff is appropriately trained, and that restrictive intervention is used safely and appropriately. The provider oversight contractor must communicate with the case manager and verify documentation of the use of restrictive intervention in the person-centered service plan, and communication record.

The CMAs must develop an individual-specific annual report that will be sent to the physician who certified the plan if the physician is the authorizing entity. The report must include identification of the restrictive interventions used, frequency of use per month, and information regarding the outcome or response to the use of the restrictive interventions. The CMAs must assure the physician reauthorizes the use of the restrictive interventions at least annually.

The CMAs must review status reports for approved plans at least monthly. This must include addressing any implementation concerns and assuring unauthorized restrictive interventions have been reported appropriately. The CMAs must review and discuss the use of restrictive interventions with the individual's team on an ongoing basis, and at least every 90 days. Additionally, the CMAs must review all incidents related to the use of restrictive interventions. They must also review the use of all restrictive interventions to ensure the use was appropriate and within prescribed guidelines.

Use of any unauthorized restrictive interventions is reported to the CMAs as an incident. Additionally, the use of any prohibited restrictive interventions is reported as an incident. Case managers are required to review these expectations with all persons authorizing and implementing a restrictive intervention.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

○ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

◉ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Seclusion is used for behaviors that pose a serious risk of harm to the individual or to others. Such behaviors include, but are not limited to, aggression to others, objects, or self. Less restrictive measures such as verbal redirection/prompting and positive reinforcement are alternative strategies to avoid or reduce the use of seclusion. They will always be explored and encouraged by the CMAs and the individual's team.

Seclusion or Time Out is any restriction that is used to address a specified behavior that prevents the individual from leaving a location for any period of time. Seclusion may include preventing the individual from leaving an area until he or she is calm. Seclusion shall never include the use of locked doors and must always include constant visual supervision of the individual. It must only be used for behaviors that are physically harmful to the individual or other persons.

Seclusion may not be used as a routine programmatic intervention, for punitive purposes or for staff convenience. Time-out or seclusion will only be permitted if approved as a part of a behavior support plan.

If it is determined through the assessment and person-centered service planning processes that seclusion is being considered by the individual's team, the CMA will work with the team to promote the least restrictive/intrusive, most positive intervention culture needed to keep the individual safe. Seclusion must be authorized pursuant to a behavior support plan developed by a physician, licensed psychologist, county board of developmental disabilities, or another behavioral health treatment professional, in conjunction with the person-centered service plan and the individual's team. The behavior support plan is an addendum to the person-centered service plan. The plan will be coordinated to ensure an integrated approach to support individuals with complex behavioral challenges. Staff who are implementing seclusion will be trained via a variety of methods including, but not limited to, training directly from the entity that is writing the plan.

When a plan for seclusion is being developed, the CMA must assure that the following elements are addressed:

- Agreement from the individual's team that the use of seclusion is appropriate.
- Promotion of the least restrictive/intrusive intervention, and the most positive intervention culture needed to keep the individual safe.
- Inclusion and requirement of the use of preventive and/or alternative and non-aversive measures to assure the safety and well-being of the individual.
- Verification of authorization of the use of seclusion by the authorizing entity.
- Identification of an oversight entity responsible for ensuring that staff are appropriately trained regarding implementation of the behavior plan, including use of the seclusion, as well as for ongoing monitoring of the use of restraint. The oversight entity can include a parent/guardian or authorized representative or a behavioral health provider. However, the person implementing the seclusion cannot be the person responsible for monitoring the use of the seclusion.
- Existence of a plan to assure, and identification of the party responsible for, training the staff who implement seclusion.
- Documentation of the planned use of seclusion in the individual's person-centered service plan and communication record.

Any use of seclusion must be documented by the provider and reviewed by the case manager during routine visits and team meetings. Any use of seclusion that is not approved or is implemented contrary to the plan must be reported as an incident via the IMS.

If seclusion is utilized, direct care staff must report the incident and follow appropriate reporting procedures. The provider must contact the CMA and the CMA must contact the individual and his/her legal representative within 24 hours of receiving the incident report. Changes to the person-centered service plan or living situation may be considered to support the person's safety and well-being. Follow-up visits in response to the incident report and to complaints by the individual and his/her legal representative will be conducted and include questions about any actions taken by the service provider that may qualify as unauthorized use or misapplication of seclusion.

Individuals who are also receiving services through a county board of developmental disabilities are eligible to access services through a behavior support plan. This includes the county board's oversight committees

and processes. CMAs are expected to collaborate with county board staff to access this service on behalf of the individual. CMAs should request to be added specifically to the list of those who receive status reports for individuals with an aversive plan, which would include those plans with seclusion.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The CMAs report data to ODM on a quarterly basis regarding such things as the number of individuals for whom seclusion is used; types of seclusion being used; and authorizing entity.

The CMAs will identify any unauthorized or inappropriate use of seclusion and report case-specific information through the State's incident management system. Data is analyzed by both the provider oversight contractor and ODM, with appropriate follow-up as needed regarding identified trends and patterns to support improvement strategies. Follow-up includes but is not limited to additional ODM or provider oversight contractor training of CMA or provider staff, and/or changes in protocols and/or rules. Through this analysis, and through both the provider oversight contractor and the incident management system, if case-specific concerns are noted, follow-up will occur with the authorizing entity and the individual's team.

Any significant injuries which result from employment of seclusion must be carefully analyzed and immediately reported to ODM and the CMA in accordance with incident reporting requirements.

In addition, the CMA and an oversight entity (e.g., a parent/guardian or authorized representative or a behavioral health provider) will help to ensure that staff is appropriately trained and that seclusion is used safely and appropriately. ODM must communicate with the case manager and verify documentation of the use of seclusion in the person-centered service plan, and communication record.

The CMAs must develop an individual-specific annual report that will be sent to the physician who certified the plan if the physician is the authorizing entity. The report must include identification of the seclusion used, frequency of use per month, and information regarding the outcome or response to the use of the seclusion. The CMAs must assure the physician reauthorizes the use of the seclusion at least annually.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The safe, effective and appropriate use of medications is an essential component to the Ohio Home Care Waiver, and to the assurance of the individual's ongoing health and welfare.

The CMA will complete a review of the individual's medications and utilization during the assessment/reassessment process. This includes all prescription, over-the-counter medications, nutritional supplements and herbal remedies. The person(s) responsible for administering medications will be identified and documented in the comprehensive assessment and on the person-centered service plan.

Administration of medication will be limited to medical personnel who are professionally licensed to do so in accordance with the Revised Code (e.g., a physician licensed to practice in the State of Ohio, and a nurse licensed to practice in Ohio in accordance with Section 4723. of the Revised Code, etc.). Providers who are responsible for medication administration will be required to record and report medication administration errors to the CMA for appropriate follow-up and referral (see incident reporting above). Medication errors will be included in the ODM-approved assessment and case management system and monitored through the incident management process. When errors are substantiated, referrals will be made to the physician, and when appropriate, the applicable state licensing authority.

Medical professionals who prescribe medication will have "first-line" responsibility for monitoring medication regimens. Ongoing monitoring of medication management will also take place during regular contacts and visits with the case manager.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Direct oversight of medication management is conducted by the CMAs; however, the State has methods to detect systemic issues. State rules and regulations outline the requirements for policies and procedural precautions that must be implemented for medication management, including prohibited practices. Case-specific situations where harmful practices are discovered receive remediation. Additionally, medication errors are reported and remediated through the incident management system. Data is reviewed and analyzed with trends and patterns noted, and follow-up as needed. Follow-up includes but is not limited to requirements for additional staff training, and changes in protocol and rules. The CMAs must report any corrective action taken or technical assistance offered to staff.

Licensed provider agencies shall comply with appropriate licensing requirements governing medication management. Unlicensed provider agencies are required to have a pharmacist or physician complete quarterly medication/drug reviews for participants taking medications with potentially serious side effects. Individuals or their authorized representatives who are employers of record are required to train or arrange for training of their employees in medication administration, if applicable.

Additionally, ODM operates a drug utilization review (DUR) program that is designed to educate providers across the Ohio Medicaid program about potentially inappropriate drug therapy. The Ohio DUR program is a provider-oriented, educational outreach program designed to alert physicians and pharmacists to inappropriate or medically unnecessary care. The purpose of the program is to safeguard the health of Medicaid consumers, to assess the appropriateness of drug therapy, and to reduce the frequency of fraud, abuse and gross overuse. The primary objective of the DUR program is to improve health care through educational intervention. Such intervention should seek to eliminate or reduce drug-induced illness, hospitalizations, and the need for remedial care or treatment. Retrospective DUR (RetroDUR) evaluates patterns of drug therapy on medications already dispensed to the patient. Interventions are aimed at patients who are at risk for a drug-related problem such as drug-induced illness, potential drug overutilization and medication misuse. There is also monitoring of physicians' prescribing activities to ensure patients are receiving appropriate care. By utilizing patient profiles generated from Medicaid paid claims data, monthly reviews are performed by the DUR Committee according to criteria approved by the DUR Board. After a review, intervention letters and response forms are emailed to selected providers. Additional guidelines and publications may be included along with the consumer's profile for the provider to review.

Finally, the Ohio Automated Rx Reporting System (OARRS) is a web-based system operated by the Ohio State Board of Pharmacy that collects information on all outpatient prescriptions for controlled substances that are dispensed by Ohio licensed pharmacies and prescribed or personally furnished by licensed prescribers in Ohio. The information in OARRS is available to prescribers when they treat patients, pharmacist when presented with prescriptions from patients and law enforcement officers and health care regulatory boards during active investigations.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Administration of medication is limited to medical personnel who are professionally licensed to do so in accordance with the Ohio Revised Code (e.g., a physician licensed to practice in the State of Ohio, and a nurse licensed to practice in the State of Ohio in accordance with Section 4723 of the Ohio Revised Code, etc.).

Personal care aides are not permitted to administer prescribed or over-the-counter medications to the individual, but pursuant to OAC Rule 4723-13-02 and unless otherwise prohibited by the provider's certification or accreditation status, may do only the following:

(1) Remind an individual when to take the medication and observe to ensure that the individual follows the directions on the container;
(2) Assist an individual in the self-administration of medication by taking the medication in its container from the area where it is stored and handing the container with the medication in it to the individual. If the individual is physically unable to open the container, the unlicensed person may open the container for the individual;
(3) Assist upon request by or with the consent of, a physically impaired but mentally alert individual, in removing oral or topical medication from the container and in taking or applying the medication. If an individual is physically unable to place a dose of medicine in the individual's mouth without spilling or dropping it, an unlicensed person may place the dose in another container and place that container to the mouth of the individual; or
(4) Assisting an individual with self-administration does not mean that an unlicensed person can administer medication to an individual, whether orally, by injection, or by any other route.

Additionally, pursuant to Sections 5166.30 – 5166.3010 of the Ohio Revised Code, certain unlicensed providers are permitted to assist individuals with self-administration of medications as part of the home care attendant service.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Providers are required to record the medication error and report to the CMAs through the incident reporting process.

The specific types of medication error that providers must record are:

- Administering the wrong drug, strength, or dose of medication;
- Missed dosage;
- Unauthorized dosage;
- Wrong time of administration (more than 1 hour);
- Incorrect route of administration;
- Medication refusals
- Wrong patient
- Adverse drug reactions

(b) Specify the types of medication errors that providers are required to *record:*

See Appendix G-3(c)(iii)(c) below.

(c) Specify the types of medication errors that providers must *report* to the state:

In accordance with OAC rule 5160-45-05 governing incident reporting, providers are required to record and report for further investigation incidents involving errors in the administration of medication to an individual.

In addition, in the case of home care attendant services, the individual who is receiving home care attendant services, the authorized representative or a provider shall report to ODM all instances in which a home care attendant appears to have provided nursing services, other than assistance with self-administration of medication or the performance of nursing tasks as authorized by state and rule, or provider services not in accordance with the authorizing health care professional's authorization. An investigation may be initiated based on the report and its findings reported to the Ohio Board of Nursing.

○ **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.

ODM and the provider oversight contractor monitor CMAs' and providers' adherence to medication protocols. Providers who are responsible for medication administration will be required to record and report medication administration errors to the CMAs for appropriate follow-up and referral through the incident reporting process. When errors are substantiated, referrals will be made to the physician, and when appropriate, the applicable state licensing authority.

The CMAs are responsible for reporting all medication errors to the provider oversight contractor. The CMAs and ODM will ensure that all applicable state requirements have been followed regarding medication errors as part of the incident report review process. Aggregate data reports will be used through the continuous quality improvement process to identify recurrent problems with providers and prevent reoccurrence.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

Performance Measures

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

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

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G-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 within the required timeframe. N= Total number of ANEM incidents reported into the ODM-approved incident management system within the required timeframe. D= Total number of ANEM incidents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ODM-approved incident management system

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

Data Aggregation and Analysis:

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

Performance Measure:
G-2: Number and percent of unexplained deaths with a required need for investigation for which an investigation was completed according to rule requirements. N=Total number of unexplained death investigations completed according to the rule requirements. D=Total number of unexplained death investigations.

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

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

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

Data Aggregation and Analysis:

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

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 (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:
ODM-approved incident management system

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

Data Aggregation and Analysis:

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

Performance Measure:
G-4: Number and percent of substantiated Abuse (physical, verbal, emotional, sexual), Neglect, Exploitation and Misappropriation (0ver $500) incidents 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:
ODM incident management system

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

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

Data Aggregation and Analysis:

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

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 restraint, seclusion or other restrictive intervention incidents with a prevention plan developed as a result of the incident. N= Total number of unauthorized restraint prevention plans completed. D= Total number of unauthorized restrain incidents needing a prevention plan.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ODM-approved incident management system

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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:
ODM-approved incident management system

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

Data Aggregation and Analysis:

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

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

Performance Measure:
G-7: Number and percent of substantiated Provider Medication Error incidents with a prevention plan developed as a result of the incident. N=Total number of Provider Medication Error incidents with prevention plans completed. D=Total number of Provider Medication Error incidents needing a prevention plan.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ODM-approved incident management system

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

Activities by ODM for addressing individual problems include:

Unmet Needs - An Unmet Need is defined as any health and safety risk for the individual, grievance, and/or concerns with case management performance identified during a field review/survey. When staff encounter a situation in which a waiver recipient's health or welfare may be at risk, or when CM deficiencies are identified, staff follow a protocol to report unmet needs. 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 CMs, 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.

Incident Management and Provider Occurrence Reporting - ODM maintains explicit reporting requirements for individual incidents and provider occurrences in administrative rules and monitors the compliance. If an incident or occurrence is substantiated, and a provider is the violator, then a Notice of Operational Deficiency is issued. Notices of Operational Deficiency are used for more severe violations, such as when ODM or the provider oversight contractor substantiates provider occurrences such as allegations of provider billing violations, substandard provider performance such as sleeping on the job, provider theft, etc., and serious and immediate threats to the health and welfare of the individual.

The provider must develop and submit a plan of correction. If the violation is extreme, there are repeat violations, or if a provider fails to implement corrective actions, ODM can impose sanctions, including termination of the provider's Medicaid agreement. ODM also relays information related to incidents and occurrences to licensing boards, to other entities that accredit or certify particular types of providers, and to other state agencies that operate Medicaid waivers, as appropriate.

Health, Safety and Welfare Oversight Committee - 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.

All potentially unexplained deaths are reviewed by provider oversight contractor clinicians. ODM maintains the ability to assume investigations from the provider oversight contractor. Investigations assumed by ODM are supported by a physician.

As described elsewhere in this application, ODM relies on data gathered through Ongoing Review, Annual CMA Review, Quarterly reporting by the CMA, and the Quality Steering Committee (QSC), as a means to identify systemic compliance and performance problems. Forums and processes through which general problems are addressed include formal corrective action planning, bi-annual Quality Briefings, and the QSC.

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**

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ **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 health and welfare that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 1915(c) of the Social Security Act and 42 CFR § 441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver quality improvement strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a quality improvement strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the quality improvement strategy.

Quality Improvement Strategy: Minimum Components

The quality improvement strategy (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities*

of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the QIS spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Medicaid Oversight Strategy

The State's quality oversight strategy for the Ohio Home Care Waiver relies on the collaborative efforts of staff at the Ohio Department of Medicaid and its case management and provider management contractors to generate and analyze both data and other performance-related information to measure compliance with federal waiver assurances and to assure the health of welfare of waiver participants.

Role of the State Medicaid Agency

Ohio Medicaid has crafted a broad quality strategy through which the State continues to pursue program and process changes intended to make care safer, improve care coordination, promote evidence-based prevention and treatment practices, support person and family- centered care and ensure effective and efficient administration. For Ohio's HCBS waivers, this approach to quality builds upon the processes and infrastructure currently in place to measure compliance with federal waiver assurances.

ODM Oversight of Case Management Agencies and the Provider Oversight Contractor - ODM has operational responsibility for the Ohio Home Care Waiver. As part of that responsibility, ODM delegates certain functions to case management agencies that operate around the state and a single provider oversight contractor. Contracts between ODM and these entities include language authorizing ODM to perform oversight activities that help to establish the program's compliance with federal and state laws and regulations, as well as auditing and fiscal compliance. In the Ohio Home Care Waiver, Ohio integrates the State's Medicaid quality strategy by aligning ODM's waiver quality processes with that work. ODM employs a multi-faceted monitoring and oversight process that includes the following:

Monthly and Quarterly Reporting – Case management agencies and the provider oversight contractor are obligated to submit a series of reports to ODM that include operational output and quality performance data.

Ongoing Review – Every year, ODM conducts interviews with approximately 400 randomly selected waiver participants to measure compliance with performance regarding 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.

Targeted Review – ODM places a priority on maintaining a presence in the community to monitor individual health outcomes and to identify opportunities for program improvement. ODM conducts a series of targeted reviews of individuals enrolled on HCBS waivers across populations. These reviews are performed on a subset of individuals enrolled on all of the State's HCBS waivers. Ohio uses claims data and other criteria to identify a target group on the basis of, for example, diagnosis, service utilization (over or under), medications and care management. The goal of these targeted reviews is to locate "hot spots" within the program and identify at-risk individuals who, with the assistance of our partners (i.e., sister agencies, case managers and providers, etc.), the

State can help to avoid or mitigate negative health outcomes. Targeted reviews may be structured to focus on individual health and safety which may include individuals who meet a certain clinical profile, such as those with uncontrolled diabetes or avoidable hospitalizations and/or the State may focus on oversight of delegated administrative functions and compliance with waiver assurances, etc. Through this process, ODM may identify opportunities for program improvement and/or increased oversight. Should ODM have findings from the targeted review, the department may require contractors and/or providers to develop and implement corrective action, as needed.

Contractor Reviews – ODM conducts a review of each CMA and the provider oversight contractor in order to ensure compliance with all contract terms. ODM issues a review report and the CMAs and the provider oversight contractor are required to develop and submit a plan of correction related to all identified deficiencies. ODM continues to monitor their compliance with the plan of correction.

Quality Briefings –ODM meets with each contracted agency on a quarterly basis to dialogue about data generated through the departments' respective quality processes. In these meetings, the departments will review performance data generated through targeted reviews and discuss remediation and/or corrective action. These

quality briefings are also informed by data presented by ODM on the oversight activities conducted by the agency, including but not limited to, problems detected, corrective measures taken and how such measures were are/were verified. The quality briefings serve as the forum for ODM and contractors to share and review performance metrics.

The Quality Steering Committee provides administrative oversight for Ohio' 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.

Health, Safety and Welfare Oversight Committee: 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.

Case-Specific Resolution - ODM assures case-specific resolution through multiple interventions including the Health, Safety, and Welfare committee oversight process and interdisciplinary case review meetings conducted with internal staff of varying disciplines.

Unmet Needs - An Unmet Need is defined as any health and safety risk for the individual, grievance, and/or concerns with case management performance identified during a field review/survey. When staff encounter a situation in which a waiver recipient's health or welfare may be at risk, or when CM deficiencies are identified, staff follow a protocol to report unmet needs. 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 CMs, 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.

Fiscal Reviews – ODM staff perform regular desk reviews of administrative costs, with A-133 Audits being performed every 1-3 years based on risk. Additional detail about Ohio's practice for maintaining fiscal oversight of the Ohio Home Care Waiver can be found in Appendix I.

Open lines of Communications – ODM regularly communicates with case management agencies and the provider oversight contractor about case-specific matters and other issues related to program operations, provides technical assistance and responds to inquiries. Topics include, but are not limited to, individual health and welfare, program administration, budgeting, enrollment, providers and provider enrollment, provider reimbursement, issues pertaining to Medicaid state plan services, pending legislation, statutory and rule changes, etc. ODM also conducts monthly "one-on-one" meetings with each contractor. Contractors are also represented on various stakeholder groups.

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: CMAs and Provider Oversight Contractor	☒ **Other** Specify:

Responsible Party*(check each that applies):*	Frequency of Monitoring and Analysis*(check each that applies):*
	Quality briefings in which performance data is reviewed in depth occur at least twice a year

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

ODM is able to detect the impact of system design changes and to assess and compare performance over time, across systems, and across counties. Depending on the nature of a change, ODM may conduct, or direct the CMAs to conduct targeted reviews to evaluate the impact or the effectiveness of that change.

Now that key measures and the means to gather data are more established, the critical next steps for data- driven systems improvement are:
1) to formalize venues for regular and sustained attention to specific performance data,
2) to improve our capacity to discover trend failures and successes,
3) to effectively communicate to all levels of the service delivery system that there will be sustained attention to particular measures, and
4) to effectively communicate to all levels of the service delivery system that under- performance in these areas must necessarily be followed-up with further investigation and active remediation.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

Ohio continues to implement new Quality Improvement Strategies to improve ongoing oversight and monitoring of all Ohio Medicaid waivers, Ohio will have access to a steady stream of performance data which should provide a basis to evaluate the overall effectiveness of that strategy.

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).*

In accordance with Rule 5160-1-29 of the Administrative Code, ODM is required to have in effect a program to prevent and detect fraud, waste and abuse in the Medicaid program. ODM, the Auditor of State and/or the Ohio Attorney General may recoup any amount in excess of that which is legitimately due to a provider based upon review or audit.

ODM created the Bureau of Program Integrity in 2014 to coordinate activities across ODM and external stakeholders in order to better detect fraud, waste and abuse. Program integrity is a continuum of activities carried out to safeguard Ohio's Medicaid program and those it serves. Activities include, but are not limited to, provider enrollment and support, automated system controls, pre-and post-payment review, contract management and staff training. Key stakeholders include, ODM, Ohio's Attorney General and Auditor of State, Ohio's Medicaid Managed Care Plans, several state agencies, healthcare-related boards, CDJFSs and the federal government. Ohio Medicaid also coordinates with other states.

Program integrity activities occur across all aspects of the Medicaid program and include, but are not limited to:

- *Enrolling individuals and providers into the program promptly and accurately;*
- *Determining if providers are billing properly;*
- *Reimbursing providers in accordance with established policies;*
- *Performing announced and unannounced provider site visits and reviews;*
- *Suspending and/or terminating providers for program violations;*
- *Conducting post-payment reviews and audits to identify and collect overpayments and identify utilization issues;*
- *Educating individuals and providers on their rights and responsibilities;*
- *Responding to individual and provider questions promptly and effectively;*
- *Monitoring utilization and quality of care;*
- *Identifying and analyzing possible cases of fraud, waste and abuse.*

If waste and abuse are suspected or apparent, ODM takes action to ensure compliance and recoup inappropriate payments through audits and reviews in accordance with OAC Rule 5160-1-27 or 5160-26-06. Where fraud is suspected, ODM refers the case to the Ohio Attorney General's Medicaid Fraud Control Unit (MFCU) for further investigation. MFCU has statewide criminal jurisdiction over Medicaid provider fraud investigations. Common types of fraud include billing for services not provided, billing for a higher level of service than authorized or rendered, billing for services not medically necessary, and offering or receiving cash to obtain business.

ODM also contracts with an entity for the purpose of performing Ohio Home Care Waiver provider oversight activities including, but not limited to provider enrollment, incident investigations, provider oversight, and provider monitoring and structural reviews. Pursuant to OAC rule 5160-45-06, Medicare-certified and otherwise accredited agencies are subject to structural reviews in accordance with their certification and accreditation bodies, and may be exempt from a regularly scheduled structural review. They are required to submit a copy of their updated certification and/or accreditation, and upon request of the provider oversight contractor, must make available all review reports and accepted plans of correction from the certification and/or accreditation bodies.

Also pursuant to OAC rule 5160-45-06, all other ODM-administered waiver providers are subject to structural reviews by the provider oversight contractor during each of the first three years after a provider begins furnishing billable services. Thereafter structural reviews are conducted annually, unless at the discretion of ODM or the provider oversight contractor, biennial structural reviews may be conducted when a) there are no findings against the provider during the provider's most recent structural review; b) the provider has not substantiated to be the violator of an incident described in OAC rule 5160-45-05; c) the provider has not been the subject of more than one provider occurrence during the previous twelve months; and d) the provider does not live with an individual receiving ODM-administered waiver services.

The provider oversight contractor examines any incident reports or provider occurrences related to the provider and documents and addresses findings of non-compliance during the structural review. The review also includes an evaluation of the provider's compliance with OAC Chapters 5160-44, 5160-45 and 5160-46; a unit of service verification for the review period to assure that all waiver services are authorized, delivered and reimbursed in accordance with the person-centered service plan for the individual receiving waiver services; and an evaluation to determine whether the provider has implemented all plans of correction that were approved since the last review. The provider oversight contractor conducts an exit conference with the provider about its preliminary findings, required remediation and other required follow-up.

ODM and the provider oversight contractor work with providers to address identified issues and to uncover evidence of possible overpayments. Providers are required to complete adjustments for any overpayments identified. If the provider does not make the adjustments, the provider oversight contractor makes referrals to ODM. ODM will issue a notice of

deficiency and a referral will be made to ODM's Surveillance and Utilization Review Section (SURS) to issue the overpayment.

SURS' primary function is to conduct audit and review activities to ensure the validity and allowability of claims paid to Medicaid providers. During the course of normal operations, Medicaid providers sometimes discover instances in which they were overpaid by the Medicaid program. When this occurs, providers contact ODM with the overpayment information and remit payment. When SURS receives a complaint regarding potential Medicaid fraud or identifies any questionable practices, it conducts a preliminary review to determine the appropriate course of action. SURS' main function is conducting post-payment reviews, many of which are conducted annually. For instance, in SFY 2020, SURS completed 87 reviews of home health providers. They do not track whether these are all Ohio Home Care Waiver providers, but those same providers are authorized to provide Ohio Home Care Waiver services.

Various methods of audit and review are applied by the ODM Surveillance and Utilization Review Section (SURS), the Auditor of State and waiver contractor PCG to identify improper payments. SURS processes referrals from all sources and conducts desk reviews in which claims are pulled for a particular time period and compared to provider records. SURS primarily uses two methods for identifying claims for review. In additional to complaint referrals, SURS employs algorithms and provider profile reports that examine larger data sets and rank providers by various criteria like total dollar value of claims, number of individuals served, and how provider billing patterns compare to their peers.

The Auditor of State conducts on-site field audits on behalf of ODM, in which a statistical sample of provider claims is used to project findings. AOS also performs reviews in which a provider's records are reviewed and dollar-for-dollar findings are issued. The Auditor of State (AOS), may select a statistical random sample of claims for audit; total improper payment findings are then extrapolated from the sample. Providers are afforded Chapter 119 hearing rights as part of the AOS audit process.

ODM contractor PCG performs waiver incident management and provider structural reviews; PCG refers suspected improper payments to SURS for recovery.

Most reviews and audits include claims at least one year old that can no longer be adjusted by the provider. ODM recovers substantiated improper payments, either by offsetting a provider's future payments, or referring outstanding debts to the Attorney General's Collections Unit. Any provider claim can be reviewed up to five years after the fiscal year the claim was paid in.

If the results of a review give SURS reason to believe that an incident of fraud has occurred in the Medicaid program, SURS refers the case to MFCU as mandated by 42 CFR 455.21(a)(1). MFCU conducts a statewide program to investigate and prosecute (or refer for prosecution) violations of all applicable state laws pertaining to fraud in the administration of the Medicaid program, the provision of medical assistance, or the activities of providers of medical assistance under the State Medicaid plan.

ODM also holds bi-weekly meetings with the provider oversight contractor, the Ohio AG's MFCU, sister-state agencies and managed care companies to share information about suspected cases of Medicaid fraud in the State's waiver programs and home health populations and to discuss related referrals, indictments and convictions. If the Attorney General's Office is unable to prosecute a case, they refer it back to ODM to collect any associated overpayments.

As needed, SURS also supports MFCU by providing copies of records and access to computerized data and provider information it has collected, while protecting the privacy rights of individuals receiving Medicaid benefits. SURS also accepts referrals from MFCU to initiate any available administrative or judicial action to recover improper payments made to providers.

The Auditor of the State of Ohio conducts an annual Single Audit of the State of Ohio of ODM in accordance with the requirements of the Single Audit Act (31 U.S.C. 7501-7507), as amended by the Single Audit Act Amendments of 1996 (P.L. 104-146).

Additionally, Ohio Home Care Waiver providers are viewed as contractors by the State, and as such, are not required to secure an independent financial statement audit.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

i. Sub-Assurances:

a. Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measures

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

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

Performance Measure:
I-1: The number and percent of paid claims for waiver services reviewed that were authorized. N= Number of paid claims for waiver services reviewed that were authorized. D= Total number of paid claims for waiver services that were reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Claims Review

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% with confidence within MOE +/- 5%*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*

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

Data Aggregation and Analysis:

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

Performance Measure:
I-2: Percent of paid claims that were properly coded and reimbursed in accordance with the authorized fee schedule. N= Number of paid claims for waiver services reviewed that were properly coded and reimbursed in accordance with the authorized fee schedule. D= Total number of paid waiver claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Medicaid-approved decision system

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

Data Aggregation and Analysis:

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

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
I-3: Number and percent of waiver claims reviewed that were paid using the correct rate as specified in Chapter 5160-45 of the Ohio Administrative Code. N= Number of waiver claims reviewed that were paid using the correct rate as specified in Chapter 5160-46 of the Administrative Code. D= Total number of approved waiver claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Claims Review

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% with confidence MOE +/- 5%*

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information*

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

ODM's billing and claims system edits prevent providers from being paid more than the approved rate for each waiver service. The amount paid is calculated by MMIS, according to the approved methodology and based on the number of units billed, etc.

The ODM Bureau of Program Integrity, Surveillance Utilization Review Section (SURS), conducts post-payment auditing. This involves data mining to discover, among other overpayments, claims paid for dates of services subsequent to a waiver participant's date of death, or for waiver services paid on the same date of service for which ODM paid a claim for inpatient hospital care. When payment for non-allowable services is discovered, SURS initiates collection of the apparent overpayment from the provider.

As part of its monitoring process, ODM and the provider oversight contractor conduct face-to-face structural reviews with providers. Included in the structural review is a unit of service verification audit that compares services authorized, delivered and billed as they relate to the individual's person-centered service plan. ODM reports all provider overpayments to SURS, and the Ohio Attorney General's Medicaid Fraud Control Unit, as appropriate, and providers are instructed to return overpayments to ODM. ODM forwards CMS the federal share of any recovered overpayment.

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).*

Provider payment rates for waiver services are outlined in Ohio Administrative Code 5160-46-06 and 5160-46-06.1. ODM staff review provider payment rates for waiver services on an ongoing basis, looking at comparable services being provided in the Ohio health care industry, community services environment, and Medicare. ODM reviews rates and recommends rate changes. ODM also works with actuaries to assure that rates are reasonable. The availability of funding in the state's biennial budget also impacts ODM's ability to adjust provider rates.

ODM staff meet with stakeholders on a regular basis to discuss a multitude of issues, including provider reimbursement. ODM regularly informs individuals, providers and stakeholders of administrative policy changes through its stakeholder process, including, but not limited to, dedicated workgroups, as well as internal and external review processes. They are afforded opportunities to discuss their concerns prior to and during public hearings. Notices for the public hearings for all rate-related policy or rate changes are made in accordance with 42 CFR 447.205. Notices of rule changes are also communicated through the remittance advices that providers receive when they are reimbursed by Medicaid.

ODM engaged stakeholders and an actuary to examine and modernize the rate setting methodologies for waiver nursing, personal care aide, home care attendant services, and state plan PDN and home health services. Among other things, the group analyzed factors related to labor market data, education, licensure status of providers, and length of time of service visits to assist in the development of the new rate modifications. The agreed upon rate modifications are based on a wage component, employee related expenses, supervisor costs, a full time and part time staffing ratio, training, productivity (travel and documentation), transportation, and administrative costs. ODM's methodology ensures that all providers are present and providing services for a minimum of 35 minutes in order to bill for a Medicaid base rate. Personal care aide service providers received a 3.2% increase in March 2020 as a result of the SFY 20/21 biennial budget. Additionally, registered nurses (RN) and licensed practical nurses (LPN) rates recognize the advanced education and skill level of RNs. Agency and non-agency providers are reimbursed at different rates.

Home Delivered Meal Service: The State uses the fee schedule model of rate setting for this service. The most recent review of the rates was performed in August 2017. As a result of the review, the State adopted a new rate, effective January 1, 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 is based on assumptions for three categories of cost: meal preparation, transportation and delivery, and administration and overhead. The methodology is 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 includes 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.

Development of the standard meal rate was based on a review of historical reimbursement for Home Delivered Meals across the three analyzed waiver programs: MyCare, OHCW, and PASSPORT. The weighted average standard meal reimbursement was $6.34. The State adjusted the meal preparation cost category ($4.60 to $4.76) and maintained the same costs for transportation and delivery ($0.95) and administration and overhead ($0.79). This change resulted in a final rate of $6.50. The selected standard meal rate of $6.50 is consistent with the reimbursement for Home Delivered Meals in the MyCare program.

The State performed a reasonability check for this information by reviewing external resources including the following studies:

- *Older Americans Act Nutrition Programs Evaluation: Meal Cost Analysis dated September 25, 2015*
- *2016-17 National Average Payments Chart for School Lunch dated August 5, 2016*

Following a review of the historical reimbursement for Home Delivered Meals, the State adjusted the fee schedule to reimburse standard meals at a rate of $6.50 and therapeutic and kosher meals at a rate of $8.68. Historically, therapeutic and kosher meals were not reimbursed at a separate rate for the MyCare and OHCW programs but were reimbursed separately for PASSPORT. Effective January 1, 2019, all three programs have separate reimbursement for standard versus therapeutic and kosher meals.

Personal Emergency Response System Service: The State uses the fee schedule model of rate setting for this service. The most recent review of the rates was performed in June 2018. As a result of the review, the State is adopting a new rate, effective January 1, 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 for this service considers the cost of providing the service in comparison to rates provided in the commercial setting. The methodology includes a review of Ohio Medicaid claims and enrollment data, research of public resources, and comparison to similar waiver service offerings in other state Medicaid programs.

It is not uncommon for individuals receiving services through the State's NF-based level of care waivers to move from one waiver to another depending on criteria such as age, Medicare eligibility, service needs and county of residence. Also, providers deliver services to individuals across waivers, but are required to meet different standards. In addition, the reimbursement methodology varies by program. This results in the provider receiving a different reimbursement for the same service depending on the waiver enrollment of the individual they are serving.

The intent of the proposed rate change for both services is to eliminate the variability in rates for the same service, comply with the Centers for Medicare and Medicaid Services' (CMS) requirement to establish a rate methodology for each waiver service, and to invest additional resources in the HCBS delivery system. The State's objective is to establish a foundation for each service by adopting a consistent service specification and a consistent reimbursement rate for the service across waivers. The State can continue to explore various strategies to address factors which impact the efficient, cost effective delivery of each service such as geography, service delivery models, and staffing.

The public is made aware of payment changes throughout the process of proposing and adopting a payment change. The following mechanisms are routinely used to educate and engage the public:

- *HCBS Rules Workgroup. The workgroup consists of individuals enrolled on a waiver, providers, community-based organizations, and advocacy groups. The group typically meetings monthly (in-person and by phone) to review and provide input on proposed changes.*
- *Targeted Stakeholder Meetings. Meetings are held with a sub-set of the HCBS Rules workgroup members who are directly impacted by the payment change. Participation in these ad-hoc meetings (in-person and by phone) allow the individuals and providers most impacted to review and provide input on proposed changes.*
- *Email Communication. Over 900 external stakeholders receive email notifications informing them of policy initiatives and providing instructions on how to provide input.*
- *Governor's Common-Sense Initiatives Office. All administrative rules that are determined to have an adverse impact on business are available for public review and comment prior to the administrative rule making process.*
- *Administrative Rule Making. This established process includes opportunities for public input throughout clearance, public hearings, and testimony at legislative committee hearings.*
- *Required 30-day public comment period for waivers. The State utilizes an established public input process, compliant with 42 CFR 441.304, for all waiver submissions.*

Community Integration Service
The State uses the fee schedule model of rate setting for this service. The service is reimbursed on a per quarter hour for all interventions and supports provided under the definition. The most recent review of the rate was performed in December 2017. As a result, the State adopted a new statewide rate, effective July 1,2019.

The rate methodology is based on historical service utilization trends of the former Independent Living Assistance service in PASSPORT and My Care, a review of Bureau of Labor Statistics data for Ohio hourly wages, and administrative overhead assumptions. The State reviewed the methodology to ensure economy, efficiency, and quality of care and found the revised rate meets these requirements and ensures provider capacity.

Independent Living Assistance was a service that was historically provided through both the PASSPORT and MyCare waiver programs, but not an approved service for the Ohio Home Care Waiver program. As part of waiver alignment across NF-LOC waivers, effective July 1, 2019 the Independent Living Assistance service was expanded to include a teaching/training component along with the previously covered services and was added as a covered service for the Ohio Home Care Waiver.

Reimbursement for Independent Living Assistance and the newly expanded Community Integration service is on a per quarter hour basis. Therefore, the State reviewed historical experience for Independent Living Assistance and established a statewide rate applicable to all waivers, including Ohio Home Care. The $3.50 per quarter hour rate was developed based on a weighted average of the PASSPORT and MyCare experience. The State did not make a reimbursement

adjustment specifically for adding the teaching/training component. The $3.50 per quarter hour rate does not represent an increase or a decrease to the reimbursement rate in the Ohio Home Care Waiver but does represent an overall expenditure increase as this will be a newly covered service upon the July 1, 2019 effective date.

Community Transition Service
The State uses the negotiated market rate model of rate setting for this service. The service is reimbursed on a per job basis. The selected provider submits a bid for the provision of the service; the bid represents all the items/supports identified in the person- centered services plan. The accepted bid is authorized in the person-centered services plan. The maximum ceiling for the service is based on historical utilization of the service in the Money Follows the Person (MFP) grant and the PASSPORT, Assisted Living, and MyCare waivers.

January 2022
As a result of Ohio's House Bill 110, The Ohio Department of Medicaid (ODM) biennial budget incorporates billing maximum rate increases for waiver nursing, personal care aide, home care attendant, home delivered meals, and adult day services in the Ohio Home Care waiver program. The purpose of this amendment is to incorporate the appropriated service rate increases, equivalent to a 6.1% increase for waiver nursing, personal care aide, and home care attendant services, 10.76% for home delivered meals, and a 25% increase for adult day services. Information relative to this rate increase is also included in Appendix J-2.

Please refer to Main Module 8B Additional Needed Information (Optional) as the number of characters in this description exceeds the number allowable in this section.

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:*

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.

Self-Directed Caregivers
Self-directed caregivers which furnish the personal care, home care attendant, or waiver nursing services submit their timesheets to the FMS which then provides ODM with the claims for details. Self-directed goods and services are paid by the FMS to the vendor or provider, or as reimbursement to the individual and submitted as provided by the FMS. The FMS pays self-directed home modifications services to the provider upon successful completion of the work. Payment to providers comes from payment provided the FMS through invoices. After the payments are documented, ODM will compile a claim from the payment records and submit it through Ohio's billing and claims system for the state to obtain the federal share.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

Claims for the Ohio Home Care Waiver services are processed through ODM's billing and claims system. As part of claims processing, the system edits to assure that:

- *The claim is for the service provided to an individual who was enrolled on a Medicaid waiver and was eligible on the date of service.*
- *The claim amount does not exceed the maximum rate approved for the service.*
- *The service was rendered by a provider that holds a valid Medicaid provider agreement on the date of service.*
- *There is no evidence of third-party insurance that is responsible for covering the cost of service.*

ODM's billing and claims system also exerts controls to ensure that waiver participants are eligible to receive certain types of waiver services, that total costs don't exceed pre-established limits for a given time period, and that providers are eligible to provide, and to receive payment for, particular services.

ODM program staff and the provider oversight contractor follow a structured process to confirm and investigate provider occurrences, including occurrences that relate to inappropriate billing. This process includes issuing notices of deficiencies and requesting plans of correction. ODM and the provider oversight contractor also review the services provided, the services identified in the individual's person-centered service plan, and the provider's billing as a means of discovering overpayments.

The State can identify and track issues (e.g. non-agency providers exceeding 40 hours/week across all services and all claims are identified) through ODM's billing and claims system and additional management reports.

In addition, the State conducts retrospective reviews and audits to assure the accuracy of provider billing to the participant's Person-centered service plan, e.g., structural reviews and unit of service verification activities as set forth in OAC rule 5160-45-06. SURS has overall responsibility for auditing all Medicaid fee-for-service billing. Federal and state audits also verify billing accuracy.

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:

☐ ***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.

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:

Less than 1% of Ohio Home Care Waiver providers are public providers. Types of public providers that receive payment for waiver services include city and county health departments with HHA services, and public ICFs-IID providing Out-of-Home Respite Services. Public providers furnish the same services that private providers furnish. Reimbursement rates are established in the Ohio Administrative Code and are the same rates paid to private providers of the same services.

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.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- (●) ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ( ) ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) ***This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

- [x] ***Appropriation of State Tax Revenues to the State Medicaid Agency***
- [ ] ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

  If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Only one Ohio Home Care Waiver service is offered in a residential setting. Out-of-Home Respite Services falls under the exception listed in 42 CFR 441.310 (a)(2). It is reimbursed at a daily rate and the rate includes 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: Hospital, Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	18643.50	52414.89	71058.39	72127.09	26185.67	98312.76	27254.37
2	19998.57	54511.48	74510.05	75012.17	27233.10	102245.27	27735.22
3	26035.06	56691.94	82727.00	78012.66	28322.42	106335.08	23608.08
4	33954.38	58959.62	92914.00	81133.17	29455.32	110588.49	17674.49
5	34297.64	61318.00	95615.64	84378.49	30633.53	115012.02	19396.38

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		Hospital	Nursing Facility
Year 1	10212	510	9702
Year 2	10968	550	10418
Year 3	11724	590	11134
Year 4	12480	620	11860
Year 5	13236	660	12576

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The average length of stay (ALOS) has been projected based on actual experience from the current waiver period, reflecting year-over-year increases during the new five-year waiver period based on projected phase-in and phase-out assumptions. The calculation of the ALOS estimate of 287 for WY 1 in the renewal period is equal to the projected total number of days for members on the waiver during WY 1 divided by the unduplicated participant count (2,925,852/10,212). The ALOS is calculated based on actual experience through June 2020 and estimated phase-in and phase-out assumptions for future time periods. Changes in ALOS over the course of the five-year renewal period are based on projected changes in enrollees over the waiver period and reflecting slightly different stays with more people phasing into the waiver than phasing out in a given year.

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 costs for the Ohio Home Care Waiver program is based on actual experience from ODM vendor files with data through late August 2020. Specifically, the State summarized unduplicated participants and days of waiver enrollment for the historical time periods. Total expenditures from the vendor files were summarized for each waiver service category for the identified Ohio Home Care Waiver participants, divided between the waiver services (Factor D) and state plan services (Factor D').

Factor D for the new five-year waiver period for the renewal (July 1, 2021 through June 30, 2026) was projected from Waiver Year 3 of the current renewal data in the following manner.

- Base number of users was calculated by determining the allocated number of users from the historical experience as described above. The percentage of individuals identified as using a service from the historical unduplicated participant count was applied to future projected unduplicated participant counts to determine the number of users across the five-year renewal period. Therefore, a projected number of users for WY 1 represents historical experience of users for WY 3 (July 1, 2018 to June 30, 2019) multiplied by the change in unduplicated participant count from current WY 3 to the renewal WY 1. Growth from WY 1 to WY 5 of the renewal period applied the same methodology, which reflects an approximate 30% composite increase from WY 1 to WY 5 of the renewal period in unduplicated participants.

** Separate number of users were established for the Personal Care Aide Services, Community Transition Services, Community Integration Service, and Home Maintenance and Chore Service categories. These services were initialized based on WY 5 (July 1, 2020 to June 30, 2021) of the current waiver filing. The estimates for these services were based on current WY 5 estimates due to the lack of historical experience associated with the current service definitions in the WY 3 time period.*

- The cost volume from vendor file FFS claims data for the Ohio Home Care Waiver Program in WY 3 (July 1, 2018 to June 30, 2019) aligns with the most currently available final OHCW CMS 372 Report, fiscal year 2018. The State combined this base data claims volume with the prescribed unit cost as described below and unduplicated users as described above to calculate the baseline utilization per user. Grow from WY 1 to WY 5 of the renewal period was developed by multiplying the change in ALOS to the baseline average units per user.

** Community Transition Services, Personal Emergency Response System – Installation and Testing, and Home Maintenance and Chore were held constant at 1 as these services should only be utilized once per user.*

- Unit costs were established based on the following methodologies:
Services in the Ohio Home Care Waiver program that have prescribed reimbursement rates per the Ohio Home Care Waiver policy reimbursement and billing procedures policy set forth in OA 5160-46-06 include: Adult Day Health Center Services, Community Transition Service, Community Integration Service, Personal Emergency Response System - Installation and Testing, Personal Emergency Response System – Service Fee, Home Delivered Meals, Out-of-Home Respite, and Supplemental Transportation. These unit costs were held constant over the five-year waiver renewal period.

- Separate cost per unit rates were established based on a review of historical experience from WY 3 (July 1, 2018 to June 30, 2019) and currently filed WY 5 values. The State has applied an annualized trend of 4% for these unit costs through the 5-year renewal period based on a review of historical trends for similar services in the State of Ohio Medicaid programs.

Added as part of January 2022 Amendment
As a result of Ohio's House Bill 110, The Ohio Department of Medicaid (ODM) biennial budget incorporates billing maximum rate increases for waiver nursing, personal care aide, home care attendant, home delivered meals, and adult day services in the Ohio Home Care waiver program. The purpose of this amendment is to incorporate the appropriated service rate increases, equivalent to a 6.1% increase for waiver nursing, personal care aide, and home care attendant services, 10.76% for home delivered meals, and a 25% increase for adult day services for WY 1-5.

*** As a result of proposed budgetary changes effective January 1, 2024 the average cost per unit for Waiver*

Nursing, Personal Care Aide Services, Home Care Attendant, Adult Day Health Center Services, Home Delivered Meals, Home Modification Services and Supplemental Transportation were updated. These changes reflect additional funding specific for SFY 2024 and SFY 2025 which coincide with WY 3 and WY 4. We have held the average cost per unit constant in WY 5 for the identified services. No adjustments were made to other services from the previously approved submission.

**** The cost per unit increases reflect the following for the listed services from the previously approved submission:*

- *Adult Day Health – 4.3% for WY 3,16.2% for WY 4*
- *Personal Care Aide – 24.5% for WY 3, 55.7% for WY 4*
- *Home Care Attendant – 24.6% for WY 3, 55.7% for WY 4*
- *Home Delivered Meals – 9.8% for WY 3, 20.8% for WY 4*
- *Home Modification Services – 9.3% for WY 3, 32.7% for WY 4*
- *Waiver Nursing – 22.6% for WY 3, 46.1% for WY 4*

These increases were based on legislative changes under Ohio House Bill 33 targeting the nursing services crisis and the ability to provide quality home and community based services. These noted increases were part of a planned provider rate increase of approximately 40% across the HCBS program. The percentages vary by service due to the budgetary appropriations made for the different services. The total projected impact of these changes reflected an approximate $57 million increase for SFY 2024 and an additional increase of approximately $146 million for SFY 2025. As the changes will take effect January 1, 2024, the impact is only for a portion of WY 3 with the full effect of the changes noted in WY 4 and WY 5.

September 2024 Amendment

With the inclusion of self-direction in the Ohio Home Care waiver program for WY 4, a separate number of users were established for the Goods and Services and Structured Family Caregiving services based on the estimated number of individuals choosing to self-direct their care. The number of self-directing individuals and users of Structured Family Caregiving services on the waiver are each independently estimated to be approximately 2% of all Personal Care Aide Services users in the filed waivers for WY4 and WY5. The number of Goods and Services users are estimated to be approximately 40% of all self-directing individuals on the waiver in WY4 and WY5 with the number of users for WY 4 prorated based on the September 9, 2024 effective date.

It is anticipated that the Structured Family Caregiving service is budget neutral to the HCBS waiver program based on the assumption that a portion of users of the Personal Care Aide Services will instead utilize Structured Family Caregiving. With a small number of exceptions, providers will not be able to bill for Structured Family Caregiving Services and Personal Care Aide Services on the same day. The average units per user is prorated for WY 4 based on the service not being effective until September 9, 2024. The WY4 estimated average cost per unit is based on a review of similar service offerings in other states' HCBS programs. The number of users in WY5 for this service are trended at the same rate as Personal Care services. Average cost per service over the waiver period is allowed to vary such that the addition of this service remains budget neutral to the HCBS program. The Goods and Services WY4 units per user and average cost per unit were estimated based on experience for similar services offered under other Ohio HCBS programs. No additional cost per unit or utilization trend has been estimated for this service from WY4 to WY5.

July 2025 Amendment
It is anticipated that the Vehicle Modification service is budget neutral to the HCBS waiver program since vehicle modification was previously available within the Supplemental Adaptive and Assistive Devices service. The Vehicle Modification WY5 units per user of 1 and average cost per unit of $10,000 reflects the annual limit per user. The estimated number of users of Vehicle Modifications was selected based on an assumed percentage of users of the Supplemental Adaptive and Assistive Devices, consistent with experience for similar services under other Ohio HCBS programs.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Base Year data for Factor D' was developed based on the state plan services identified in the base data summarization process discussed above.

Factor D' was trended at a rate of 4% per year based on historical experience and budget forecast trends for acute care services covered within D'. An annual inflation factor of 4.0% was applied to the Factor D' expenditures to reflect increases from WY 1 to WY 5. This adjustment is based on a review of historical trends and budget forecasts for acute care services covered within D'.

Estimates of Factor D' for each waiver year are illustrated in the cost neutrality in Table 1.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Base Year data reflects currently filed Factor G costs for WY 5 for the current waiver: July 1, 2020 through June 30, 2021.

Factor G was trended at a rate of 4% per year based on historical experience and budget forecast trends to assess future Ohio Home Care Waiver expenses. Institutional costs (Factor G) were prospectively trended using an annual inflation factor of 4.0% based on a review of historical experience and budget forecasts specific to institutional costs covered under Factor G.

Estimates of Factor G for each waiver year are illustrated in the cost neutrality summary in Table 1.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Base Year data reflects currently filed Factor G' costs for WY 5 of the current waiver year: July 1, 2020 through June 30, 2021.

Factor G' was trended at a rate of 4% per year based on historical experience and budget forecast trends to assess future Ohio Home Care Waiver expenses. An annual inflation factor of 4.0% was also applied to the Factor G' expenditures to reflect increases from WY 1 to WY 5. Consistent with other trend adjustments, this was developed based on a review of historical trends and budget forecasts for acute care services covered within G'.

Estimates of Factor G' for each waiver year are illustrated in the cost neutrality summary in Table 1.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Health Center Services	
Personal Care Aide Services	
Community Integration Services	
Community Transition Services	
Home Care Attendant Services	
Home Delivered Meal Services	
Home Maintenance and Chore Services	
Home Modification Services	
Out-of-Home Respite Services	
Personal Emergency Response Systems	
Self-directed goods and services	

Waiver Services	
Structured Family Caregiving Services	
Supplemental Adaptive and Assistive Device Services	
Supplemental Transportation Services	
Vehicle Modification	
Waiver Nursing Services	

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
Adult Day Health Center Services Total:						**567290.88**
Adult Day Health Center Services	1 day	90	83.20	75.76	**567290.88**	
Personal Care Aide Services Total:						**165233503.20**
Personal Care Aide Services	1/4 hour	7588	4828.30	4.51	**165233503.20**	
Community Integration Services Total:						**12176.50**
Community Integration Services	1/4 hour	49	71.00	3.50	**12176.50**	
Community Transition Services Total:						**714000.00**
Community Transition Services	per item	357	1.00	2000.00	**714000.00**	
Home Care Attendant Services Total:						**888857.76**
Home Care Attendant Services	1/4 hour	42	4166.00	5.08	**888857.76**	
Home Delivered Meal Services Total:						**4444419.21**
Home Delivered Meal Services	1 meal	3215	211.70	6.53	**4444419.22**	

GRAND TOTAL:	**190387409.31**
Total Estimated Unduplicated Participants:	**10212**
Factor D (Divide total by number of participants):	**18643.50**
Average Length of Stay on the Waiver:	287

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Maintenance and Chore Services Total:						**619783.77**
Home Maintenance and Chore Services	1 job	771	1.00	803.87	**619783.77**	
Home Modification Services Total:						**4528904.18**
Home Modification Services	1 item	886	1.00	5111.63	**4528904.18**	
Out-of-Home Respite Services Total:						**53671.65**
Out-of-Home Respite Services	1 day	17	15.80	199.82	**53671.65**	
Personal Emergency Response Systems Total:						**1663750.94**
Emergency Response Services-Service fee, per month	1 monthly	5828	8.40	32.95	**1613073.84**	
Emergency Response Services-Installation and Testing	1 time installation	1538	1.00	32.95	**50677.10**	
Self-directed goods and services Total:						**0.00**
Self-directed goods and services	0	0	0.00	0.01	**0.00**	
Structured Family Caregiving Services Total:						**0.00**
Structured Family Caregiving Services	0	0	0.00	0.01	**0.00**	
Supplemental Adaptive and Assistive Device Services Total:						**1901960.68**
Supplemental Adaptive and Assistive Device Services	1 item	1134	1.10	1524.74	**1901960.68**	
Supplemental Transportation Services Total:						**1009.74**
Supplemental Transportation Services	1 mile	4	664.30	0.38	**1009.74**	
Vehicle Modification Total:						**0.00**
Vehicle					**0.00**	

GRAND TOTAL:	**190387409.31**
Total Estimated Unduplicated Participants:	**10212**
Factor D (Divide total by number of participants):	**18643.50**
Average Length of Stay on the Waiver:	287

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Modification		0	0.00	0.01		
Waiver Nursing Services Total:						**9758080.80**
Waiver Nursing Services	15 minutes	1482	744.00	8.85	**9758080.80**	

GRAND TOTAL:	**190387409.31**
Total Estimated Unduplicated Participants:	**10212**
Factor D (Divide total by number of participants):	**18643.50**
Average Length of Stay on the Waiver:	287

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
Adult Day Health Center Services Total:						**659311.49**
Adult Day Health Center Services	1 day	96	84.60	81.18	**659311.49**	
Personal Care Aide Services Total:						**190972006.20**
Personal Care Aide Services	1/4 hour	8150	4912.40	4.77	**190972006.20**	
Community Integration Services Total:						**13393.10**
Community Integration Services	1/4 hour	53	72.20	3.50	**13393.10**	
Community Transition Services Total:						**768000.00**
Community Transition Services	per item	384	1.00	2000.00	**768000.00**	
Home Care Attendant Services Total:						**1026165.06**
Home Care Attendant Services	15 minutes	45	4238.60	5.38	**1026165.06**	

GRAND TOTAL:	**219344326.55**
Total Estimated Unduplicated Participants:	**10968**
Factor D (Divide total by number of participants):	**19998.57**
Average Length of Stay on the Waiver:	292

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Delivered Meal Services Total:						**4856858.59**
Home Delivered Meal Services	1 meal	3453	215.40	6.53	**4856858.59**	
Home Maintenance and Chore Services Total:						**692224.56**
Home Maintenance and Chore Services	1 job	828	1.00	836.02	**692224.56**	
Home Modification Services Total:						**5060917.68**
Home Modification Services	1 item	952	1.00	5316.09	**5060917.68**	
Out-of-Home Respite Services Total:						**57907.84**
Out-of-Home Respite Services	1 day	18	16.10	199.82	**57907.84**	
Personal Emergency Response Systems Total:						**1807702.90**
Emergency Response Services-Service fee, per month	1 monthly	6260	8.50	32.95	**1753269.50**	
Emergency Response Services-Installation and Testing	1 time installation	1652	1.00	32.95	**54433.40**	
Self-directed goods and services Total:						**0.00**
Self-directed goods and services	0	0	0.00	0.01	**0.00**	
Structured Family Caregiving Services Total:						**0.00**
Structured Family Caregiving Services	0	0	0.00	0.01	**0.00**	
Supplemental Adaptive and Assistive Device Services Total:						**2124561.05**
Supplemental Adaptive and Assistive Device Services	1 item	1218	1.10	1585.73	**2124561.05**	
Supplemental Transportation Services Total:						**1027.37**
Supplemental					**1027.37**	

GRAND TOTAL:	**219344326.55**
Total Estimated Unduplicated Participants:	**10968**
Factor D (Divide total by number of participants):	**19998.57**
Average Length of Stay on the Waiver:	292

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation Services	1 mile	4	675.90	0.38		
Vehicle Modification Total:						**0.00**
Vehicle Modification		0	0.00	0.01	**0.00**	
Waiver Nursing Services Total:						**11304250.72**
Waiver Nursing Services	15 minutes	1592	757.00	9.38	**11304250.72**	

GRAND TOTAL:	**219344326.55**
Total Estimated Unduplicated Participants:	**10968**
Factor D (Divide total by number of participants):	**19998.57**
Average Length of Stay on the Waiver:	292

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Center Services Total:						**749918.28**
Adult Day Health Center Services	1 day	103	86.00	84.66	**749918.28**	
Personal Care Aide Services Total:						**269447654.52**
Personal Care Aide Services	1/4 hour	8712	4996.50	6.19	**269447654.52**	
Community Integration Services Total:						**14643.30**
Community Integration Services	1/4 hour	57	73.40	3.50	**14643.30**	
Community Transition Services Total:						**820000.00**
Community Transition Services	per item	410	1.00	2000.00	**820000.00**	
Home Care						**1444424.45**

GRAND TOTAL:	**305235003.98**
Total Estimated Unduplicated Participants:	**11724**
Factor D (Divide total by number of participants):	**26035.06**
Average Length of Stay on the Waiver:	297

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Services Total:						
Home Care Attendant Services	15 minutes	48	4311.20	6.98	**1444424.45**	
Home Delivered Meal Services Total:						**5798365.38**
Home Delivered Meal Services	1 meal	3691	219.10	7.17	**5798365.38**	
Home Maintenance and Chore Services Total:						**769472.10**
Home Maintenance and Chore Services	1 job	885	1.00	869.46	**769472.10**	
Home Modification Services Total:						**6150023.04**
Home Modification Services	1 item	1018	1.00	6041.28	**6150023.04**	
Out-of-Home Respite Services Total:						**62263.91**
Out-of-Home Respite Services	1 day	19	16.40	199.82	**62263.91**	
Personal Emergency Response Systems Total:						**1954218.37**
Emergency Response Services-Service fee, per month	1 monthly	6691	8.60	32.95	**1896028.67**	
Emergency Response Services-Installation and Testing	1 time installation	1766	1.00	32.95	**58189.70**	
Self-directed goods and services Total:						**0.00**
Self-directed goods and services	0	0	0.00	0.01	**0.00**	
Structured Family Caregiving Services Total:						**0.00**
Structured Family Caregiving Services	0	0	0.00	0.01	**0.00**	
Supplemental Adaptive and Assistive Device Services Total:						**2361912.63**
Supplemental Adaptive and Assistive Device	1 item	1302	1.10	1649.15	**2361912.63**	

GRAND TOTAL:	**305235003.98**
Total Estimated Unduplicated Participants:	**11724**
Factor D (Divide total by number of participants):	**26035.06**
Average Length of Stay on the Waiver:	297

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services						
Supplemental Transportation Services Total:						**1155.00**
Supplemental Transportation Services	1 mile	4	687.50	0.42	**1155.00**	
Vehicle Modification Total:						**0.00**
Vehicle Modification		0	0.00	0.01	**0.00**	
Waiver Nursing Services Total:						**15660953.00**
Waiver Nursing Services	15 minutes	1702	770.00	11.95	**15660953.00**	

GRAND TOTAL:	**305235003.98**
Total Estimated Unduplicated Participants:	**11724**
Factor D (Divide total by number of participants):	**26035.06**
Average Length of Stay on the Waiver:	297

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
Adult Day Health Center Services Total:						**905005.20**
Adult Day Health Center Services	1 day	110	87.20	94.35	**905005.20**	
Personal Care Aide Services Total:						**371755523.72**
Personal Care Aide Services	1/4 hour	9274	4979.60	8.05	**371755523.72**	
Community Integration Services Total:						**15884.40**
Community Integration Services	1/4 hour	61	74.40	3.50	**15884.40**	
Community Transition Services						**872000.00**

GRAND TOTAL:	**423750707.61**
Total Estimated Unduplicated Participants:	**12480**
Factor D (Divide total by number of participants):	**33954.38**
Average Length of Stay on the Waiver:	301

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:						
Community Transition Services	per item	436	1.00	2000.00	**872000.00**	
Home Care Attendant Services Total:						**2018878.76**
Home Care Attendant Services	15 minutes	51	4369.30	9.06	**2018878.76**	
Home Delivered Meal Services Total:						**6885057.80**
Home Delivered Meal Services	1 meal	3929	222.10	7.89	**6885057.80**	
Home Maintenance and Chore Services Total:						**851794.08**
Home Maintenance and Chore Services	1 job	942	1.00	904.24	**851794.08**	
Home Modification Services Total:						**8270182.88**
Home Modification Services	1 item	1084	1.00	7629.32	**8270182.88**	
Out-of-Home Respite Services Total:						**66340.24**
Out-of-Home Respite Services	1 day	20	16.60	199.82	**66340.24**	
Personal Emergency Response Systems Total:						**2103574.13**
Emergency Response Services-Service fee, per month	1 monthly	7122	8.70	32.95	**2041628.13**	
Emergency Response Services-Installation and Testing	1 time installation	1880	1.00	32.95	**61946.00**	
Self-directed goods and services Total:						**161820.00**
Self-directed goods and services	per item	62	6.00	435.00	**161820.00**	
Structured Family Caregiving Services Total:						**6285784.96**
Structured Family Caregiving Services	per day	185	291.70	116.48	**6285784.96**	
Supplemental						**2614871.95**

GRAND TOTAL:	**423750707.61**
Total Estimated Unduplicated Participants:	**12480**
Factor D (Divide total by number of participants):	**33954.38**
Average Length of Stay on the Waiver:	301

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adaptive and Assistive Device Services Total:						
Supplemental Adaptive and Assistive Device Services	1 item	1386	1.10	1715.12	**2614871.95**	
Supplemental Transportation Services Total:						**1393.60**
Supplemental Transportation Services	1 mile	4	696.80	0.50	**1393.60**	
Vehicle Modification Total:						**0.00**
Vehicle Modification		0	0.00	0.01	**0.00**	
Waiver Nursing Services Total:						**20942595.89**
Waiver Nursing Services	15 minutes	1812	780.40	14.81	**20942595.89**	

GRAND TOTAL:	**423750707.61**
Total Estimated Unduplicated Participants:	**12480**
Factor D (Divide total by number of participants):	**33954.38**
Average Length of Stay on the Waiver:	301

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
Adult Day Health Center Services Total:						**972531.49**
Adult Day Health Center Services	1 day	117	88.10	94.35	**972531.50**	
Personal Care Aide Services Total:						**396838738.49**
Personal Care Aide Services	1/4 hour	9639	5114.30	8.05	**396838738.48**	
Community Integration Services Total:						**17085.25**

GRAND TOTAL:	**453963627.28**
Total Estimated Unduplicated Participants:	**13236**
Factor D (Divide total by number of participants):	**34297.64**
Average Length of Stay on the Waiver:	304

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Integration Services	1/4 hour	65	75.10	3.50	**17085.25**	
Community Transition Services Total:						**924000.00**
Community Transition Services	per item	462	1.00	2000.00	**924000.00**	
Home Care Attendant Services Total:						**2158918.27**
Home Care Attendant Services	15 minutes	54	4412.80	9.06	**2158918.27**	
Home Delivered Meal Services Total:						**7374452.41**
Home Delivered Meal Services	1 meal	4167	224.30	7.89	**7374452.41**	
Home Maintenance and Chore Services Total:						**939469.59**
Home Maintenance and Chore Services	1 job	999	1.00	940.41	**939469.59**	
Home Modification Services Total:						**8773718.00**
Home Modification Services	1 item	1150	1.00	7629.32	**8773718.00**	
Out-of-Home Respite Services Total:						**70496.50**
Out-of-Home Respite Services	1 day	21	16.80	199.82	**70496.50**	
Personal Emergency Response Systems Total:						**2255770.18**
Emergency Response Services-Service fee, per month	1 monthly	7553	8.80	32.95	**2190067.88**	
Emergency Response Services-Installation and Testing	1 time installation	1994	1.00	32.95	**65702.30**	
Self-directed goods and services Total:						**206190.00**
Self-directed goods and services	per item	79	6.00	435.00	**206190.00**	
Structured Family Caregiving Services Total:						**8110588.50**

GRAND TOTAL:	**453963627.28**
Total Estimated Unduplicated Participants:	**13236**
Factor D (Divide total by number of participants):	**34297.64**
Average Length of Stay on the Waiver:	304

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Structured Family Caregiving Services	per day	197	350.00	117.63	**8110588.50**	
Supplemental Adaptive and Assistive Device Services Total:						**2784290.08**
Supplemental Adaptive and Assistive Device Services	1 item	1460	1.10	1733.68	**2784290.08**	
Supplemental Transportation Services Total:						**1407.40**
Supplemental Transportation Services	1 mile	4	703.70	0.50	**1407.40**	
Vehicle Modification Total:						**100000.00**
Vehicle Modification	1 item	10	1.00	10000.00	**100000.00**	
Waiver Nursing Services Total:						**22435971.12**
Waiver Nursing Services	1/4 hour	1922	788.20	14.81	**22435971.12**	

GRAND TOTAL:	**453963627.28**
Total Estimated Unduplicated Participants:	**13236**
Factor D (Divide total by number of participants):	**34297.64**
Average Length of Stay on the Waiver:	304