

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:

PASSPORT January 2025 Amendment

C. Waiver Number: OH.0198

Original Base Waiver Number: OH.0198.3

D. Amendment Number:

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

01/01/25

Approved Effective Date of Waiver being Amended: 07/01/23

2. Purpose(s) of Amendment

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

The purpose of this amendment is to include a new Medicaid eligibility category in Appendix B, 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).

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)
<input type="checkbox"/> Waiver Application	
<input type="checkbox"/> Appendix A Waiver Administration and Operation	

Component of the Approved Waiver	Subsection(s)
<input checked="" type="checkbox"/> Appendix B Participant Access and Eligibility	<div style="border: 1px solid black; width: 50%; margin: auto; padding: 5px;">B-4-b</div>
<input type="checkbox"/> Appendix C Participant Services	<div style="border: 1px solid black; width: 50%; margin: auto; height: 20px;"></div>
<input type="checkbox"/> Appendix D Participant Centered Service Planning and Delivery	<div style="border: 1px solid black; width: 50%; margin: auto; height: 20px;"></div>
<input type="checkbox"/> Appendix E Participant Direction of Services	<div style="border: 1px solid black; width: 50%; margin: auto; height: 20px;"></div>
<input type="checkbox"/> Appendix F Participant Rights	<div style="border: 1px solid black; width: 50%; margin: auto; height: 20px;"></div>
<input type="checkbox"/> Appendix G Participant Safeguards	<div style="border: 1px solid black; width: 50%; margin: auto; height: 20px;"></div>
<input type="checkbox"/> Appendix H	<div style="border: 1px solid black; width: 50%; margin: auto; height: 20px;"></div>
<input type="checkbox"/> Appendix I Financial Accountability	<div style="border: 1px solid black; width: 50%; margin: auto; height: 20px;"></div>
<input type="checkbox"/> Appendix J Cost-Neutrality Demonstration	<div style="border: 1px solid black; width: 50%; margin: auto; height: 20px;"></div>

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

- Modify target group(s)
 - Modify Medicaid eligibility
 - Add/delete services
 - Revise service specifications
 - Revise provider qualifications
 - Increase/decrease number of participants
 - Revise cost neutrality demonstration
 - Add participant-direction of services
 - Other
- Specify:

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

1. Request Information (1 of 3)

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

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

PASSPORT January 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.0198

Draft ID: OH.004.07.03

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/23

Approved Effective Date of Waiver being Amended: 07/01/23

PRA Disclosure Statement

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

- Hospital as defined in 42 CFR §440.10**

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

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

Nursing Facility

Select applicable level of care

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

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

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

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

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

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

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

§1915(b)(2) (central broker)

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

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

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

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

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

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

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The PASSPORT waiver offers home and community-based services (HCBS) to eligible individuals, as an alternative to receiving medicaid services in a nursing facility setting.

The goals and objectives of the waiver include:

1. Serving individuals meeting the following eligibility criteria:

- Age sixty or older at the time of enrollment.
- Determined to meet the criteria for an intermediate or skilled level of care in accordance with rule 5160-3-08 of the Administrative Code and, in the absence of PASSPORT, would require NF services as defined in 42 C.F.R. 440.40.
- Determined financially eligible for Medicaid.
- With assessed need for waiver services that do not exceed the individual cost limit of fourteen thousand and seven hundred dollars per month at the time of initial enrollment.
- The needed waiver services are not readily available through another source at the level required to allow the individual to live in the community.
- Agrees to participate in PASSPORT and while enrolled in PASSPORT, shall not be simultaneously enrolled in another medicaid home and community-based program or the program of all-inclusive care for the elderly.
- Health related needs can be safely met in a home and community-based setting as determined by ODA's designee.
- Participates in the development of a person-centered services plan in accordance with the process and requirements set forth in rule 5160-44-02 of the Administrative Code.
- Requires the provision of at least one waiver service on a monthly basis.
- Services in the person-centered services plan are approved by a medical practitioner, within the scope of his/her or their practice.
- Resides in a setting that possesses the home and community-based setting characteristics set forth in rule 5160-44-01 of the Administrative Code and not reside in a hospital, nursing facility (NF), intermediate care facility for individuals with an intellectual disability (ICF-IID) or another licensed/certified facility, any facility covered by section 1616(e) of the Social Security Act (42 U.S.C. 1382e(e)), residential care facility, adult foster home or another group living arrangement subject to state licensure or certification.

2. Increasing choice and control of HCBS through

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

3. Maintaining cost neutrality.

The organizational structure of the PASSPORT waiver is comprised of the State Medicaid Agency Ohio Department of Medicaid (ODM), the Ohio Department of Aging (ODA), and ODA's designees (the thirteen PASSPORT Administrative Agencies (PAA's)). The ODM enters into a biennial interagency agreement (IAA) with the ODA and three-party agreements between ODM, ODA and ODA's designees.

ODM administers this waiver program through its oversight and supervision activities including:

- Program quality improvement and oversight and supervision of activities delegated to ODA and ODA's designees through the IAA and three-party agreements
- Monitoring ODAs compliance with state and federal law and policies relative to waiver operations
- The issuance of policies
- Both adopting and authorizing waiver program rules implemented in alignment with the approved waiver application, and applicable state and federal regulations.

ODA is the operational entity responsible for the daily management of the waiver including:

- monitoring the PAAs compliance with state and federal law and policies relative to waiver operations
- operational policies and procedures,
- ensuring appropriate mechanisms are in place to maintain the financial integrity of PASSPORT,
- managing waiver enrollment against approved limits,
- monitoring waiver expenditures against approved levels, and
- conducting utilization management functions.

The 13 regional entities PAAs are located across the state and are responsible for the day-to-day operation and management of the waiver, including the following activities:

- disseminating information concerning the waiver to potential enrollees
- assisting individuals in waiver enrollment,
- conducting level of care determinations,
- providing administrative case management, and
- recruiting providers.

Waiver assessors and case managers conduct person-centered comprehensive assessments of participant needs. Using information gathered through the assessment, the case manager works with the individual to build a service plan in accordance with 42 CFR 441.301 and arrange for the delivery of services, including the option to self-direct, to meet the individual's assessed needs.

The PASSPORT waiver provides participants access to nineteen (19) waiver services and includes both participant-directed and provider managed service delivery methods. Available services include:

- adult day service
- alternative meals
- choices home care attendant services
- home maintenance and chores
- personal emergency response system
- home medical equipment and supplies
- homemaker
- home modification
- nutritional consultation
- personal care
- social work or counseling
- home delivered meals
- community integration
- community transition
- non-medical transportation
- enhanced community living
- waiver nursing
- out-of-home respite
- home care attendant service

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

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

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

4. Waiver(s) Requested

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

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

Not Applicable

No

Yes

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

No

Yes

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

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

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

5. Assurances

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

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

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

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the state secures public input into the development of the waiver:

For each required public comment period associated with waiver program renewal and amendments, Ohio uses the following methods to notify the public of the opportunity to review and comment on the waiver renewal/amendment:

- **Electronic:** Ohio posts a public notice, summary of the draft waiver, the draft waiver itself on the ODM website. ODA and the 13 PAAs post public notices on their websites, which link to the ODM website. The public has the ability to submit electronic comments via email to a mailbox designated by the state. The public may also submit written comments to the state at a mailing address designated to receive written comments.
- **Non-Electronic:** 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 waiver and the proposed amendments.
- The Area Agencies on Aging, as the lead agency for the state's Aging and Disability Network, posts a copy of the Public Notice and Request for Comment announcement in their offices, which includes information about how to obtain a non-electronic copy of the waiver and a summary of the proposed revisions to the draft statewide transition plan.
- Stakeholder advisory groups. Announcements are issued to ODA Stakeholder Advisory Groups regarding the formal public comment period with a request to disseminate the information to their respective colleagues and distribution lists, which link to the electronic documents.

September 2024 Amendment:

The proposed September 2024 PASSPORT Amendment received a total of nine comments through the public comment period from 05/03/2024-06/01/2024. Most of the feedback revolved around the incorporation of the new Structured Family Caregiving service.

Structured Family Caregiving Service

The State received comments on the addition of the Structured Family Caregiving Service that were specific to the version of the proposed rule for the new service. As a result of stakeholder feedback received for proposed new rule 5160-44-33 Nursing facility-based level of care home and community-based services programs structured family caregiving services, the Ohio Department of Medicaid determined additional edits to the rule were needed. The following changes were made to the proposed new rule:

- Better defined role of the caregiver.
- Provider requirements are specific to waiver program.
- Better defined full day and half day of service.
- To avoid duplication, rules where requirements already exist were cited.

The updated proposed new rule will be posted for public comment on the Ohio Department of Medicaid's rule page soon.

The State received positive comments supporting the inclusion of the LPN and SWT as eligible licensure for initial and re-evaluation of waiver enrollees.

The State also received comments that did not relate to the proposed amendment changes. Topics included:

- Alignment across the nursing facility level of care waivers,
 - *Comments focused on alignment and consistent naming conventions related to PASSPORT Participant Direction vs. Ohio Home Care and MyCare Ohio waivers Self-Direction.
- Increase the home modification amount of \$10,000 in a calendar year,
- Recommendations to operational changes.

The State addressed the above comments. The Ohio Department of Medicaid and the Ohio Department of Aging will collaborate to work on continued waiver alignment efforts and Ohio Administrative Code updates.

No changes were made to the waiver application as a result of stakeholder feedback received.

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 (ODM)

Address:

50 W. Town Street, Suite 400

Address 2:

P. O. Box 182709

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:

Jones

First Name:

Sarah

Title:

Agency:

Address:

Address 2:

City:

State: **Ohio**

Zip:

Phone: **Ext:** **TTY**

Fax:

E-mail:

8. Authorizing Signature

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Ohio**

Zip:

Phone: Ext: TTY

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

- Replacing an approved waiver with this waiver.
- Combining waivers.
- Splitting one waiver into two waivers.
- Eliminating a service.
- Adding or decreasing an individual cost limit pertaining to eligibility.
- Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
- Reducing the unduplicated count of participants (Factor C).
- Adding new, or decreasing, a limitation on the number of participants served at any point in time.
- Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
- Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

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

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

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

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

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

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

- The waiver is operated by the state Medicaid agency.**

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

- The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

Ohio Department of Aging Division for Community Living

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid

Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

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

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

The Ohio Department of Medicaid (ODM), as the single State Medicaid Agency, maintains administrative oversight of operational and policy development at the Ohio Department of Aging (ODA), the operation agency, through an interagency agreement between ODM and ODA, and thirteen three-party agreements with ODM, ODA and the Passport Administrative Agencies (PAAs). These agreements provide for ODM reviews of programmatic compliance with federal and state laws and regulations and in addition to auditing and fiscal compliance.

The PAA's, which serve as ODA's designee as outlined in the agreement, are delegated responsibility for the daily operation of the PASSPORT waiver as designated ODAs designees. ODA is primarily responsible for monitoring the PAAs compliance with state and federal law and policies relative to waiver operations.

ODM's oversight of ODA performance occurs through a combination of on-site assessment, reviews of performance data and management reports, interagency quality briefings, and fiscal reviews. ODM monitors ODA's compliance and performance by:

1) Performing Targeted Reviews of HCBS waiver participants (described below and in Appendix H)

ODM will identify a target group of waiver participants using claims and diagnosis information. ODM's staff will perform reviews of the target group to identify best practices as well as areas for improvement in waiver operations, including both service delivery and case management. These reviews will help the State identify and implement system changes that address vulnerabilities and improve individuals' experiences and health outcomes.

2) Conducting the Continuous Review of ODA Performance Data (described below and in Appendix H);

ODM will also examine performance data and other information gathered both by ODM and ODA to measure compliance and performance with respect to the federal waiver assurances including service planning, care management, free choice of provider, level of care, health and welfare, hearing rights, participant satisfaction, and validation of service delivery.

This data and any remediation (if necessary) will be submitted in accordance with the approved performance measures in the waiver. This information will also be used by ODM to complete the quality sections of the CMS 372 report required to demonstrate cost neutrality in the waiver.

3) Assuring the resolution of case-specific problems.

4) Generating and compiling quarterly performance data.

5) Convening operating agency Quality Briefings at a minimum, twice a year.

ODM will host quality briefings for ODM and ODA to review and discuss both monitoring and oversight processes and quality data. Quality briefings will be informed by data and other findings gathered through the mechanisms and activities described throughout this section. The State will also discuss additional program information obtained through ODAs monitoring and review activities, including any area of PAA or waiver service provider non-compliance and/or opportunities to identify best practices throughout the program.

The departments will review strategies used to impact program improvement in areas where deficiencies were detected, discuss what corrective measures are or were taken, and how the operating agency verified, or intends to verify, that the actions were effective.

6) Convening multi-agency quality forums (the Quality Steering Committee described further below and in Appendix H) approximately four times per year;

ODM convenes the interagency HCBS waiver quality steering committee (QSC), comprised of mid-level management staff to monitor waiver operations. The QSC 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. Reports for programs may include monthly enrollment, disenrollment & census reports; data gathered through the waiver’s approved performance measures; financial reports, and annual provider certification & activity reports.

The QSC 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.

7) Performing fiscal reviews and audits (described below and in Appendix I).

Ongoing fiscal reviews includes desk reviews of administrative costs and A-133 Audits, which occur at least every three years based on risk.

In the event areas of non-compliance or opportunities to improve program performance are identified through ODM monitoring and oversight activities, ODM may require ODA to develop and implement quality improvement plans and monitor their effectiveness at achieving desired outcomes.

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.:*

- 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:

As ODA's designee, the waiver operations are conducted by thirteen PASSPORT Administrative Agencies (PAA) of which twelve are Area Agencies on Aging and one is a not-for-profit human services agency), designated by ODA as PASSPORT Administrative Agencies (PAAs). Two of the Area Agencies on Aging are non-state public agencies. One is a city agency and the other is a federally designated Regional Planning and Development Commission. The remaining eleven are regional non-governmental, non-state entities.

The relationship, roles, and responsibilities of the PAA, ODA, and ODM are defined in an interagency agreement, referred to as the three-party agreement. This agreement gives ODM the authority to review and provide oversight to all programmatic functions. Through the three-party agreement, operational responsibility is delegated to ODA's designees for screening and level of care evaluations, assessment, and administrative case management.

ODA's designees are responsible for testifying at state hearings and are bound by the hearing officer decisions.

Through the three-party agreement, operational responsibility is delegated to ODA's designees for the recruitment, screening and facilitating the certification and enrollment of the HCBS waiver providers to ensure an adequate supply of qualified providers. ODA's designees maintain HCBS waiver provider quality assurance processes to ensure provider claims for waiver services don't exceed the authorized limits as specified in approved service plans, that enrollees were eligible for waiver services on the service claim dates and verifying waiver services were delivered on the claim's dates submitted by the provider.

All functions are subject to the quality control oversight of ODM and ODA. The ODM conducts scheduled, and as needed, reviews of ODA's oversight of the ODA designees. The Office of Research, Assessment and Accountability (ORAA) conduct audits of ODA's designees at least every three years based on risk.

- 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:

Same as the description above.

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:

The three-party agreement outlines the responsibilities of each entity and the processes established to assure compliance with operational and administrative functions.

ODM's monitoring and oversight ensures ODA is exercising its authority for the day-to-day operation of the waiver in accordance with federal Medicaid requirements. ODM supports and facilitates ongoing qualitative improvements in the systems, procedures, and protocols that ODA employs to ensure the compliance of providers, participants, and other entities with federal Medicaid requirements. When a program component is determined to be out of compliance with the federal requirements, ODM works with ODA to identify the root cause and develop an appropriate systematic remediation plan.

ODA monitoring and oversight ensures ODA's designees have established procedures to ensure the compliance of providers, participants, and other entities with federal Medicaid requirements. When a program component is determined to be out of compliance with the federal requirements, ODA provides the necessary technical assistance and guidance so the PAAs can identify the root cause and develop an appropriate systemic and/or PAA-specific remediation plans.

Appendix A: Waiver Administration and Operation

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

The three-party agreements between the ODM, ODA, and the PAAs outline the responsibilities of the two state agencies for assessing the performance of the PAAs. ODM is responsible for ensuring ODA and PAA compliance with federal regulations, including the amount, duration and scope of services, free choice of providers, timeliness of delivery of services to waiver eligible participants and the availability of services statewide. Additionally, ODM conducts A-133 audits of the regional entities at least once every three years.

In addition, ODM reviews performance data and other information, facilitates interagency quality briefings, and convenes the interagency Quality Steering Committee (QSC).

ODA is responsible for assuring that PAAs perform their delegated responsibilities in accordance with the following, in order precedence: Code of Federal Regulations, Ohio’s HCBS waivers, Ohio Revised Code, Ohio Administrative Code, interagency agreements, and operational policies.

ODA's assessment methods and their frequency include annual reviews of the PAAs; on-site technical assistance visits performed as needed; monthly review of established performance indicators, and analysis of the results from the PAA quarterly retrospective record reviews. ODA analyzes the data, develops remediation plans (as needed), and oversees the implementation of the remediation plan and evaluates the subsequent results.

Appendix A: Waiver Administration and Operation

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

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Local Non-State Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

A-3: Number and percent of quality improvement plans required by Ohio Department of Medicaid (ODM) that were submitted on time by Ohio Department of Aging (ODA) and accepted by ODM. Numerator: Number of quality improvement plans required by ODM that were submitted on time by ODA 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: <input type="text" value="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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

A-2: Number and percent of quarterly performance measure reports that were submitted to Ohio Department of Medicaid (ODM) by Ohio Department of Aging on time and in the correct format. N: Number of quarterly performance measure reports submitted on time and in the correct 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(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="text"/>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

A-5-a: Number and percent of Passport Administrative Agency (PAA) monitoring reports submitted to Ohio Department of Medicaid (ODM) by Ohio Department of Aging on time and in the approved format. N: Number of reports submitted on time and in the approved format. D: Total number of PAA monitoring 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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>

	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>

Performance Measure:

A-1: Number and percent of quality briefings conducted timely between Ohio Department of Medicaid and Ohio Department of Aging (ODA) to review ODA 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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative

		Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

A-6: Number and percent of Passport Administrative Agency (PAA) activity reports submitted to Ohio Department of Medicaid (ODM) by Ohio Department of Aging on time and in the approved format. N: Number of reports submitted on time and in the approved format. D: Total number of PAA activity 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

A-4: Number and percent of annual quality monitoring and improvement reports submitted to Ohio Department of Medicaid (ODM) by Ohio Department of Aging on time and in the approved format. N: Number of reports submitted on time and in the approved format. D: Total number of annual quality monitoring and improvement 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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 20px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 20px;"></div>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 20px;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 20px;"></div>

Performance Measure:

A-5-b: Number and percent of Financial Management Services (FMS) entity monitoring reports submitted to Ohio Department of Medicaid (ODM) by Ohio Department of Aging on time and in the approved format. N: Number of reports submitted on time and in the approved format. D: Total number of FMS entity monitoring 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):
<input type="checkbox"/> State Medicaid	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

Agency		
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<div style="border: 1px solid black; width: 100%; height: 100%;"></div>

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

b. Methods for Remediation/Fixing Individual Problems

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

Activities by ODM for addressing individual problems include:

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

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

Quarterly Record Review - The PAAs submit quarterly reports to ODA on a series of performance and compliance measures. Through the information submitted by the PAAs, ODA is able to identify and address individual problems as they are discovered and provide technical assistance that may include plans of corrective action. When problems are discovered, the individual PAA is notified and technical assistance is provided using e-mail, phone contact and/or letters to PAA Director. When issues are noted that are systemic, ODA will provide statewide training and incorporate that corrective action into its monitoring during the next monitoring cycle.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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 A§441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input checked="" type="checkbox"/> Aged or Disabled, or Both - General					
	<input checked="" type="checkbox"/>	Aged	65		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Disabled (Physical)	60	64	
	<input type="checkbox"/>	Disabled (Other)			
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>
<input type="checkbox"/> Mental Illness					

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	<input type="checkbox"/>	Mental Illness		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Serious Emotional Disturbance		<input type="checkbox"/>	

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

Participants must be 60 years of age or older and meet the level of care criteria at the time of enrollment.

Individuals enrolled in the Passport waiver who are potentially subject to mandatory enrollment in the ICDS 1915(b)(c) waiver shall be eligible for participation in PASSPORT only until the date on which enrollment in the ICDS waiver commences. Transition into the ICDS waiver shall occur as described in the waiver's Transition Plan.

ODA will be permitted to enroll individuals disenrolling from another NF-LOC waiver who meet the eligibility criteria for the PASSPORT 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. The PASSPORT case manager at the PAA will assist the individual enrolling from another NF-LOC waiver to facilitate their transition.

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

- Not applicable. There is no maximum age limit
- The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

Once a Disabled (Physical) participant reaches the maximum age limit they then become part of the Aged category and continue on the PASSPORT waiver. As indicated in (B)(1)(a), there is no maximum age limit under the aged category.

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:

Not to exceed \$14,700 per month for waiver services.

- 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:

The individual applying for PASSPORT services is assessed prior to enrollment to identify long-term services and supports needs. If the individual's needs cannot be met within the cost limit, the individual may not be enrolled in PASSPORT. The individual may also be referred to a nursing home or another program that would meet the individual's needs.

Any individual denied access to the waiver because the individual's needs exceed the cost limit is informed of his or her right to a State hearing.

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 PAA 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 ODA the approval of the person-centered service plan authorizations when the monthly cost of waiver services exceeds \$14,700.

Service Specific Limitation: The inter-disciplinary clinical review committee process is also used to inform service planning for high risk individuals and for recommending to ODA 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.

The individual retains hearing rights in the event the clinical review committee does not approve the additional services 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 ODA 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	39807
Year 2	39807
Year 3	39807

Waiver Year	Unduplicated Number of Participants
Year 4	39807
Year 5	39807

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
Reserve capacity for waiver participants transitioning from the Ohio Home Care Waiver.
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):*

Reserve capacity for waiver participants transitioning from the Ohio Home Care Waiver.

Purpose *(describe):*

The state will reserve waiver slots to accommodate currently enrolled Ohio Home Care waiver (OH.0337) participants who will reach age 60 during this 5 year waiver cycle and will have the option to transition to the PASSPORT waiver. Waiver year 1 reserves capacity to facilitate transitioning individuals over 60 and remaining on the OHC waiver through Appendix K authority.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity is based on the projected number of currently enrolled Ohio Home Care Waiver (OH.0337) participants who will reach age 60 during this 5 year waiver cycle.

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

Waiver Year	Capacity Reserved
Year 1	1068
Year 2	562
Year 3	582
Year 4	602
Year 5	623

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 PASSPORT 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

Waiver Year	Capacity Reserved	
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:

The PASSPORT waiver is open to all eligible individuals. All applicants must meet all eligibility requirements that are rule-filed in Ohio Administrative Code.

Specifically, these rules are in Ohio Administrative Code in the ODM section:

- 5160-31-03 (Eligibility)
- 5160-31-04 (Enrollment)

In addition, eligibility and enrollment rules are in ODA's section of the Ohio Administrative Code:

- 173-42-02 (Eligibility)
- 173-42-03 (Enrollment)

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- §1634 State
 SSI Criteria State
 209(b) State

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

- No
 Yes

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

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

- Low income families with children as provided in §1931 of the Act
 SSI recipients
 Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
 Optional state supplement recipients
 Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

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

Specify percentage:

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

Specify:

- 42 CFR 435.110: Parents and other Caretaker Relatives
- Section 1925: Transitional Medical Assistance
- 42 CFR 435.115: Extended Medicaid due to Spousal Support Collections
- 42 CFR 435.116: Pregnant Women
- 42 CFR 435.130: 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 435.213: Certain Individuals Needing Treatment for Breast or Cervical Cancer
- 42 CFR 435.210: Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash Assistance
- 42 CFR 435.119: Adult Group - Individuals at or below 133% FPL Age 19 through 64 - newly eligible for all states

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- A special income level equal to:

Select one:

- 300% of the SSI Federal Benefit Rate (FBR)
- A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

- A dollar amount which is lower than 300%.

Specify dollar amount:

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
- Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
- Medically needy without spend down in 209(b) States (42 CFR §435.330)
- Aged and disabled individuals who have income at:

Select one:

- 100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

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

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

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

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

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who

is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

- The following standard included under the state plan**

Select one:

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

(select one):

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

Specify the percentage:

- A dollar amount which is less than 300%.**

Specify dollar amount:

- A percentage of the Federal poverty level**

Specify percentage:

- Other standard included under the state Plan**

Specify:

- The following dollar amount**

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

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

Specify:

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

- Other**

Specify:

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

- Not Applicable**
- The state provides an allowance for a spouse who does not meet the definition of a community spouse in**

§1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

Specify the amount of the allowance (select one):

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

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

- The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

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

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

- The amount is determined using the following formula:

Specify:

- Other

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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

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

i. Allowance for the personal needs of the waiver participant

(select one):

- SSI standard**
- Optional state supplement standard**
- Medically needy income standard**
- The special income level for institutionalized persons**
- A percentage of the Federal poverty level**

Specify percentage:

- The following dollar amount:**

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

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

Specify formula:

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

Other

Specify:

[Empty text box]

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:

[Empty text box]

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

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

Select one:

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

The state does not establish reasonable limits.

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

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

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

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

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

- Directly by the Medicaid agency
- By the operating agency specified in Appendix A
- By a government agency under contract with the Medicaid agency.

Specify the entity:

As ODA's designee, level of care evaluations and reevaluations are conducted by the PAAs, of which twelve are Area Agencies on Aging and one is a not-for-profit human services agency, designated by ODA as PASSPORT Administrative Agencies (PAAs). Two of the Area Agencies on Aging are non-state public agencies. One is a city agency and the other is a federally designated Regional Planning and Development Commission. The remaining eleven are regional non-governmental, non-state entities.

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

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

Registered Nurses (RN), Licensed Practical Nurses (LPN) 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 PAAs verify the current licensure status of applicants during the hiring process and PAAs provide training to enable staff to be certified by ODA as assessors/case managers. ODA reviewers verify that this activity has been completed during biennial reviews that include a review of personnel qualifications.

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

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

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

The ILOC criteria are met when long term care services and supports needs exceed the criteria for protective level of care. ILOC criteria includes skilled nursing service needs, skilled rehabilitation service needs, activities of daily living (ADL) assistance need, assistance with medication self-administration, and the need for twenty-four (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 are met when long-term services and supports needs exceed the criteria for the intermediate level of care or the developmental disabilities level of care. An individual 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.

The ODM 03697, "Level of Care Assessment" (rev. 7/2014) or alternative form, as defined in rule 5160-3-05 is used for level of care assessment. If an ODM approved alternative form is used, the outcomes of the evaluations are equivalent.

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.

The level of care for an individual seeking nursing nursing-facility based waiver services is determined through ODM assessment tools consistent with the criteria set forth in OAC 5160-3-08 and are integrated in ODM-approved assessment and case management system. They identify the medical, behavioral, and ADL/instrumental activities of daily living (IADL) needs of the individual. The assessment tool also includes an evaluation of the individual's living arrangements, family circumstances, caregiver needs, and formal/informal supports.

The ODM 03697, "Level of Care Assessment" (rev. 7/2014) or alternative form, as defined in rule 5160-3-05 is used for level of care assessment. If an ODM approved alternative form is used, the outcomes of the evaluations are equivalent.

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:

Per the 3-party agreement with ODM, ODA, and ODA’s designee, each PAA is required to complete the initial assessment within 10 working days after receiving a request for assessment, unless the individual or the individual’s family requests the assessment be completed at a later date. The individual can include other parties of their choosing in the assessment.

An RN, LPN, LSW, LISW, or SWT completes the assessment and determines whether the applicant meets the SLOC or ILOC criteria set forth in OAC rule 5160-3-08. The individual is also assessed for PASSPORT eligibility pursuant to OAC rule 5160-31-03.

The assessment is documented 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 results of the initial assessment and level of care determination are maintained in an ODM-approved assessment and case management system.

The process for re-evaluation of the 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*):

Timely re-evaluations are ensured through the PAA's use of an ODM-approved assessment and case management system that generates a report identifying waiver participants who are due for a re-evaluation. On a monthly basis, ODA runs this report retrospectively to ensure the timely completion of the re-evaluations.

In addition, ODA generates reports monthly that include timely reevaluations. By monitoring these reports, ODA identifies participants who do not receive their re-evaluations timely. In the event that ODA finds this type of discrepancy, ODA would provide remediation (technical assistance in the form of calls, emails, and if needed, on-site visits) to the PAA(s). If a statewide pattern or trend is noted, ODA will develop and implement strategies to educate the PAAs about program expectations and monitor compliance.

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

Electronically retrievable documentation of all level of care evaluations and reevaluations are maintained in an ODM-approved assessment and case management system and in accordance with state and federal regulations.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

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

Denominator: Total number new enrollees

Data Source (Select one):

Other

If 'Other' is selected, specify:

PASSPORT Information Management System (PIMS)

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence

		Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 participants with a level of care redetermination completed within 12 months of the previous level of care determination. Numerator: Number of level of care redetermination completed within 12 months of the previous level of care determination. Denominator: Total number of waiver participants with redetermination due.

Data Source (Select one):

Other

If 'Other' is selected, specify:

PASSPORT Information Management System (PIMS)

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

	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	
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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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>

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

Performance Measures

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

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

Performance Measure:

B-3: Number and percent of participants with LOC determinations/redeterminations reviewed that were completed using the processes and instruments required by the approved waiver. N: Number of participants that LOC determinations/redeterminations reviewed that were completed using the process required by the approved waiver D: Total number of participants with LOC

determinations completed

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: <input type="text" value="Regional PAA"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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

b. Methods for Remediation/Fixing Individual Problems

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

Activities by ODM for addressing individual problems include:

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

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

Quarterly Record Review - The PAAs submit quarterly reports to ODA on a series of performance and compliance measures. Through the information submitted by the PAAs, ODA is able to identify and address individual problems as they are discovered and provide technical assistance that may include plans of corrective action. When problems are discovered, the individual PAA is notified and technical assistance is provided using e-mail, phone contact and/or letters to PAA Director. When issues are noted that are systemic, ODA will provide statewide training and incorporate that corrective action into its monitoring during the next monitoring cycle.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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, assessors/case managers are responsible for collect information about the individual's strengths, needs and preferences and, determines if the individual meets level of care and other waiver eligibility requirements. From this comprehensive evaluation, the assessor/case manager presents the individual with options for having their needs met, which may include initial/on-going, if appropriate, enrollment in a Medicaid waiver or referral to alternative home and community-based or nursing facility services. The assessor may provide written materials or other documentation detailing the available options and supports the individual as they exercise freedom of choice.

The individual's choice to enroll in the Medicaid waiver is documented both in the electronic record and with their signature on the Agency-Client Agreement form. The assessor informs the individual of feasible care options available under the waiver and supports the individual as they exercise freedom of choice among the service options available.

The person-centered services plan is developed in accordance with federal and state person-centered planning requirements. OAC 5160-44-02 outlines nursing facility-based level of care home and community-based services programs: person-centered planning requirements.

- 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.

Written copies of the Agency-Client Agreement are maintained by the PAAs 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):

County Department of Job and Family Services (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.

ODA and PAA

ODA has policies and procedures in place to ensure that individuals enrolled on the PASSPORT who have communication barriers such as limited English proficiency (LEP) or a speech and/or hearing impairment are able to communicate effectively. The PAAs, acting as ODA's regional designee, assure interpretation services are available to participants through sub--contracts with local immigrant and refugee agencies and organizations serving the hearing impaired. Accommodations for limited English proficient participants are provided at the time of application, at assessment, and in conjunction with routine case management activities. Each PAA adapts program and educational materials to accommodate the language needs of participants served in their specific geographical location.

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 Service		
Statutory Service	Homemaker		
Statutory Service	Personal Care		
Other Service	Alternative Meals Service		
Other Service	Choices - Home Care Attendant Service (Participant Directed Home Care Attendant)		
Other Service	Community Integration		
Other Service	Community Transition		
Other Service	Enhanced Community Living Service		
Other Service	Home Care Attendant		
Other Service	Home Delivered Meals		
Other Service	Home Maintenance and Chore		

Service Type	Service
Other Service	Home Medical Equipment and Supplies
Other Service	Home Modification
Other Service	Non-medical Transportation
Other Service	Nutritional Consultation
Other Service	Out-of-Home Respite
Other Service	Personal Emergency Response System
Other Service	Social Work Counseling
Other Service	Structured Family Caregiving Services
Other Service	Waiver Nursing Service

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 Service

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04050 adult day health

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

"Adult day service" (ADS) means a regularly-scheduled service delivered at an adult day center in a non-institutional, community-based setting. ADS includes educational programming to support an individual's health and independence goals; at least one meal, but no more than two meals per day; and health status monitoring, skilled therapy services, and transportation to and from the center.

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Center

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Service

Provider Category:

Agency

Provider Type:

Adult Day Center

Provider Qualifications

License (specify):

Certificate (specify):

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:

- Active Medicaid provider agreement
- ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.
- Adult day service providers are provider owned and controlled service settings.

OAC 173-39-02.1 Adult Day Service Specifications establishes the parameters for the type of tasks and describes the timelines and documentation requirements for this service.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08050 homemaker

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

"Homemaker" means a service enabling individuals to achieve and maintain clean, safe and healthy environments, assisting individuals to manage their personal appointments and day-to-day household activities, and ensuring individuals maintain their current living arrangements. The service consists of general household activities, such as meal preparation and routine household care when persons regularly responsible for these activities are temporarily absent or unable to manage the home. Homemaker staff may act as travel attendants for individuals. Homemaker activities include the following when authorized in the person-centered services plan:

- Assistance with meal planning.
- Meal preparation, grocery purchase planning, and assisting individuals with shopping and other errands.
- Laundry, including folding, ironing, and putting away laundry.
- House cleaning including dusting furniture, sweeping, vacuuming, and mopping floors; kitchen care including dishes, appliances, and counters; bathroom care; emptying and cleaning bedside commodes; changing bed linens; washing inside windows within reach from the floor; and removing trash.
- Errands outside of the presence of the individual which are needed by the individual to maintain the individual's health and safety (e.g., picking up a prescription or groceries for the individual).

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

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Skilled Home Health Agency, Non-medical Home Health Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Skilled Home Health Agency, Non-medical Home Health Agency

Provider Qualifications

License *(specify):*

Current, valid license from the Ohio Department of Health, as applicable.

Certificate *(specify):*

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:

- Active Medicaid provider agreement
- ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

OAC 173-39-02.8 - Homemaker Service Specifications. This rule establishes the parameters for the type of tasks and describes the timelines and documentation requirements for this service.

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Personal Care service provides hands-on assistance with ADLs and IADLs (when incidental to providing ADLs) in the individual's home and community. Personal care activities include the following, when authorized in a person-centered services plan:

- Assisting the individual with managing the home, handling personal affairs, and providing assistance with self-administration of medications.
- Assisting the individual with ADLs and IADLs.
- Homemaker activities when those activities are specified in the individual's service plan and are incidental to the activities in (1) and (2) above or are essential to the health and welfare of the individual rather than the individual's family.
- Providing an errand outside of the presence of the individual that is needed by the individual to maintain the individual's health and safety (e.g., picking up a prescription or groceries for the individual).

Personal care service 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.

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

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Skilled Home Health Agency, Non-medical Home Health Agency
Individual	Qualified participant-directed provider

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Skilled Home Health Agency, Non-medical Home Health Agency

Provider Qualifications

License (*specify*):

Current, valid license from the Ohio Department of Health, as applicable

Certificate (*specify*):

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:

- Active Medicaid provider agreement
- ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

OAC 173-39-02.11 Personal Care Service Specifications establishes the parameters for the type of tasks and describes the timelines and documentation requirements for this service.

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Care

Provider Category:

Individual

Provider Type:

Qualified participant-directed provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:
-Active Medicaid provider agreement
-ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

OAC 173-39-02.11 Personal Care Service Specifications establishes the parameters for the type of tasks, describes the agency and individual provider qualifications and documentation requirements for this service.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

- 1. Waiver Participant
- 2. Ohio Department of Aging
- 3. ODA's Designee

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Alternative Meals Service

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17990 other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

This is a participant-directed service for sustaining an individual's health by enabling the individual to procure up to two meals per day from a non-traditional provider, such as a restaurant, but not an adult day center.

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

Individuals may utilize a combination of alternative and home delivered meal services, not to exceed two meals per day.

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Restaurants

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Alternative Meals Service

Provider Category:

Agency

Provider Type:

Restaurants

Provider Qualifications

License (specify):

[Empty box]

Certificate (specify):

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:

- Active Medicaid provider agreement
- ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

173-39-02.2 alternative meals service describes the agency provider qualifications and documentation requirements for the service.

Other Standard (specify):

[Empty box]

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Choices - Home Care Attendant Service (Participant Directed Home Care Attendant)

HCBS Taxonomy:

Category 1:

Sub-Category 1:

08 Home-Based Services 08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Choices home care attendant service is a service that provides one or more of the following activities to support the needs of an individual with impaired physical or cognitive functioning through a participant-directed provider who is the individual's employee of record:

- Assisting the individual with money management and correspondence as directed by the individual, managing the home, handling personal affairs, and providing assistance with self-administration of medications.
- Assisting the individual with ADLs and IADLs.
- Homemaker activities when those activities are specified in the individual's service plan and are incidental to the activities in (1) and (2) above or are essential to the health and welfare of the individual instead of other persons living with the individual.
- Escort and non-medical transportation to community services, activities, and resources.
- Providing an errand outside of the presence of the individual that is needed by the individual to maintain the individual's health and safety (e.g., picking up a prescription or groceries for the individual).
- Home maintenance and chores.

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

This service cannot be used concurrently with personal care or with the home maintenance and chore waiver services.

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Participant-Directed Provider
Agency	Skilled Home Health Agency, Non-medical Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Choices - Home Care Attendant Service (Participant Directed Home Care Attendant)

Provider Category:

Individual

Provider Type:

Participant-Directed Provider

Provider Qualifications

License (specify):

Certificate (specify):

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:

- Active Medicaid provider agreement
- ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

173-39-02.04 Choices home care attendant establishes the parameters for types of tasks, timeline and documentation requirements for this service.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

1. Waiver participant
 2. Ohio Department of Aging
 3. ODA's designee

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Choices - Home Care Attendant Service (Participant Directed Home Care Attendant)

Provider Category:

Agency

Provider Type:

Skilled Home Health Agency, Non-medical Home Health Agency

Provider Qualifications

License *(specify):*

Current, valid license from the Ohio Department of Health, as applicable

Certificate *(specify):*

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:
-Active Medicaid provider agreement
-ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

173-39-02.04 Choices home care attendant establishes the parameters for types of tasks, timeline and documentation requirements for this service.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

- 1. Ohio Department of Aging
- 2. ODAs designee

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Integration

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17990 other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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 plan. Coaching and training topics include to how manage finances, identifying and accessing community resources such as legal, employment, leisure, educational, recreational and transportation.

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Integration

Provider Category:

Agency

Provider Type:

Home Health Agency, Social Service Agency

Provider Qualifications

License (specify):

Certificate (specify):

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:

- Active Medicaid provider agreement
- ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

OAC 173-39-02.15 Community Integration establishes the parameters for the type of tasks and describes the timelines and documentation requirements for this service.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Integration

Provider Category:

Individual

Provider Type:

Social Workers; Nurses; Homemakers; Individual Workers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:
-Active Medicaid provider agreement
-ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

OAC 173-39-02.15 Community Integration establishes the parameters for the type of tasks and describes the timelines and documentation requirements for this service.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transition

HCBS Taxonomy:

Category 1:

16 Community Transition Services

Sub-Category 1:

16010 community transition services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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

Essential household furnishings needed to occupy and use a community residence, including furniture, window coverings, food preparation items, and bed/bath 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, 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. In such cases, the service may not be billed for until, the date the individual leaves the institution and enters the waiver.

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

The service may be used one time per individual per waiver enrollment.
 The service must be provided no later than 30 days after the date on which an individual enrolls on the waiver.
 The total cost of the service may not exceed \$2000.

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition

Provider Category:

Individual

Provider Type:

Social Workers; Healthcare Professionals; Community-based Social Service Provider, ODM-contracted Transition Coordinators

Provider Qualifications

License (specify):

License as required by profession.

Certificate (specify):

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:

- Active Medicaid provider agreement
- ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

OAC 173-39-02.17 community transition establishes the parameters for the type of tasks and describes the timelines and documentation requirements for this service.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Transition

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License (specify):

Certificate (specify):

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:

- Active Medicaid provider agreement
- ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

OAC 173-39-02.17 community transition establishes the parameters for the type of tasks and describes the timelines and documentation requirements for this service.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Enhanced Community Living Service

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08020 home health aide

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

"Enhanced community living" is a service promoting aging in place, in multi-family affordable housing, through access to on-site, individually-tailored, health-related, and supportive interventions for individuals who have functional deficits resulting from one or more chronic health conditions and includes:

- The establishment of measurable health goals.
- The identification of modifiable healthcare risks.
- The provision of regular health-status monitoring interventions.
- Assistance with accessing additional allied health services.
- The provision of, or arrangement for, education on self-managing chronic diseases or chronic health conditions.
- Daily wellness checks.
- Access to planned and intermittent personal care under rule 173-39-02.11 of the Administrative Code, excluding respite care.
- Activities to assist an individual who is returning home following a hospital or nursing facility stay.

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

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Skilled Home Health Agency, Non-medical Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Enhanced Community Living Service

Provider Category:

Agency

Provider Type:

Skilled Home Health Agency, Non-medical Home Health Agency

Provider Qualifications

License (specify):

Current, valid license from the Ohio Department of Health, as applicable

Certificate (specify):

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:

- Active Medicaid provider agreement
- ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

OAC 173-39-02.20 Enhanced Community Living Service establishes the parameters for the type of tasks and describes the timelines and documentation requirements for this service.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Care Attendant

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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

- Assistance with the self-administration of medications in accordance with OAC rule 5160-44-27.
- The performance of certain nursing tasks in accordance with OAC rule 5160-44-27 and
- Personal care aid tasks as set forth in rule 5160-46-04 or rule 173-39-02.11 of the Administrative Code.

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

Home care attendants are non-agency providers. 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.

A home care attendant shall assist an individual with the self-administration of only the following medication: oral medication; 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 scheduled II, III, IV, and V drugs only when administered orally or topically.

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

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

Individuals who receive home care attendant services do not have employer authority or budget authority, nor do they bear any liability for home care attendant services.

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Non-agency home care attendant

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Care Attendant

Provider Category:

Individual

Provider Type:

Non-agency home care attendant

Provider Qualifications

License (specify):

Certificate (specify):

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:

- Active Medicaid provider agreement
- ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

OAC 173-39-02.24 Home Care Attendant establishes the parameters for the type of tasks and describes the timelines and documentation requirements for this service.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1:

06 Home Delivered Meals

Sub-Category 1:

06010 home delivered meals

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

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.
-Individuals may utilize a combination of alternative and home delivered meal services, not to exceed two meals per day.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Food preparation agency, home health agency, senior centers, social service agency, churches, hospitals, and caterers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Food preparation agency, home health agency, senior centers, social service agency, churches, hospitals, and caterers

Provider Qualifications

License (specify):

Certificate (specify):

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:

- Active Medicaid provider agreement
- ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.
- The home delivered meal waiver service provider must meet all Federal, State and local regulations for preparation, handling and transport of food; must meet ORC chapter 3117 and OAC chapter 117-1; must meet Ohio Uniform Food Safety Code; must pass all local health department inspections; and must pass all Ohio Department of Agriculture meat and poultry inspections.

OAC 173-39-02.14 Home Delivered Meal Service establishes the parameters for the type of meals and describes the timelines and documentation requirements for this service.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Maintenance and Chore

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

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 may include inspecting, maintaining, and repairing furnaces, including pilot lights and filters; inspecting, maintaining, and repairing water faucets, drains, heaters, and pumps; replacing or installing electrical fuses; plumbing and electrical repairs; repair or replacement of screens or window panes; fixing floor surfaces posing a threat to the individual's health, safety, and welfare; and moving heavy items to provide safe ingress and egress. The service also includes heavy household cleaning, non-routine disposal of garbage posing a threat to the individual’s health and welfare, non-routine yard maintenance, pest control and related tasks to prevent, suppress, eradicate or remove pests posing a threat to the individual’s health and welfare.

The service does not include tasks that are the legal or contractual responsibility of someone other than the individual, that can be accomplished through existing informal or formal supports, or do not provide a direct medical or remedial benefit to the individual. The service does not include tasks performed or interventions available through the homemaker service.

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Handymen, House cleaners, Maids, Home Repair Workers,
Agency	Social Service Agency, Home Health Agency, Exterminators, Neighborhood Organizations; Community Action Agencies

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Handymen, House cleaners, Maids, Home Repair Workers,

Provider Qualifications

License (specify):

Certificate (specify):

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:

- Active Medicaid provider agreement
- ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

OAC 173-39-03 home maintenance and chore establishes the parameters for the type of tasks and describes the timelines and documentation requirements for this service.

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Maintenance and Chore

Provider Category:

Agency

Provider Type:

Social Service Agency, Home Health Agency, Exterminators, Neighborhood Organizations; Community Action Agencies

Provider Qualifications

License (*specify*):

Certificate (*specify*):

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:

- Active Medicaid provider agreement
- ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

OAC 173-39-03 home maintenance and chore establishes the parameters for the type of tasks and describes the timelines and documentation requirements for this service.

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Medical Equipment and Supplies

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:

Home medical equipment and supplies provides rented or purchased home medical equipment and supplies to individuals to enable those individuals to function safely in their homes with greater independence. Items may include, but are not limited to

- devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living;
- devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live;
- items necessary for the life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;
- such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant functional limitations

Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan.

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Pharmacies, Owner/operator Drug Stores
Agency	Medical Equipment & Supplies Company, Durable Medical Equipment Suppliers

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Medical Equipment and Supplies

Provider Category:

Individual

Provider Type:

Pharmacies, Owner/operator Drug Stores

Provider Qualifications

License *(specify):*

Certificate *(specify):*

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:

- Active Medicaid provider agreement
- ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

OAC 173-39-02.7 Home Medical Equipment & Supplies establishes the parameters for the type of equipment & supply requirements and describes the timelines and documentation requirements for this service.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Medical Equipment & Supplies Company, Durable Medical Equipment Suppliers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:

- Active Medicaid provider agreement
- ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

OAC 173-39-02.7 Home Medical Equipment & Supplies establishes the parameters for the type of equipment & supply requirements and describes the timelines and documentation requirements for this service.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

-Ohio Department of Aging
 -ODA's Designee

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Modification

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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

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

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

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Improvement Companies; Builders; Neighborhood Organizations; Community Action Agencies
Individual	Independent Contractors and Independent General Contractors

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Modification

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License (specify):

Certificate (specify):

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:
-Active Medicaid provider agreement
-ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

OAC 173-39-02.9 Home Modification, Maintenance & Repair establishes the parameters for the type of tasks and describes the timelines and documentation requirements for this service.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Modification

Provider Category:

Individual

Provider Type:

Independent Contractors and Independent General Contractors

Provider Qualifications

License (specify):

[Empty text box]

Certificate *(specify):*

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:

- Active Medicaid provider agreement
- ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

OAC 173-39-02.9 Home Modification establishes the parameters for the type of tasks and describes the timelines and documentation requirements for this service.

Other Standard *(specify):*

[Empty text box]

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Non-medical Transportation

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:

Non-medical transportation provides transport to individuals from one place to another for a non-medical purpose.

Non-medical transportation does not include the following:

- Transportation otherwise available, or funded by, Ohio's medicaid program or another source.
- Transportation for a non-emergency medical purpose.
- Transportation being provided through a similar service in this chapter.
- Transportation the individual's family, neighbors, friends, or community agencies are willing to, or required to provide to the individual free of charge.
- Escort or transportation by a participant-directed provider.

Non-medical transportation:

- Is offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan.
- Is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the state plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them; and
- Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Cab drivers; Senior Companions
Agency	Social Service Agencies; Licensed Ambulette and Transportation Service providers; Senior Centers; Community Action Organizations

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Cab drivers; Senior Companions

Provider Qualifications

License (specify):

Individuals employed to transport participants must have valid Ohio driver's licenses and proof of insurance.

Certificate (specify):

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:

- Active Medicaid provider agreement
- ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

OAC 173-39-02.18 Non-medical Transportation establishes the parameters and requirements for this service and describes the timelines and documentation requirements for this service.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Social Service Agencies; Licensed Ambulette and Transportation Service providers; Senior Centers; Community Action Organizations

Provider Qualifications

License *(specify):*

Individuals employed by the agency to transport participants must have valid Ohio driver's licenses and proof of insurance.

Certificate *(specify):*

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:
-Active Medicaid provider agreement
-ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

OAC 173-39-02.18 Non-medical Transportation establishes the parameters and requirements for this service and describes the timelines and documentation requirements for this service.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Nutritional Consultation

HCBS Taxonomy:

Category 1:

11 Other Health and Therapeutic Services

Sub-Category 1:

11040 nutrition consultation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Nutritional consultation means individualized guidance to an individual who has special dietary needs. Consultations take into consideration the individual's health; cultural, religious, ethnic, socio-economic background; and dietary preferences and restrictions. Consultations are also known as medical nutrition therapy.

Nutritional consultation does not include either of the following:

- A consultation provided to an individual's authorized representative or caregiver to improve the individual's well-being.
- A consultation provided to an individual if the individual receives a similar service paid (in full or in part) by Medicare state plan Medicaid, or another third-party payer.

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Dietitians
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: Nutritional Consultation

Provider Category:

Individual

Provider Type:

Licensed Dietitians

Provider Qualifications

License (specify):

Licensed by the Ohio Board of Dietitians under Chapter 4759 of the Ohio Revised Code.

Certificate (specify):

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:

- Active Medicaid provider agreement
- ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

OAC 173-39-02.10 Nutritional Consultation establishes the parameters for the type of tasks and describes the timelines and documentation requirements for this service.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nutritional Consultation

Provider Category:

Agency

Provider Type:

Home Health Agency, Social Service Agency

Provider Qualifications

License (specify):

[Empty text box]

Certificate (specify):

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:

- Active Medicaid provider agreement
- ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

OAC 173-39-02.10 Nutritional Consultation establishes the parameters for the type of tasks and describes the timelines and documentation requirements for this service.

Other Standard (specify):

[Empty text box]

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Out-of-Home Respite

HCBS Taxonomy:

Category 1:

Sub-Category 1:

09 Caregiver Support 09011 respite, out-of-home

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Out-of-home respite services are services delivered to individuals in a licensed ICF-IID, licensed NF or another licensed setting approved by ODM or certified by ODA, 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

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 Ohio Department of Medicaid or certified by ODA

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Out-of-Home Respite

Provider Category:

Agency

Provider Type:

ICF-IID, NF, or another licensed setting approved by Ohio Department of Medicaid or certified by ODA

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:
-Active Medicaid provider agreement
-ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

OAC 173-39-02.23 Out of Home Respite establishes the parameters for the type of tasks and describes the timelines and documentation requirements for the service.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System

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:

A personal emergency response systems (PERS) is a service with a monitoring, reminder and/or reporting component available to support individuals' independence in the community. The PERS service includes all of the following: telecommunications equipment, a central monitoring station (station), and a medium for two-way, hands-free communication between the individual and the station. Personnel at the station respond to an individual's alarm signal via the individual's PERS equipment.

PERS does not include:

- Remote video monitoring of the individual in his or her home.
- Systems that only connect to emergency service personnel.

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

- 1) Wearable water resistant devices; and

Devices that offer:

- 1) Voice to voice communication capability,
- 2) Visual indication of an alarm;
- 3) Audible indication of an alarm.

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

The following are not permissible:

- 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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Social Service Agency, Medical Equipment & Supply Company, Durable Medical Equipment Suppliers

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Personal Emergency Response System

Provider Category:

Agency

Provider Type:

Social Service Agency, Medical Equipment & Supply Company, Durable Medical Equipment Suppliers

Provider Qualifications

License (specify):

Certificate (specify):

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:

- Active Medicaid provider agreement
- ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

OAC 173-39-02.6 Personal Emergency Response System establishes the parameters for the type of tasks/requirements and describes the timelines and documentation requirements for this service.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Social Work Counseling

HCBS Taxonomy:

Category 1:

10 Other Mental Health and Behavioral Services

Sub-Category 1:

10090 other mental health and behavioral services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Social work or counseling means a service to an individual or to an individual's caregiver to promote the individual's physical, social, or emotional well-being; and the development and maintenance of a stable and supportive environment for the individual.

Social work or counseling" includes crisis interventions, grief counseling, and other social work and counseling interventions that support the individual's health and welfare.

State plan counseling services are available for the treatment of a specific behavioral health diagnosis.

The PASSPORT waiver service allows payment for counseling services to promote the individual's physical, social, or emotional well-being; and the development and maintenance of a stable and supportive environment for the individual.

An individual on the PASSPORT waiver in need of counseling for the treatment of a behavioral health diagnosis would use state plan services. Additionally, they would have access to the SW/counseling waiver service if they have a need for counseling for "promotion of well-being/supportive environment" for the individual or their caregiver beyond what is available through the state plan for treatment of a specific behavioral health diagnosis.

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Independent Social Workers, Licensed Professional Clinical Counselors, Psychologists (MA or PhD) or Masters of Social Service Administration
Agency	Human/Social Service agencies that employ licensed independent social workers, licensed professional clinical counselors, psychologists (MA or PhD) or Masters of Social Service Administration.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Social Work Counseling

Provider Category:

Individual

Provider Type:

Licensed Independent Social Workers, Licensed Professional Clinical Counselors, Psychologists (MA or PhD) or Masters of Social Service Administration

Provider Qualifications

License (specify):

Licensed by the Ohio Board of Counselors, Social Workers and Marital Family Therapists under Ohio Revised Code Chapter 4757 as one of the following:

LISW, LPCC, LPC, or MSSA; or licensed by the Ohio Board of Psychology as a Psychologist (MA or PhD) under Ohio Revised Code Chapter 4732.

Certificate *(specify):*

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:

- Active Medicaid provider agreement
- ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

OAC 173-39-02.12 social work or counseling establishes the parameters for the type of tasks and describes the timelines and documentation requirements for this service.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Social Work Counseling

Provider Category:

Agency

Provider Type:

Human/Social Service agencies that employ licensed independent social workers, licensed professional clinical counselors, psychologists (MA or PhD) or Masters of Social Service Administration.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:

- Active Medicaid provider agreement
- ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

OAC 173-39-02.12 social work or counseling establishes the parameters for the type of tasks and describes the timelines and documentation requirements for this service.

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Structured Family Caregiving Services

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicare-certified home health agency or otherwise-accredited agency.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Structured Family Caregiving Services

Provider Category:

Agency

Provider Type:

Medicare-certified home health agency or otherwise-accredited agency.

Provider Qualifications

License (specify):

Current, valid licenses from the Ohio department of health, as applicable

Rule 5160-44-33 outlines requirements.

Certificate (specify):

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:

-Active Medicaid provider agreement

-ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community-based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

OAC 173-39-02.25 provider certification: structured family caregiving establishes the parameters for the type of tasks and describes the timelines and documentation requirements for this service.

Other Standard (specify):

For ODA certified agencies, the caregiver will successfully meet 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:

1. Ohio Department of Aging

2. ODA's Designee

Frequency of Verification:

In accordance with rule 173-39-04 of the Ohio Administrative Code, provider qualifications are verified at the time of initial enrollment, the one-year anniversary of the providers certification date, and the one-year anniversary of the previous review.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Waiver Nursing Service

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08010 home-based habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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.

Waiver nursing affords flexibility to meet individual's needs when the need is outside of the parameters established for similar state plan services.

State plan home health visits

- are part time/intermittent
- may not exceed more than four hours in length
- must have a lapse of time of two or more hours between any previous or subsequent visit
- must have a lapse of two or more hours between the provision of home health nursing and PDN service
- is not for the provision of respite care (provided to an individual unable to care for himself or herself because of the absence or need for relief of those persons normally providing care)

Private Duty Nursing visits

- must be more than four hours in length
- must have a lapse of time of two or more hours between any previous or subsequent visit
- must have a lapse of two or more hours between the provision of home health nursing and PDN service
- When an individual is enrolled in a home and community-based services waiver and is receiving consecutive home health or PDN service(s) with waiver service(s) that have the same scope of service, there must be a lapse of time of two or more hours between the services.

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

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Skilled home health agency
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 Service

Provider Category:

Agency

Provider Type:

Skilled home health agency

Provider Qualifications

License (specify):

RN/LPN
Current, valid license from the Ohio Department of Health, as applicable

Certificate (specify):

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:
-Active Medicaid provider agreement
-ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

OAC 173-39-02.22 Waiver Nursing establishes the parameters for the type of tasks and describes the timelines and documentation requirements for this service.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Waiver Nursing Service

Provider Category:

Individual

Provider Type:

Non-agency employed RN; non-agency employed LPN

Provider Qualifications

License (specify):

RN/LPN

Certificate (specify):

ODA certification described in chapter 173-39 of the Ohio Administrative Code.

ODA certification requirements include, but are not limited to:

- Active Medicaid provider agreement
- ODA certification requirements incorporate HCBS setting compliance upon initial certification and as an ongoing certification standard (OAC 5160-44-02 Nursing Facility-based level of care home and community-based programs: home and community -based settings) and include heightened scrutiny of provider settings with institutional characteristics, as applicable and outlined in OAC 173-39-03-01.

OAC 173-39-02.22 Waiver Nursing establishes the parameters for the type of tasks and describes the timelines and documentation requirements for this service.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- As a waiver service defined in Appendix C-3.** Do not complete item C-1-c.
- As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** Complete item C-1-c.
- As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** Complete item C-1-c.

- As an administrative activity.** Complete item C-1-c.
- As a primary care case management system service under a concurrent managed care authority.** Complete item C-1-c.

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

Case management activities are conducted by PAAs as outlined in the Three-Party Agreement signed by ODM, ODA and the PAAs.

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):

-Types of positions: Any paid direct-care position, unless exempted under OAC 173-9-02.
 -Entity responsible: ODA, ODAs designee, waiver service provider
 -Scope of investigation: State and national criminal records checks (R.C. §§ 109.572, 173.38, 173.381)
 -Process for ensuring compliance: ODA does not certify, and will terminate certification of, disqualified non-agency providers and conducts annual or biennial monitoring of agency providers and participant-directed providers.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- No. The state does not conduct abuse registry screening.**
- Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

OAC Chapter 173-9 requires the responsible party to check the abuser registries maintained by the Ohio Department of Developmental Disabilities' and the state tested nurse aide registry maintained by the Ohio Department of Health as follows:

-When hiring an applicant for, or retaining an employee in, a paid direct-care position, the responsible party is the area agency on aging, PASSPORT administrative agency, provider, or sub-contractor.

-When hiring an applicant for, or retaining an employee in, a paid direct-care position in a participant-direction or self-direction arrangement, the responsible party is the consumer or individual.

-When considering a self-employed applicant for ODA-certification under section 173.391 of the Revised Code or a self-employed person already ODA-certified section 173.391 of the Revised Code, the responsible party is the ODA or the PASSPORT administrative agency.

-When considering a self-employed bidder for an AAA-provider agreement under section 173.392 of the Revised Code or a self-employed person already in an AAA-provider agreement under section 173.392 of the Revised Code, the responsible party is the area agency on aging.

The state assures mandatory screenings are conducted through the provider certification review process described in OAC 173-39-04.

Appendix C: Participant Services

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

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

Requirements are outlined in OAC 5160-44-32.

Type of legally responsible individuals: spouse of an individual may serve as a direct care worker for personal care aide, Choices Home Care Attendant Service (CHCAS), Homemaker, Structured Family Caregiving, and Waiver Nursing Services, as described below.

Through assessment and care planning activities, the case manager determines each of the following are met:

- *Services are needed from the 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 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).

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/SSA oversight activities when this allowance is implemented.

Limitations:

- *The 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.

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 spouse serving as a direct care worker are required to meet provider certification requirements for the service provided.

Self-directed

Agency-operated

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

Requirements are outlined in OAC 5160-44-32.

Individuals with legal decision-making authority (authority granted to an individual or entity to act on behalf of an individual through the designation of authorized representative, declaration for mental health treatment, general power of attorney, representative payee, or appointment of legal custody or guardianship pursuant to a court order are prohibited from serving as a direct care worker for an individual, except as follows:

Parent of an adult individual with the following designations may serve as a direct care worker of personal care, Choices Home Care Attendant Service (CHCAS), Homemaker, Structured Family Caregiving, and Waiver Nursing Services, 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, or waiver nursing, through agency employment:

*authorized representative

*declaration for mental health treatment

*general power of attorney

*healthcare (medical) power of attorney

*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 activities 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 ODA, ODM, or their designee. Additional hours may be authorized by ODA, 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 chapter 173-39 of the Ohio administrative code.

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:

All willing and qualified person or agency may apply to enroll as waiver service provider through electronic submission of an application. Applications are accepted 24 hours a day/365 days per year. Upon receipt of a complete application, enrollment activities occur in accordance with requirements described in chapter 173-39 of the Ohio Administrative Code.

OAC Chapter 173-39 contains requirements, procedures and timeframes required for waiver service providers.

Prospective providers have ready access to information regarding requirements and procedures to qualify, and timeframes are established for qualifying and enrolling in the program through:

-ODAs website (<https://aging.ohio.gov/wps/portal/gov/aging/agencies-and-service-providers/certification>)

-Ohio Administrative Code <https://codes.ohio.gov/ohio-administrative-code/chapter-173-39>

-Contacting ODA or their local PASSPORT Administrative Agency to obtain assistance and information about the application process.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

- a. Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.**

Performance Measures

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

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

Performance Measure:

C-1: Number and percent of agency providers that continue to meet certification requirements at time of Structural Compliance Review (SCR). Numerator: Number of agency providers that continue to meet certification requirements at the time of the structural compliance review. Denominator: Total number of agency provider structural compliance reviews conducted.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
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<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: <input type="text" value="Regional PAA"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

C-2: Number and percent of individual providers that continue to meet certification requirements at time of Structural Compliance Review (SCR). Numerator: Number of individual providers that continue to meet certification requirements at the time of a structural compliance review. Denominator: Total number of individual provider structural compliance reviews conducted.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: 100%; margin-top: 5px;">Regional PAA</div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> Other	

	Specify: <input style="width: 100%;" type="text"/>	
--	---	--

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

Performance Measure:

C-3: Number and percent of new agency providers that meet initial certification requirements prior to providing waiver services. Numerator: Number of new agency providers that meet initial certification requirements prior to providing waiver services. Denominator: Total number of new agency providers enrolled.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: <input type="text" value="Regional PAA"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

C-4: Number and percent of enrolled providers for which appropriate background checks were conducted timely at the time of their structural compliance review.

Numerator: Number of enrolled providers for which appropriate background checks were conducted timely at the time of the structural compliance review. **Denominator:** Total number of structural compliance reviews conducted.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: <input type="text" value="Regional PAA"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

C-5: Number and percent of individual providers that meet initial certification requirements prior to providing waiver services. Numerator: Number of new individual providers that meet initial certification requirements prior to providing service. Denominator: Total number of individual providers enrolled.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input checked="" type="checkbox"/> Other	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: <input type="text" value="Regional PAA"/>		Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

C-6: Number & percent of provider owned & controlled settings reviewed that meet OAC 5160-44-01 home and community-based settings requirements. N: Number of HCBS provider owned and controlled settings reviewed that meet all requirements of OAC 5160-44-01 home and community-based services programs: home and community-based settings. D: Number of HCBS provider owned and controlled settings reviewed

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

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

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

Performance Measure:

N/A

Data Source (Select one):

Other

If 'Other' is selected, specify:

N/A

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

<input checked="" type="checkbox"/> Other Specify: <input type="text" value="N/A"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: <input type="text" value="N/A"/>
	<input checked="" type="checkbox"/> Other Specify: <input type="text" value="N/A"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: <input type="text" value="N/A"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: <input type="text" value="N/A"/>

c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

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

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

Performance Measure:

C-7: Number and percent of agency providers who have been verified at the time of their structural compliance review to have met training requirements. Numerator: Number of agency providers who have been verified at the time of their structural compliance review to have met training requirements. Denominator: Total number of agency provider structural compliance reviews conducted.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: <input type="text" value="Regional PAA"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
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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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

C-8: Number and percent of individual providers who have been verified at the time of their structural compliance review to have met training requirements. Numerator: Number of individual providers who have been verified at the time of the structural compliance review to have met training requirements. Denominator: Total number of individual provider structural compliance reviews conducted.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative

		Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: <input type="text" value="Regional PAA"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

b. Methods for Remediation/Fixing Individual Problems

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

ODA is responsible for assuring PAAs perform their delegated responsibilities in accordance with the following, in order precedence: Code of Federal Regulations, Ohio’s HCBS waivers, Ohio Revised Code, Ohio Administrative Code, interagency agreements, and operational policies.

ODA monitors both activities performed by the PAAs to assure that all provider enrollment and oversight requirements and protocols are followed. ODA's assessment methods and their frequency include, at minimum, quarterly review of established performance indicators, and analysis of the results from the PAA quarterly retrospective record reviews. ODA analyzes the data, upon discovery of non-compliance develops remediation plans (as needed), oversees the implementation of the remediation plan and evaluates the subsequent results. When non-compliance or opportunities for improvement are discovered, the individual PAA is notified and technical assistance is provided using on-site technical assistance, e-mail, phone contact, letters to PAA Director. When assessed as needed, ODM will provide individual PAA or state-wide training.

Using quarterly reports received from ODA, ODM will examine performance data and other information gathered both by ODM and ODA to measure compliance and performance with respect to the federal waiver assurances including service planning, care management, free choice of provider, level of care, health and welfare, hearing rights, participant satisfaction, and validation of service delivery.

This data and any remediation (if necessary) will be submitted in accordance with the approved performance measures in the waiver. This information will also be used by ODM to complete the quality sections of the annual program CMS 372 report.

ODM and ODA collaborate to identify and communicate observed trends, propose changes to rules and protocols, and support ongoing improvement in systems intended to assure compliance with waiver assurances.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

c. Timelines

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

No

Yes

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

Not applicable- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Applicable - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

Furnish the information specified above.

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

Furnish the information specified above.

- Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

- Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Ohio identified and updated Ohio Administrative Code (OAC) regulations needed to assure incorporation of HCBS settings requirements for HCBS programs. Ohio added regulations to the OAC to require individuals enrolled in programs reside in settings that meet HCBS settings rule requirements, provider compliance with the regulations, and person-centered service planning activities to be completed in accordance with the federal regulations. Below is a listing of state statute and administrative code that have been updated or created in response to meet the HCBS settings rule requirements.

Ohio Departments of Medicaid and Aging Administered Programs adopted new regulations, essentially mirroring CFR.

OAC 5160-44-01 | Nursing facility-based level of care home and community-based services programs: home and community-based settings

OAC 5160-44-02 | Nursing facility-based level of care home and community-based services programs: person-centered planning

HCBS Settings requirements are integrated into the PASSPORT program enrollment and certification processes in the following Ohio Administrative Code rules:

OAC 173-39-02 | ODA provider certification: requirements for providers to become, and to remain, certified

OAC 173-39-03 | ODA provider certification: applying for certification

OAC 173-39-03.1 | ODA provider certification: federal heightened scrutiny of provider settings with institutional characteristics

OAC 173-39-03.2 | ODA provider certification: changes of ownership interest or organizational structure

OAC 173-39-04 | ODA provider certification: structural compliance reviews

OAC 173-39-05 | ODA provider certification: disciplinary actions

OAC 5160-31-03 | Eligibility for enrollment in the PASSPORT HCBS waiver program

OAC 173-42-01 | PASSPORT program (Medicaid-funded component): introduction and definitions

OAC 173-42-06 | PASSPORT program (Medicaid-funded component): individuals' choices and responsibilities

Specific settings where individuals reside

-Individuals enrolled on this waiver reside either alone in a private residence or with families/friends in a private residence.

Individuals are not permitted to be enrolled in this waiver if they reside in facilities subject to 1616(e) of the Social Security Act.

Specific settings where individuals receive services.

-Individuals enrolled on this waiver may receive HCB services in residential and non-residential settings.

Process to assess and determine all waiver settings meet the HCB settings requirements.

-Residential settings: The State has determined the residential settings are compliant since all of the individuals enrolled in this waiver live alone in a private residence or with families/friends in a private residence. As a function of service planning and monitoring, the waiver case manager conducts home visits, in accordance with Appendix D of the approved waiver application, to ensure individuals are residing, initially and ongoing, in settings compliant with 42 CFR 441.301.(c)(4)-(5).

-Non-residential settings: Prior to issuing the ODA-certification and the Medicaid provider agreement, the non-residential settings are assessed, as outlined in OAC 173-39-03, to determine compliance with the 42 CFR 441.301 (c)(4)-(5). Continued compliance is ensured through the structural compliance review process outlined in OAC 173-39-04. Event based compliance reviews may be conducted upon receipt of complaints.

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.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Service Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- Registered nurse, licensed to practice in the state**
- Licensed practical or vocational nurse, acting within the scope of practice under state law**
- Licensed physician (M.D. or D.O)**
- Case Manager** (qualifications specified in Appendix C-1/C-3)
- Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

- Social Worker**

Specify qualifications:

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:

Licensure described above and at least one year prior experience in healthcare, medical social worker, or geriatrics.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Ohio's nursing facility based waiver programs implement person-centered planning requirements contained in CFR 441.540 Person-centered service plan requirements through adoption of Ohio Administrative Code (OAC) 5160-44-02 Nursing facility based level of care home and community-based services programs. The service planning process and documentation requirements describe how individuals are afforded the opportunity to lead service planning development processes, are offered informed choice of program participation, receipt of services, etc.

The PASSPORT service plan development process provides the individual with the opportunity to actively lead and engage in the development of the plan, including identifying individuals who will be involved in the process. Chapter 173-32 of the Ohio Administrative Code describes this process for the PASSPORT waiver.

Through written and verbal descriptions of services and supports available through the waiver, the case manager provides individuals with education needed to facilitate informed choice of waiver participation, provider selection options (including participant-directed service options) and opportunities to engage in their community in a meaningful way.

Supports and information 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 include

- Assistance with development of an individualized person-centered service plan.
- Participant education in order to promote informed choice, understanding of risk and benefits of care options/decisions, and confidentiality standards including the following topics: related to how to contact the PAA and the assigned case manager, becoming the employer of record and the self direction of care, services provided by the long-term care ombudsman program and the medicaid hotline.

Additional details describing the person-centered services process are described in section D-1-d of this waiver application.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Ohio's nursing facility based waiver programs, including PASSPORT) implement person-centered planning requirements contained in CFR 441.540 Person-centered service plan requirements through adoption of Ohio Administrative Code (OAC) 5160-44-02 Nursing facility based level of care home and community-based services programs.

The case manager is responsible for facilitating the person-centered planning process described below and described in OAC 5160-44-02:

The person-centered planning process is required to:

- Include a team of people chosen by the individual.
- Provide 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.
- Be timely and occur at times and locations of convenience to the individual.
- Reflect cultural considerations of the individual. The process shall be conducted by providing information in plain language and in a manner that is accessible to persons with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b).
- Include strategies for solving conflict or disagreement within the process.
- Ensure that providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management, provider oversight, or develop the person-centered services plan.
- Offer informed choices to the individual regarding the services and supports he or she receives and from whom.
- Include a method for the individual to request updates to the plan as needed. The individual may request a person-centered services plan review at any time.

The person-centered services plan describes the person-centered goals, objectives and interventions selected by the individual and 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 must:

- Identify the setting in which the individual resides is chosen by the individual and record the alternative home and community-based settings that were considered by the individual.
- Reflect the individual's strengths.
- Reflect the individual's preferences.
- Reflect clinical and support needs as identified through the assessment process.
- Include 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.
- Reflect that the setting chosen by the individual is integrated in, and supports the 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 people not receiving medicaid HCBS.

The person-centered services plan contains documentation that any modification of the additional conditions for provider-owned or controlled residential settings set forth in rule 5160-44-01 of the Administrative Code must be supported by a specific assessed need and justified in the person-centered services plan. The following requirements must be documented in the person-centered services plan:

- Identify a specific and individualized assessed need;
- Document the positive interventions and supports used prior to any modifications to the person-centered services plan;
- Document less intrusive methods of meeting the need that have been tried but did not work;
- Include a clear description of the condition that is directly proportionate to the specific assessed need;
- Include a regular collection and review of data to measure the ongoing effectiveness of the

- modification;
- Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
- Include informed consent of the individual; and
- Include an assurance that interventions and supports will not cause any harm to the individual.

The person-centered services plan must:

- Be understandable to the individual receiving services and supports, and the people important in supporting him or her. At a minimum, it must be written in plain language and in a manner that is accessible to persons with disabilities and persons who are limited english proficient, consistent with 42 CFR 435.905(b) (as in effect on October 1, 2021).
- Identify the person and/or entity responsible for monitoring the plan.
- 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. 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 shall be documented on the plan.
- Be distributed to the individual and other people involved in the plan.
- Prevent the provision of unnecessary or inappropriate services and supports.
- Be reviewed, and revised upon reassessment of functional need as required by 42 CFR 441.365(e) (as in effect on October 1, 2021), at least every twelve months, when the individual experiences a significant change, or at the request of 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 PAAs may initiate risk and safety planning via the implementation of a Health and Safety Action Plan developed by the PAA 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 or participant-directed 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.

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 PAA assessor/case manager will make available to the participant, prior to enrollment, at annual re-assessment, and at any time upon request, a summary of each ODA certified long-term care agency and non-agency provider serving participants in that PAA’s region. This list of providers includes information about the location, size, and general demographics of the provider in addition to current certification reports. The provider list includes current ODA certified long-term care individual providers who have expressed an interest in being employed by additional participants.

Participants review the provider list with their assessor/case manager, who will explain the information presented to assist the participant in making the best decisions for their care needs. If the participant has any questions, the PAA staff either responds to, or researches, the question and provides information back to the participant so they may make an informed choice of service provider. The PAA will be responsible for ensuring the provider information is current by updating the summary document on an ongoing basis.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

ODA monitors person-centered planning compliance through ongoing oversight activities, providing policy and operational guidance and reviewing service authorizations and documentation of individual records.

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. Topics can include service planning, care management satisfaction, free choice of provider, level of care, health and welfare, hearing rights, and validation of service delivery. ODM 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.

Additional descriptions of ODM service planning oversight is described throughout this waiver application.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

- Medicaid agency
- Operating agency
- Case manager

Other
Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The PAAs are primarily responsible for implementing the person-centered service plans.

Face to face monitoring visits occur at least quarterly (no more than 90 calendar days between face to face visits) to determine if the service plan has been appropriately implemented, meets the needs of the participant, ensures participant health and welfare, and to verify that the participant has ongoing access to non-waiver services. Additional contacts may occur either by face to face visit or telephone, based on the individual's assessed need and/or per individual request.

Monitoring activities include reviewing and assuring the following:

- Services are furnished in accordance with the service plan
- Participant has access to waiver services identified in service plan
- Participants exercise free choice of provider
- Services meet participants' needs
- Effectiveness of back-up plans
- Participant health and welfare needs are met

Modifications to the service plan and service delivery schedule are initiated upon discovery. The individual chooses from a variety of methods to resolve the identified issue(s) including: the selection of alternate providers or direct service workers, negotiation with current providers for service modifications, adding (waiver and non-waiver) services, and changes in the level of involvement of the participant's informal support systems.

The written service plan is updated to describe the intervention developed to address the issue(s), time frames for implementation, entities responsible for implementation and times frames to evaluate the effectiveness of the intervention in resolving the identified need or problem. The case manager is responsible for ongoing monitoring and evaluation of the effectiveness and participant satisfaction of the intervention.

The PAAs are required by ODA policy to have established internal quality assurance practices for assessment and case management activities. These internal practices identify trends and patterns related to clinical practice issues that impact participant outcomes. The PAAs use this data to identify training needs in the clinical and provider network and to develop best practices and protocols to enhance participant outcomes.

ODA will continue a quarterly record review system for PAAs. The record reviews ensure that services are furnished in accordance with the participant's service plan; participants have access to waiver services identified in their service plan which includes: participants are provided with information about service providers in their geographic area and given their free choice of providers; and participants are asked questions about their back-up plans, if they have had to use their back-up plans and how the back-up plan worked when used. ODA may provide remediation needs identified through one-on-one technical assistance or practice directives issued to the PAAs.

At least annually, ODA compiles aggregate findings of trends and patterns related to service plan implementation and monitoring. ODA recommends concerns/issues for further remediation and/or quality initiatives in accordance with the Quality Management Strategy.

b. Monitoring Safeguards. *Select one:*

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

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

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

Performance Measure:

D-2: Number and percent of participants whose service plans have identified potential health & safety risks and include interventions to mitigate/eliminate these risks. N: Number of participants whose service plans have identified potential health & safety risks and include interventions to mitigate/eliminate these risks. D: Total number of participants' service plans reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

Agency		
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;">95% CI with a MOE +/- 5%</div>
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;">Regional PAA</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 20px;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 20px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 20px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 20px;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

D-1: Number and percent of participants whose service plans are comprehensive and interventions are sufficient to meet the individual's assessed needs. Numerator: Number of participants whose service plans are comprehensive and interventions are sufficient to meet the individual's assessed needs. **Denominator:** Total number of participants' service plans reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; display: inline-block;">95% CI with a MOE +/- 5%</div>
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; display: inline-block;">Regional PAA</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify:	

	<div style="border: 1px solid black; width: 80%; margin: 0 auto; height: 20px;"></div>	
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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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>

b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.

Performance Measures

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

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

c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to

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

Performance Measure:

D-3: Number and percent of service plans reviewed that were updated when the participant’s needs changed. Numerator: Number of service plans reviewed that were updated when the participant’s needs changed. Denominator: Total number of service plan reviewed for whom participants experienced a change in need.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;">95% CI with a MOE +/- 5%</div>
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">Regional PAA</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

D-4: Number and percent of service plans reviewed that were updated at least annually. Numerator: Number of service plans reviewed that were updated at least annually. Denominator: Total number of service plan reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input checked="" type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

Regional PAA		
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: 	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to

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

Performance Measure:

D-5: Number and percent of participants reviewed who received services in the type, scope, amount, duration and frequency specified in the service plan. Numerator: Number of participants reviewed who received services in the type, scope, amount, duration and frequency specified in the service plan. Denominator: Total number of participants' service plan reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;">95% CI with a MOE +/- 5%</div>
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">Regional PAA</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

e. *Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.*

Performance Measures

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

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

Performance Measure:

D-6: Number and percent of participants notified of their rights to choose among waiver services and/or providers. Numerator: Number of participants notified of their rights to choose among waiver services and/or providers. Denominator: Total number of participants' records reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 5px auto;">95% CI with a MOE +/- 5%</div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>

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

b. Methods for Remediation/Fixing Individual Problems

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

ODA is responsible for assuring PAAs perform their delegated responsibilities in accordance with the following, in order precedence: Code of Federal Regulations, Ohio’s HCBS waivers, Ohio Revised Code, Ohio Administrative Code, interagency agreements, and operational policies.

ODA monitors both activities performed by the PAAs to assure that all provider enrollment and oversight requirements and protocols are followed. ODA's assessment methods and their frequency include, at minimum, quarterly review of established performance indicators, and analysis of the results from the PAA quarterly retrospective record reviews. ODA analyzes the data, upon discovery of non-compliance develops remediation plans (as needed), oversees the implementation of the remediation plan and evaluates the subsequent results. When non-compliance or opportunities for improvement are discovered, the individual PAA is notified and technical assistance is provided using on-site technical assistance, e-mail, phone contact, letters to PAA Director. When assessed as needed, ODM will provide individual PAA or state-wide training.

Using quarterly reports received from ODA, ODM will examine performance data and other information gathered both by ODM and ODA to measure compliance and performance with respect to the federal waiver assurances including service planning, care management, free choice of provider, level of care, health and welfare, hearing rights, participant satisfaction, and validation of service delivery.

This data and any remediation (if necessary) will be submitted in accordance with the approved performance measures in the waiver. This information will also be used by ODM to complete the quality sections of the annual program CMS 372 report.

ODM and ODA collaborate to identify and communicate observed trends, propose changes to rules and protocols, and support ongoing improvement in systems intended to assure compliance with waiver assurances.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>

c. Timelines

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

No

Yes

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

Appendix E: Participant Direction of Services

Applicability (*from Application Section 3, Components of the Waiver Request*):

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (*select one*):

Yes. The state requests that this waiver be considered for Independence Plus designation.

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

A. The nature of the opportunities afforded to participants:

The nature of the employment authority opportunities afforded to participants enables them to act as the employers of record with the authority to hire, train, direct, and dismiss their participant-directed providers. Participant-directed providers may include friends, neighbors, and some relatives. Participants exercising this authority may have multiple participant-directed providers.

Participants can also exercise budget authority when developing their person-centered services plans in conjunction with their case managers and determining the budget amount for participant-directed services, including Choices home care attendant, personal care, alternative meals, home maintenance and chores, home modification, and home medical equipment and supplies.

Participants identify participant-directed providers for program enrollment. Participants 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.

B. How the participants take advantage of these opportunities:

At each initial assessment and annual reassessment, case managers give participants an overview of the waiver program that includes a description of the participant direction options available. This includes a discussion of the purpose of participant direction, the differences between provider-managed and participant-directed services, and the additional responsibilities of participants who choose this option. Participants may choose a representative to support their use of participant direction, but some participants may need a representative. Participants and their representatives must be willing and able to direct the services to use the participant-directed service delivery method.

Information about the participant-directed service option is also available on ODA's website and on request.

C. The entities that support participants who direct their service and the supports that they provide:

PAA staff, including case managers, provide information and assistance, help participants gain knowledge of employer responsibilities, and assist with the development and management of their person-centered services plans. When participants express an interest in using the participant-directed option, PAA staff provide them with information and guidance on the qualifications of a participant-directed provider, recruitment, hiring, and training of a qualified provider, and employer-related tasks, including working with the FMS. Case managers also work with participants on budget authority for identified services. If participants identify representatives to assist with directing their service, the representatives work with the participants and the PAA staff to understand the participant-directed option. Case managers work with participants 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 participants with administrative functions.

The FMS assists with participant education on becoming an employer by providing participants with an employer packet. On behalf of participants, the FMS vendor furnishes participant-directed providers employee packets that include an employment application, the participant 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 participants by reviewing time sheets and processing the participant-directed provider's payroll. The FMS reports payroll processing issues to participants, employees, 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 participants express interest in becoming employers through participant direction, case managers work with them to develop person-centered services plans that include any support needed to assist participants with the responsibilities of an employer. Case managers provide these participants with information that explains all of the following employer expectations:

1. Understanding methods for selecting, managing, and dismissing employees.
2. Understanding what service activities are covered.
3. Participating in the development, monitoring, and revision of the person-centered services plan and reliable back-up plans.
4. Understanding corresponding provider requirements, including criminal records checks.
5. Working with the FMS for timely payroll processing, including written approval of provider time sheets.

Case Managers also provide participants who express interest in budget authority through participant-direction the following information: 1. Determining wages and establishing billable rates for participant directed caregivers; and 2. Deciding spending for eligible participant directed services.

The case manager will arrange for additional skills development in specific areas as requested by the participant or as deemed necessary by the case manager to assist the participant in the role of the employer. Participants who cannot meet any of the expectations as employers may elect to use participant direction if case managers determine that their representatives are able to meet those expectations. Participants who elect to exercise budget authority 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 participants 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 participant direction option. This description includes a discussion of the purpose of participant direction, the differences between the provided-managed and participant-directed services, and the additional responsibilities of participants who choose the participant-directed option.

Information about participant-directed option is also available on ODA's website and on request.

When participants express interest in participant-directed services, PAA staff provide detailed information about participant direction, including the requirements for hiring, taxes, insurance, and working with the FMS. They will also provide information on the budgeting process.

When participants elect to proceed with participant direction, the PAA staff provide more information on several components of participant direction, including:

- Identification of the elements of the service to be provided by the participant-directed provider.
- Qualifications of participant-directed provider.
- Recruitment, hiring, and training of a qualified provider.
- Employer-related tasks, including working with the FMS.
- Service planning, including development of a back-up plan.
- * Budget development, including wage setting and determining a billable rate.

The FMS also assists participants with onboarding their participant-directed providers. The FMS provides support from the time participants identify their participant-directed providers and ongoing as participants change or add providers. The FMS assigns enrollment specialists to work with participants, participant-directed providers, and case managers. The enrollment specialists conduct orientation and assist with onboarding and paperwork through the providers' first paychecks.

Any materials issued by the case management agencies and FMS will be subject to ODA approval or utilize an ODA-supplied template. ODA will provide guidance to the PAAs and FMS on the requirements for these materials to ensure individuals receive the same information on participant-direction regardless of which PAA the individual works with 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 a participant with employer or budget authority can be a legally responsible person such as a participant’s legal guardian or any other person identified by the participant. If the case manager or individual identifies that the participant 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 participant’s record and communicated to the FMS.

A representative that is not the participant's legal representative carries out decisions made by the participant but cannot make decisions without the participant's consent.

A representative must:

1. Demonstrate a strong personal commitment to the participant and show knowledge about the participant's preferences.
2. Be willing and able to fulfill all the employer responsibilities on behalf of the waiver participant when they are using employer authority.
3. Agree to meet with the participant, case manager, and FMS as identified on the service plan.

A representative may not be paid for this function or be hired by the participant as a participant-directed provider. As reflected in the care plan, the case manager must assess the participant’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
Choices - Home Care Attendant Service (Participant Directed Home Care Attendant)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Home Maintenance and Chore	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Personal Care	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Home Medical Equipment and Supplies	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Alternative Meals Service	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Home Modification	<input type="checkbox"/>	<input checked="" type="checkbox"/>

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. Through a Request for Proposal (RFP) process, the State of Ohio has contracted with a single FMS vendor for the PASSPORT participant-directed services.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The FMS vendor is paid a monthly fee per participant utilizing participant-directed employer authority. Payment is through an administrative contract with the Ohio Department of Administrative Services.

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:

ODA may delegate participant-directed employer certification activities to the FMS.

Supports furnished when the participant exercises budget authority:

- Maintain a separate account for each participant's participant-directed budget
- Track and report participant funds, disbursements and the balance of participant funds
- Process and pay invoices for goods and services approved in the service plan
- Provide participant with periodic reports of expenditures and the status of the participant-directed budget
- Other services and supports

Specify:

The FMS will maintain timekeeping records for participant directed providers. ODA may delegate participant-directed employer certification activities to the FMS. These activities would include serving as an enrollment broker for participant directed caregivers, facilitating the completion by an ODA-approved criminal records check and other validations to ensure the providers are eligible to render Medicaid services.

The FMS will provide participant directed providers with information and/or training in the following areas:

- * Applicable Ohio Administrative Code requirements
- * Accurate time reporting
- * Correct completion of time sheets
- * Incident reporting
- * Medicaid fraud detection and reporting.

Additional functions/activities:

- Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
- Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
- Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget
- Other

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The State provides oversight of interactions of the FMS with participants and PAAs through regularly occurring meetings with the vendor. The State monitors the effectiveness of the FMS’s established protocols for customer service, reporting, participant directed provider enrollment, as applicable, payroll processing, and employer related activities as defined in the FMS contract and operational protocols. The FMS RFP selection criteria are the same criteria used to monitor their compliance with the contract. The FMS vendor provides monthly, quarterly, and semiannual program reports to the State that are used to assess FMS vendor performance. 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, participant-directed provider enrollments, and service claims for state data monitoring.

The State oversees the employee payroll process with the PAAs and the FMS. The State reviews the monthly FMS invoice prior to payment to ensure the invoice remittance only includes the authorized services, scope, duration, and frequency and timely resolution of identified issues. The State monitors the timeliness and fluidity of FMS process to ensure the best service for participants and their employees.

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
Non-medical Transportation	<input type="checkbox"/>
Choices - Home Care Attendant Service (Participant Directed Home Care Attendant)	<input type="checkbox"/>
Home Maintenance and Chore	<input type="checkbox"/>
Personal Care	<input type="checkbox"/>
Social Work Counseling	<input type="checkbox"/>
Home Care Attendant	<input type="checkbox"/>
Home Medical Equipment and Supplies	<input type="checkbox"/>
Structured Family Caregiving Services	<input type="checkbox"/>
Home Delivered Meals	<input type="checkbox"/>
Enhanced Community Living Service	<input type="checkbox"/>
Community Integration	<input type="checkbox"/>
Homemaker	<input type="checkbox"/>
Alternative Meals Service	<input type="checkbox"/>
Waiver Nursing Service	<input type="checkbox"/>
Home Modification	<input type="checkbox"/>
Nutritional Consultation	<input type="checkbox"/>
Out-of-Home Respite	<input type="checkbox"/>
Adult Day Service	<input type="checkbox"/>
Community Transition	<input type="checkbox"/>
Personal Emergency Response System	<input type="checkbox"/>

- 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 participants in exercising their employer and/or budget authority.
- B. The information and assistance support are an administrative function of the PAA and the State contracts with a vendor to furnish the FMS statewide. The FMS contractor is established through a competitive bidding process that meets the requirements of 45 CFR §74.
- C. Before and throughout enrollment, case managers inform participants of their employer responsibilities including hiring, training, dismissing, and tracking the time sheets of their participant-directed providers and developing person-centered services plans and associated budgets. Regular in-person home visits are conducted by the case manager with the participant and any other individuals of their choice to review responsibilities and mitigate risk on-going.
- The FMS provides payroll functions for participants including completing federal and state employment and tax forms and tracking time sheets. They may also, if delegated by ODA, complete participant-directed provider enrollment tasks and assist the participant and participant-directed provider with onboarding tasks. The FMS supplies individuals exercising budget authority with bi-monthly reports of all payments made for participant-directed services.
- D. The PAAs conduct participant-directed provider record reviews in accordance with the processes described in rule 173-39-04 of the Administrative Code. The State oversees the function, reviews the findings, and directs the remediation, when indicated.
- E. The oversight of the participant-directed service delivery method is the shared responsibility of ODA and the State Medicaid agency.
- F. The participant may designate a representative of their choice to assist with some, or all, their employer and/or budget authority responsibilities. This individual cannot be the participant-directed provider.
- The FMS contractor is established through a competitive bidding process that meets the requirements of 45 CFR §74. Additionally, AAAs serve in an information and assistance role however, as established under 173-2-02, are eligible to receive the subaward for this work.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (select one).

- No. Arrangements have not been made for independent advocacy.
- Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

The Office of the State Long-Term Care Ombudsman program (ombudsman) is responsible for addressing complaints regarding the health, safety, welfare, and civil rights of long-term care participants in PASSPORT, as well as the rights of nursing homes and residential care facility residents found in Chapter 3721.10 - 3721.17 of the Ohio Revised Code. Further, the ombudsman investigates allegations of the action or inaction of providers of long-term care or representatives of providers of long-term care, government entities, or private social service agencies whose actions may adversely affect the health, safety, welfare, or rights of participants.

Participants receive ombudsman information from the case manager, including contact information for the state and local programs at enrollment, annually at reassessment, and as needed.

Ohio Administrative Code rule 173-14-16 addresses timeframes for responding to inquiries and resolution. Contact with the ombudsman does not have an effect on the timeframes for appeal rights.

The Department of Jobs and Family Services Adult Protective Services (APS) is responsible for investigating and evaluating all reports of suspected abuse, neglect, and exploitation of adults aged 60 and over. Case managers and all service providers are mandated reporters and mandated to report suspicion of abuse, neglect, and exploitation of a participant to APS. Participants 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 participants voluntarily terminate participant direction, case managers must do all of the following:

1. Identify the contributing factors which led to the voluntary termination.
2. Reassess the participant's current needs to identify alternative services.
3. Authorize provider-managed services.
4. Assist the participant with the provider selection.
5. Coordinate the last day of participant-directed service with the first day of provider-managed service or the backup plan if there is a gap between the last day of participant-directed service and the first day of provider-managed service.
6. Ensure that the participant, participant-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 participant-directed provider 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 participant direction may be necessary under any of the following situations:

1. The participant no longer has an assessed need for the participant-directed service.
2. The participant and the participant’s representatives are unable to perform their responsibilities as employers.
3. Participant direction cannot assure the participant’s health and welfare.

PAA 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 participant -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		636
Year 2		827
Year 3		1075
Year 4		1398
Year 5		1817

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 State pays the cost for the background investigation as required by ORC 173.38.

- 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:

Participants may require specific skill training to ensure tasks will be performed in a manner that is responsive to their individual needs and preferences. The participant specific required skill training does not change the State's method for conducting background checks as outlined in chapter 173-9 of the Ohio Administrative Code. If ODA delegates participant-directed enrollment activities to the FMS, the FMS must ensure ODA-approved screening and criminal record checks are completed for all providers that the FMS enrolls. This includes ensuring that criminal records and registry verifications are completed.

ODA will also allow conditional employment for participant-directed providers to begin employment while the criminal record check is conducted. The conditional employment will only be effective with a signed affidavit from the self-directed caregiver indicating no prohibited offenses are on their record and will be valid for up to 60 calendar days. The prohibited offenses outlined in OAC 173-9-06 and OAC 173-9-07 will be verified and, if identified during the criminal record check, the participant-directed provider will be terminated.

- Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- Determine staff wages and benefits subject to state limits**
- Schedule staff**
- Orient and instruct staff in duties**
- Supervise staff**
- Evaluate staff performance**
- Verify time worked by staff and approve time sheets**
- Discharge staff (common law employer)**
- Discharge staff from providing services (co-employer)**
- Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- Reallocate funds among services included in the budget**
- Determine the amount paid for services within the state's established limits**
- Substitute service providers**
- Schedule the provision of services**
- Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- Identify service providers and refer for provider enrollment**
- Authorize payment for waiver goods and services**
- Review and approve provider invoices for services rendered**
- Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Case managers review participants' current provider-managed service packages with participants and work with them to develop the participant-directed service packages to meet their needs. Participants use the current amount budgeted for their services to establish their initial budgets for participant-directed services. Participants determine the number of participant-directed service hours that will be purchased and the number of participant-directed providers that will be hired to provide the service. Participants utilize budget authority for Choices home care attendant services, alternative meals, home medical equipment and supplies, and home modification service by designing their person-centered services plans in conjunction with their case managers including determining the budget amount for services.

Participants also establish the rate of pay for each participant-directed provider and any pay differentials (early morning/late night) that will be offered. Participants must pay each worker no less than the current federal minimum wage. The PAA staff share average cost for workers in home care agencies and the maximum rates for participant-directed providers with participants to assist them with determining pay rates. The PAA staff inform participants about the correlation of wages and the amount of service hours available for purchase based on those wages. Participants may not pay a wage that is higher than the established maximum for participant directed services in rule 5160-1-06.1 of the Administrative Code.

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 PAA staff works with participants, informing them of the available budget for services, then working with them to develop the participant-directed services budget. Participants may request a reassessment if their current person-centered services plan needs change. A reassessment of need will be conducted and, if appropriate, participants' person-centered services plans and budgets will be revised.

The PAA will inform participants 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 participant-directed budget amounts. The PAA informs participants 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:

--

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:

Case managers and the FMS will monitor participants' monthly use of the of participant-directed services. If participants are able to overspend their service budgets, case managers will contact the participants to discuss their service use and, if necessary, reassess their service needs and person-centered services plans.

If participants under-utilize their budgets, case managers will ensure that participants have adequate access to all services stated in their person-centered services plans. If under-utilization continues for three months, reassessment of the participant's service needs will be conducted and the person-centered services plan and budget may be revised. Participants have the fair hearing rights described in E-2-b-iii above.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

At the time of enrollment in the waiver, the PAA assessor/case manager provides the individual with information in both written and verbal formats including: the right to choose HCBS as an alternative to institutional care, and the right to appeal any decision regarding 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 or termination of benefits, etc.).

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 waiver participant receives written information regarding instructions on how to locate free legal services; the date, time and location of their hearing at least ten days in advance; the right to have representation during the hearing, access to the case file, and any rules being applied to the case; hearing decisions are rendered no later than 90 days from the date of the hearing request; ODM must take the action ordered by the decision within 15 days of the date of the decision; and instructions on how to ask for an administrative appeal in the event the individual loses the hearing.

Computer-generated adverse action notices and formal notices of approval are stored in ODM's eligibility system. When an enrolled participant requests an appeal in a timely manner, the PAA will continue waiver services as outlined in the service plan pending resolution of the appeal.

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:

ODA is responsible for the operation of the complaint process pertaining to the PASSPORT HCBS waiver program.

ODM is responsible for the Medicaid Hot Line which is a toll-free number available to anyone to lodge a complaint regarding a Medicaid-funded program or provider.

- 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: 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, PAA 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.

Process and Timelines for Addressing Complaints: Complaints can be directed to staff of the PAA, ODA or ODM. They can originate from a face-to-face conversation, phone call, email, ODA or ODM inquiry, or regular mail.

Details of the complaint are assessed by the receiver to determine level of priority (health and safety related complaints require initiation of care coordination activities upon discovery) and triaging of complaint resolution to the PAA, ODA or ODM staff most appropriate to address the complaint. If ODM receives a complaint about the PASSPORT program, the complaint is referred to ODA for follow -up and resolution (as is possible) and provides a deadline for response to the complaint. The length of time given to provide a response/resolution depends on the type and seriousness of the complaint registered, but the length of time for a response rarely exceeds 30 days.

When referred to the PAA for response/resolution: Within seven days of receipt of the complaint by the case manager and/or supervisor, the problem-solving process will be initiated. However, issues with immediate health or safety implications are addressed upon receipt. Documentation of the outcome must occur no later than 30 days from receipt of the complaint.

Mechanisms in place used to resolve grievances/complaints include tracking of complaints received through resolution, PAA documentation of activities completed in the individual's case record as applicable and routine ODA and ODM quality oversight activities described throughout this waiver application.

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
- 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.

Information regarding how to prevent, identify, and report abuse, neglect and exploitation is provided to individuals and/or their informal caregivers.

Entities Responsible for providing the training/information

The PAA is primarily responsible for providing the training/information regarding how to prevent, identify, and report abuse, neglect and exploitation.

Frequency the Training/Information is Provided

At a minimum, the training/information is required to be provided at initial enrollment and at the annual re-assessment. Information will also be provided during the course of the waiver enrollment in response to participant specific circumstances. Training is provided to the individual by the Case Manager in all three formats: Written, Verbal and In-Person. Documentation of this training is noted in the individual's Case Notes in ODA's PASSPORT Information Management System (PIMS). ODA evaluates compliance with this requirement on a quarterly basis as part of the Quarterly Record Review process.

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 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 thirty 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
 ODA is responsible for overseeing the operation of the incident management system.

Methods for overseeing the operation of the incident management system

Oversight of the incident management system includes regular monitoring of reports generated by the system as well as any ad hoc pulling or review of data to review and trend incidents and reportable events to predict and prevent future re-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:

ODA does not permit for the use of restraints or seclusion during the delivery of waiver services.

ODA will instruct PAA case management staff and/or their supervisors that if during an in-person visit or a telephone conversation with the participant, staff learns of the use of restraints or seclusion, staff is to alert PAA management of any situation where restraints or seclusion are used in the waiver participant's home. In cases where the PAA staff has witnessed the use of restraints or seclusion with a waiver participant, ODA will instruct the PAA staff to alert any involved family/caregiver, agency providing services, PAA management and the local APS agency and file an incident report with ODA.

ODA will notify ODM of the event via the established incident reporting system. ODA's oversight would be conducted on an individual basis and as frequently as necessary until the issue is resolved.

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).

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:

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:

ODA does not permit the use of restrictive interventions during the delivery of waiver services.

ODA will instruct PAA case management staff and/or their supervisor that if during an in-person visit staff or a telephone conversation with waiver participant, staff learns of the use of restrictive interventions, staff is to alert PAA management of the situation occurring in the participant's home. In cases where the PAA staff has witnessed the use of restrictive interventions on a PASSPORT participant, ODA will instruct the PAA staff to alert any involved family/caregiver, agency providing services, PAA management and the local APS agency and file an incident report with ODA.

ODA will notify ODM of the event via our established incident reporting system. ODA's oversight would be conducted on an individual basis and as frequently as necessary until the issue is resolved.

- 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.

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:

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:

ODA does not permit the use of restraints or seclusion during the delivery of waiver services.

ODA will instruct PAA case management staff and/or their supervisors that if during an in-person visit or a telephone conversation with the waiver participant, staff learns of the use of restraints or seclusion, staff is to alert PAA management of any situation where restraints or seclusion are used in the participant's home. In cases where the PAA staff has witnessed the use of restraints or seclusion on a PASSPORT participant, ODA will instruct the PAA staff to alert any involved family/caregiver, agency providing services, PAA management and the local APS agency and file an incident report with ODA.

ODA will notify ODM of the event via our established incident reporting system. ODA's oversight would be conducted on an individual basis and as frequently as necessary until the issue is resolved.

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).

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:

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.

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.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

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).

iii. Medication Error Reporting. *Select one of the following:*

- Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the state:

- Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

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.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

a. Sub-assurance: *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:

G-1: Number and percent of Abuse (physical, verbal, emotional, sexual), Neglect, Exploitation, and Misappropriation incidents (over \$500) reported into the ODA-approved incident management system within the required timeframe. N= total number of ANEM incidents reported into the ODA-approved incident management system within the required timeframe. D= total number of ANEM incidents.

Data Source (Select one):

Other

If 'Other' is selected, specify:

ODA Wired data system

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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:

ODA WIRED data system

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: 	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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-4: Number and percent of substantiated Abuse (physical, verbal, emotional,

sexual), Neglect, Exploitation, and Misappropriation incidents (over \$500) with a prevention plan developed as a result of the incident. N= total number of ANEM prevention plans completed. D= Total number of ANEM incidents needing a prevention plan.

Data Source (Select one):

Other

If 'Other' is selected, specify:

ODA - WIRED data system

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

G-3: Number and percent of Abuse (physical, verbal, emotional, sexual), Neglect, Exploitation, and Misappropriation incidents (over \$500) incident investigations that were completed according to the rule requirements. N= Total number of ANEM investigations completed according to the rule requirements. D= Total number of ANEM investigations.

Data Source (Select one):

Other

If 'Other' is selected, specify:

ODA - WIRED data system

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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 unapproved restraint, seclusion or other restrictive intervention incidents with a prevention plan developed as a result of the incident. N= Total number of unapproved restraint prevention plans completed. D= Total number of unapproved restraint incidents needing a prevention plan.

Data Source (Select one):

Other

If 'Other' is selected, specify:

ODA - WIRED data 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify:	

	<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	
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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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>

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-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:

WIRED-ODA Data System

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="text"/>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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:

ODA - WIRED data system

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

	Ongoing	Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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

b. Methods for Remediation/Fixing Individual Problems

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

For critical incidents ODM monitors both prevention and outcome activities performed by ODA and the PAAs to assure that all prevention, investigation and resolution protocols are followed through and to completion. ODM meets regularly with ODA and works collaboratively to identify and observe trends, propose changes to rules and protocols, and support ongoing improvement in systems intended to assure prevention and adequate response to incidents of abuse.

In addition, ODA is able to address individual problems as they are discovered and provide technical assistance that may include plans of corrective action. When problems are discovered, the individual PAA is notified and technical assistance is provided using e-mail, phone contact and/or letters to PAA Director. When issues are noted that are systemic ODA will provide statewide training and monitor during the next monitoring cycle.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

c. Timelines

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

- No
- Yes

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

ODM system improvement activities as described in Appendix A of this waiver application.

ODA is responsible for assuring PAAs perform their delegated responsibilities in accordance with the following, in order precedence: Code of Federal Regulations, Ohio’s HCBS waivers, Ohio Revised Code, Ohio Administrative Code, interagency agreements, and operational policies.

ODA monitors both activities performed by the PAAs to assure that all provider enrollment and oversight requirements and protocols are followed. ODA's assessment methods and their frequency include, at minimum, quarterly review of established performance indicators, and analysis of the results from the PAA quarterly retrospective record reviews. ODA analyzes the data, upon discovery of non-compliance develops remediation plans (as needed), oversees the implementation of the remediation plan and evaluates the subsequent results. When non-compliance or opportunities for improvement are discovered, the individual PAA is notified and technical assistance is provided using on-site technical assistance, e-mail, phone contact, letters to PAA Director. When assessed as needed, ODM will provide individual PAA or state-wide training.

Using quarterly reports received from ODA, ODM will examine performance data and other information gathered both by ODM and ODA to measure compliance and performance with respect to the federal waiver assurances including service planning, care management, free choice of provider, level of care, health and welfare, hearing rights, participant satisfaction, and validation of service delivery.

This data and any remediation (if necessary) will be submitted in accordance with the approved performance measures in the waiver. This information will also be used by ODM to complete the quality sections of the annual program CMS 372 report.

ODM and ODA collaborate through mechanisms described throughout this waiver application to identify and communicate observed trends, propose changes to rules and protocols, and support ongoing improvement in systems intended to assure compliance with waiver assurances.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Other Specify: <input type="text"/>

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 monitoring and oversight responsibilities include ensuring that ODA is exercising its authority for the day-to-day operation of the waiver in accordance with federal Medicaid requirements. ODM supports and facilitates ongoing qualitative improvements in the systems, procedures, and protocols ODA employs to ensure conformity of providers, recipients, and other entities with federal Medicaid requirements. When a program component is determined to be out of compliance with federal Medicaid requirements, ODM will work with ODA to assess the root cause and develop and implement an appropriate course of action to remedy the program.

ODA monitoring and oversight and responsibilities include ensuring that the regional entities are establishing and implementing systems, procedures and protocols to ensure conformity of providers, recipients, staff, or other entities with federal Medicaid requirements. The ODA will support and facilitate ongoing qualitative improvements in the systems, procedures, and protocols at the PAA level. When a program component is determined to be out of compliance with federal Medicaid requirements, ODM will work with ODA to assess the root cause and develop and implement an appropriate course of action to remedy the problem.

ODM is responsible for ensuring ODA and PAA compliance with federal regulations, including the amount, duration and scope of services, free choice of providers, timeliness of delivery of services to waiver eligible participant and the availability of services statewide and conducts A-133 audits of the regional entities at least once every three years based on risk.

ODA is responsible for ensuring the PAAs performance is in accordance with the following, in order of precedence: Code of Federal Regulations, Ohio’s HCBS waivers, Ohio Revised Code, Ohio Administrative Code, and operational policies.

The assessment Methods and Frequency include: on-site operational reviews conducted every year; on-site technical assistance visits performed as needed; review of performance data related to screening, assessment, enrollments, disenrollments, and ongoing census on a monthly basis.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

ODM in conjunction with ODA will, at least annually, review the effectiveness of the systems improvement strategy including plans of correction, quality improvement projections completed, technical assistance provided, and training offered to improve program operations.

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).

Each of the PASSPORT Administrative Agencies (PAA) that the Department of Medicaid (ODM) passes funds on to receive and expend sufficient funding require an annual Single Audit as required by OMB Circular A-133. The Single Audits are performed by independent public accounting firms. The results of these audits are forwarded to ODA along with a corrective action plan to address any audit findings. ODA reviews the results of the audits and follows up with the PAA regarding their corrective action plans. ODA has achieved the goal of reviewing the Single Audit results within 45 days of receiving them.

In addition to the Single Audits, OMB Circular A-133 requires that ODA engage in a sub-recipient monitoring process. Each PAA is fiscally monitored by ODAs Fiscal Management Division on an annual basis and programmatically monitored by ODA's Performance Center division every year. ODA requires the PAAs to submit corrective action plans when the results of the monitoring visit identify noncompliance with laws, rules, regulations and/or ODA policy or weaknesses in internal accounting controls.

Each PAA also receives a financial and compliance audit performed by ODM, the Single State Medicaid Agency in Ohio.

ODM audits cost reports from ODA and the regional PAAs to establish that ODA and the PAA operations are compliant with applicable federal and state requirements, and with the terms and conditions established in three-party agreements between ODM, ODA, and each PAA. The state is currently utilizing a risk-based auditing approach. Under this approach, individual PAAs are audited at least once every three years and ODM determines which PAAs to audit by assessing various risk factors, including: percentage of program dollars, significant changes in expense levels, operational concerns, and the significance of prior audit findings. ODM will continue the practice of performing monthly desk reviews of PAA cost reports.

Additionally as part of the subrecipient monitoring audit, the ODM assesses the fiscal and programmatic monitoring efforts of ODA to assure they satisfy the requirements of OMB Circular A-133. Incorporated within ODM's testing is an assessment as to whether ODA monitors the PAA's activities related to services rendered to beneficiaries and that ODA personnel verifies, on a sample basis, the accuracy and allowability of paid service units. ODM also examines and analyzes data from ODA's claims authorization system as a means to evaluate statewide compliance of paid claims. These sub-recipient audits are conducted annually, and may be for a period of six months to one year based on risk.

ODM performs ongoing audits and reviews to verify the medical necessity and legitimacy of Medicaid paid claims, including whether claims are allowable, reasonable, and compliant with applicable requirements. On an annual basis ODM staff conduct a risk-assessment to determine which types of Medicaid providers and services represent higher risk for potential fraud, waste, abuse, or noncompliance with other requirements. To determine risk, ODM considers the amount of funds dispersed (materiality), reimbursement changes, fraud risk factors (opportunity, attitude, incentive, and pervasiveness), the strength of Ohio Administrative Code rules, recent rule changes, recent industry changes, control factors, and the program's age. All Risk Factors are rated on a scale of 1 to 10 and then weighted to generate a total risk assessment by category of service.

ODM relies on the outcomes of this risk assessment to guide its strategy for data mining (to identify abnormalities and/or outliers in relation to Medicaid paid claims) and to inform the design of direct audit and review activities. All Medicaid services provided under any Medicaid waiver are subject to the risk-based assessment and review.

ODM communicates the amount of monetary findings to ODA for tracking as an accounts receivable and for collection. ODM staff refer any provider suspected of engaging in fraudulent activities to the Attorney General's Medicaid Fraud Control Unit. Final resolution of these recovery efforts is managed by ODM and/or the office of the Attorney General as appropriate.

ODA also receives an annual Single Audit as performed by the Ohio Auditor of State and is audited under the same guidelines as the PAAs by ODM.

Independent audit requirements: The State requires the PASSPORT Administrative Agencies (PAA) to secure an independent audit of their financial statements on an annual basis. PASSPORT waiver providers are viewed as contractors and as such are not required to secure an independent audit.

On-site reviews: The Ohio Department of Aging (ODA) conducts on-site reviews of the PAAs on an annual basis. These reviews include both fiscal and program components to ensure the PAA adheres to state and federal law and program/operational guidance.

As outlined in the approved waiver, the Ohio Department of Medicaid (ODM) performs desk reviews of the PAAs. If a desk review performed by ODM reveals an issue, ODA may conduct an on-site review of the PAA at the direction of ODM.

As outlined in Appendix C of the approved waiver, the PAAs conduct on-site reviews of all waiver service providers in accordance with OAC 173-39-04. If an issue is identified through the PAAs provider oversight processes, the state may take disciplinary action against the provider as outlined in OAC 173-39-05.

Review Process for Self-Directed and Agency-Directed Services: The state follows the same process for reviewing self-directed and agency providers. This process is outlined in OAC 173-39-04.

Assignment of Risk Factors: A risk factor rating of low, medium or high is determined by the aggregate score of all components. The score assigned to each component is determined by the pre-audit environmental scan. Examples of when the assessment may lead to further action includes the following: an aggregate high-risk rating, a significant change in the rating compared to previous ratings, or an indication that previous actions to resolve findings were not effective or sustained.

All PAAs are reviewed annually.

Personal care, waiver nursing adult day, choices home care attendant, consumer directed personal care, home care attendant, and enhanced community livingcare subject to an in-person review by ODA or their designee within 365 days from the first date of service delivery. Thereafter in-person annual reviews are conducted. This schedule may not be modified.

Medicare-certified and otherwise accredited agencies certified to provide personal care services and/or waiver nursing are subject to reviews in accordance with their certification and accreditation bodies, and at ODM or ODAs discretion 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 ODA, ODM or their designee, must make available all review reports and accepted plans of correction from the certification and/or accreditation bodies. This would allow for ODA to set it at every 3 years unless circumstances indicate a need for more frequent reviews.

Alternative meals, , homemaker, home maintenance and chores, personal emergency response system, home medical equipment and supplies, home modification, nutritional consultation, social work or counseling, home delivered meals, community integration, community transition, non-medical transportation, , out-of-home respite, are subject to an in-person review by ODA or their designee within 365 days from the first date of service delivery. Thereafter in-person annual reviews are conducted. At the discretion of ODA, ODM or their designee, structural reviews may be conducted, no more than every 3 years, when a) there are no findings against the provider during the provider's most recent review; b) the provider has not been determined as 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 complaint investigation during the previous twelve months; d) the provider does not live with an individual receiving ODA-administered waiver services; and e) the provider does not serve individuals in a provider owned and controlled setting.

Scope of Claims Review: The on-site reviews conducted by the PAA of all waiver service providers in accordance with OAC 173-39-04 includes a claims review. The sample size of claims reviewed must be 10% of the provider's services furnished, at minimum, during the on-site visit. The frequency of the review is established above.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

- a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.**
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver

actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:

I-1: Number and percent of claims paid for individuals who were enrolled on the waiver on the date of services. Numerator: Number of waiver claims paid for individuals who were enrolled on the waiver on the date of services. Denominator: Total number of submitted waiver claims.

Data Source (Select one):

Other

If 'Other' is selected, specify:

PASSPORT Information 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other	

	Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	
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Data Aggregation and Analysis:

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input checked="" type="checkbox"/> <i>Quarterly</i>
<input type="checkbox"/> <i>Other</i> Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	<input checked="" type="checkbox"/> <i>Annually</i>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>
	<input type="checkbox"/> <i>Other</i> Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>

Performance Measure:

I-2: Number and percent of waiver claims submitted supported by required documentation at time of review. Numerator: Number of waiver claims submitted supported by required documentation at the time of review. Denominator: Total number of waiver claims submitted.

Data Source (Select one):

Other

If 'Other' is selected, specify:

PASSPORT Information Management System

<i>Responsible Party for data collection/generation (check each that applies):</i>	<i>Frequency of data collection/generation (check each that applies):</i>	<i>Sampling Approach (check each that applies):</i>
<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>100% Review</i>
<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>Less than 100% Review</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input checked="" type="checkbox"/> <i>Representative</i>

		<p>Sample Confidence Interval =</p> <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: auto; margin-right: auto;"> <p>95% CI with +/-5% MOE</p> </div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>

Performance Measure:

I-3: The percent of authorized waiver claims submitted that were paid. Numerator: Number of authorized waiver claims submitted that were paid. Denominator: Total number of submitted waiver claims.

Data Source (Select one):

Other

If 'Other' is selected, specify:

PASSPORT Information 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):
<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input checked="" type="checkbox"/> <i>100% Review</i>
<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input type="checkbox"/> <i>Less than 100% Review</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input type="checkbox"/> <i>Representative Sample</i> Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> <i>Other</i> Specify: <input type="text" value="Regional PAA"/>	<input checked="" type="checkbox"/> <i>Annually</i>	<input type="checkbox"/> <i>Stratified</i> Describe Group: <input type="text"/>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Other</i> Specify: <input type="text"/>
	<input type="checkbox"/> <i>Other</i> Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> <i>Sub-State Entity</i>	<input checked="" type="checkbox"/> <i>Quarterly</i>
<input type="checkbox"/> <i>Other</i> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <i>Annually</i>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>
	<input type="checkbox"/> <i>Other</i> Specify: <input type="text"/>

Performance Measure:

I-4: Number and percent of waiver claims paid using the correct input rate. Numerator: Number of waiver claims paid using the correct input rate. Denominator: Total number of submitted waiver claims.

Data Source (Select one):

Other

If 'Other' is selected, specify:

PASSPORT Information 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):
<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input checked="" type="checkbox"/> <i>100% Review</i>
<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input type="checkbox"/> <i>Less than 100% Review</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input type="checkbox"/> <i>Representative Sample</i> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <i>Other</i> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <i>Annually</i>	<input type="checkbox"/> <i>Stratified</i> Describe Group: <input type="text"/>

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin-left: auto;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin-left: auto;"></div>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin-left: auto;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin-left: auto;"></div>

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-5: Number and percent of waiver claims that were paid using the rate authorized for the service set in accordance with rule 5160-31-07 of the Administrative Code and not to exceed maximum rates set in rule 5160-1-06.1 of the Administrative Code. Numerator: Total number of claims paid using the authorized rate. Denominator: Total number of paid claims.

Data Source (Select one):

Other

If 'Other' is selected, specify:

PASSPORT Information Management System (PIMS) MITS

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

PASSPORT Information Management System (PIMS) MITS

<i>Responsible Party for data collection/generation (check each that applies):</i>	<i>Frequency of data collection/generation (check each that applies):</i>	<i>Sampling Approach (check each that applies):</i>
<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input checked="" type="checkbox"/> <i>100% Review</i>
<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input type="checkbox"/> <i>Less than 100% Review</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input type="checkbox"/> <i>Representative Sample</i> <i>Confidence Interval =</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> <i>Other Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> <i>Annually</i>	<input type="checkbox"/> <i>Stratified Describe Group:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Other Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> <i>Other Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input checked="" type="checkbox"/> <i>Quarterly</i>
<input type="checkbox"/> <i>Other Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> <i>Annually</i>

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis(check each that applies):</i>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>
	<input type="checkbox"/> <i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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

b. Methods for Remediation/Fixing Individual Problems

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

ODA is responsible for assuring PAAs perform their delegated responsibilities in accordance with the following, in order precedence: Code of Federal Regulations, Ohio’s HCBS waivers, Ohio Revised Code, Ohio Administrative Code, interagency agreements, and operational policies.

ODA monitors both activities performed by the PAAs to assure that all provider enrollment and oversight requirements and protocols are followed. ODA’s assessment methods and their frequency include, at minimum, quarterly review of established performance indicators, and analysis of the results from the PAA quarterly retrospective record reviews. ODA analyzes the data, upon discovery of non-compliance develops remediation plans (as needed), oversees the implementation of the remediation plan and evaluates the subsequent results. When non-compliance or opportunities for improvement are discovered, the individual PAA is notified and technical assistance is provided using on-site technical assistance, e-mail, phone contact, letters to PAA Director. When assessed as needed, ODM will provide individual PAA or state-wide training.

Using quarterly reports received from ODA, ODM will examine performance data and other information gathered both by ODM and ODA to measure compliance and performance with respect to the federal waiver assurances including service planning, care management, free choice of provider, level of care, health and welfare, hearing rights, participant satisfaction, and validation of service delivery.

ii. Remediation Data Aggregation

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

<i>Responsible Party(check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input checked="" type="checkbox"/> <i>Quarterly</i>
<input type="checkbox"/> <i>Other</i> <i>Specify:</i>	<input checked="" type="checkbox"/> <i>Annually</i>

<i>Responsible Party</i> (check each that applies):	<i>Frequency of data aggregation and analysis</i> (check each that applies):
<input type="checkbox"/>	
	<input type="checkbox"/> <i>Continuously and Ongoing</i>
	<input type="checkbox"/> <i>Other</i> Specify: <input type="text"/>

c. Timelines

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

- No**
- Yes**

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The Ohio Department of Medicaid and the Ohio Department of Aging develop provider reimbursement rates in the PASSPORT waiver. ODM provides oversight in developing the methodology used to determine the rate and reviewing the data and analysis used by ODA in determining these rates. The methods used to determine provider rates for the PASSPORT home and community based services waiver program are set forth in rule 5160-31-07 of the Ohio Administrative Code (OAC). This rule establishes the three categories: per job bid rate; per item rate; and unit rate for use in reimbursing providers of appropriately billed PASSPORT waiver services.

Per Job Bid Rate – A Negotiated Market Rate methodology is used determine the reimbursement for the following services.

**community transition, per job bid, provider managed negotiated between the provider and the individual's case manager*

**home maintenance and chore, provider managed negotiated between the provider and the individual's case manager or participant -directed services in which the individual may negotiate rates up to the maximum for the service*

**home modification, per job bid, provider managed negotiated between the provider and the individual's case manager or participant -directed services in which the individual may negotiate rates up to the maximum for the service*

**non-medical transportation, provider managed negotiated between the provider and the individual's case manager*

Per Item Rate –A negotiated market rate methodology is used to determine the reimbursement. The cost of the item cannot exceed the maximum Medicaid state plan rate as applicable. The cost of an item that does not have an established Medicaid rate is reimbursed at a per item bid rate submitted and agreed to in writing by the PASSPORT administrative agency (PAA) prior to delivery of the item.

**home medical equipment and supplies, per item rate, provider managed negotiated between the provider and the individual's case manager or participant -directed services in which the individual may negotiate rates up to the maximum for the service*

Unit Rate –The fee schedule rate methodology is used to reimburse the following waiver services:

**adult day, unit rate, provider managed (current maximum rate billable established 2024)*

**alternative meals, unit rate negotiated between the provider and the individual may negotiate rates up to the maximum for the service*

**choices home care attendant, unit rate negotiated between the provider and the individual within the bounds of minimum wage, the participants service budget and the established maximum for the service*

**non-medical transportation, unit rate, provider managed (current maximum rate billable established 2024)*

**enhanced community living, unit rate, provider managed (current maximum rate billable established 2024)*

**home delivered meals, unit rate provider managed (current maximum rate billed set 2024)*

**homemaker, unit rate, provider managed (current maximum rate billable established 2024)*

**social work counseling,, unit rate provider managed (current maximum rate billable established prior to 2014)*

**nutritional consultation, unit rate provider managed (current maximum rate billable established prior to 2014)*

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

**community integration, unit rate provider managed (current maximum rate billable established 2019)*

**personal emergency response system, unit rate provider managed (current maximum rate billable established 2019)*

**waiver nursing, unit rate unit rate provider managed (current maximum rate billable established 2024)*

**out-of-home respite, unit rate provider managed (current maximum rate billable established 2013)*

**home care attendant, unit rate provider managed (current maximum rate billable established 2024)*

The State has established Medicaid maximum rates for each service and all rates, regardless of if the service is provider managed or participant-directed, shall not exceed the maximum set in Appendix A to rule 5160-1-06.1 of the Ohio Administrative Code.

The service plan development and modification processes encourage the waiver participant to consider a range of information in order to make an informed choice when selecting a waiver provider. The provider rate information is one

element of this decision. The informed choice of provider process allows the waiver participant to select any willing and qualified provider regardless of the provider's unit of service reimbursement rate. The PAA assessor/case manager makes reimbursement rate information available to the waiver participant prior to enrollment, at annual re-assessment, when service plans are modified, and upon request.

PASSPORT provider rates are established either through Ohio's legislative budget process or Ohio's administrative rule making process. The legislative budget process allows public input from any interested member of the public including general members of the public, waiver participants, provider associations and any other PASSPORT stakeholders. There are several public hearings held throughout the budget process with notices posted on the Ohio General Assembly website with additional information about hearings in many of Ohio's major newspapers.

The public is also encouraged to write or telephone their state legislators to express their views. Public input into the administrative rule making process is outlined in the "Participating in ODA's Rule Development" guidebook. Any older Ohioan, advocate, service provider, or member of the general public is encouraged to contact ODA or ODM any time to propose changes in the area of administrative law regarding PASSPORT.

The proposed rule is posted on ODA's website and public hearings are advertised and held at both the agency level and at the legislative Joint Committee on Agency Rule Review (JCARR) prior to adopting new rules regarding provider rate changes.

In addition, 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 review rates and recommend rate changes. The availability of funding in the state's biennial budget also impacts ODM's ability to adjust provider rates.

ODM regularly informs waiver participants, providers and stakeholders of administrative policy changes through its internal and external department clearance process. Stakeholders are afforded opportunities to discuss their concerns prior to and during public hearings. Notices for the public hearings for all rate-related policy or rate changes are made in accordance with 42 CFR 447.205 and as outlined in the Main Module 6-I of this application.

Some rates are negotiated on either a per job or per item basis. For these services, since they are effectively market rates, they should be sufficient to attract a qualified provider pool. For the services that use unit rates the state reviews these rates regularly including receiving both consumer and provider feedback. Based on the overall budgeting authority for the Ohio Department of Medicaid, ODM then would propose a rate increase in a waiver amendment to CMS.

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

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.

- 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:

PASSPORT waiver provider billings are submitted for review through ODA's ODM approved case management and billing system). Providers can either use a direct data entry module into the database or use a HIPAA compliant electronic data interchange. Paper invoices can also be submitted to the PAA for data entry into the system by PAA staff. The regional entities (as described in A-4) process the billings to determine the extent of payment to the providers. Prior to payment, service claims are verified against program and provider service eligibility requirements, and in accordance with person-centered service plan authorizations.

Payment to providers comes from advances provided to the regional entities from state GRF dollars. Consumer-directed providers which furnish the Choices Home Care Attendant Service (CHCAS) or personal care service submit their timesheets to the FMS which then provides the PAA with the claims for entry into PIMS. Payment to providers comes from advances provided to the regional entities by ODA from state GRF dollars. After the payments are documented, ODA will compile a claim from the payment records and submit it through Ohio's MITS to in order for the state to obtain the federal share.

PASSPORT providers have the option to bill and be directly reimbursed by ODM. They may choose to exercise this right during their provider certification process.

Electronic Visit Verification (EVV)

Ohio's EVV program requirements are outlined in chapter 5160-32 of the Ohio administrative code.

ODM operates an EVV system to electronically document services furnished to individuals. Providers of personal care and nursing type services verify service delivery using the EVV system. EVV captures and logs visit data electronically and includes visit elements required under Section 1903 of the Social Security Act (42 U.S.C. 1396b). ODM, ODA, DODD or their designee edits against visit information before provider payment processing.

As of the date of submission of this waiver application, claims payment is not impacted by EVV status.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures (select one):

- No. state or local government agencies do not certify expenditures for waiver services.**
- Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

- Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

- Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

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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:

Provider claims are initially reviewed using ODA's claims processing system. This system contains edits to assure that the participant is enrolled, that the service is prior authorized and it is delivered according to the participant's service plan using certified providers who have a Medicaid provider agreement. The system identifies an approved payment amount for each service. ODA compiles claims from these approved payment records and submits an electronic file to ODM's claims processing system. The ODM claims processing system has controls in place to ensure that participants are Medicaid eligible and entitled to receive certain waiver services at a certain maximum cost for a given period of time; that providers are eligible to receive payment for those waiver services; and that providers are eligible to provide the certain waiver services.

Process for Removing Inappropriate billings: The State's claims validation and payment process is designed to reduce the likelihood of inappropriate billings being included in the State's FFP calculation.

PASSPORT waiver providers submit claims into ODA's PASSPORT Information Management System (PIMS). Prior to issuing payment, the provider claims are pre-adjudicated to determine the following conditions are met for service dates: participant eligibility, provider eligibility, service authorization, billing units are consistent with the authorization, and correct reimbursement rate.

Claims that are not validated by PIMS are not paid, are not submitted to MITS for adjudication and subsequently are not included in the State's FFP calculation.

Claims that are validated by PIMS are paid and ODA submits the claims to MITS. ODM adjudicates the claims in MITS to determine the following conditions are met for service dates: validity, eligibility, general policy restrictions, waiver policy restrictions and utilization auditing.

Claims that are not adjudicated in MITS are not included in the State's FFP calculation.

In addition, ODM compiles a report on a quarterly basis of all claims adjustments, including waiver claims. The report findings are categorized by federal fiscal year and inappropriate billings are removed from the State's FFP calculation.

Recouping payment for inappropriate billings: The State recoups payment for inappropriate billing in accordance with ORC 5164.57 and OAC 5160-1-27.

In accordance with OAC 173-39-04, providers are to refund overpayments, resulting from inappropriate billings to ODA using acceptable state auditing procedures including adjusting against a future payment or repayment of the overpaid claims.

In accordance with OAC 5160-1-19, providers are to refund overpayments to ODM within sixty days of discovery. Providers can offset overpaid claims against a future payment.

- 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:

ODM uses the ODA and its regional entities as a limited fiscal agent to pay for all waiver services. As stated previously, waiver providers use the option of submitting their claims to the regional entities for payment. The regional entity adjudicates the claims using the ODA payment system edits to assure appropriateness and accuracy of payment. Subsequently, ODA compiles the claims for submission to ODM's claims system in order for the state to obtain FFP. ODM through its claims system will adjudicate the ODA claim.

Provider claims are initially adjudicated through ODAs electronic claims system. This system adjudicates claims to assure several factors are met for the service dates including:

- Participant is enrolled in the PASSPORT waiver program.
- Service is authorized by the case manager as shown through the service plan
- Number and types of units of services billed are included within the service plan.
- The provider is certified by ODA and has a Medicaid provider number.
- Payments to the provider are limited to the rates identified for each service
- ODA then compiles its claim for FFP from these approved payment records and submits an electronic file to ODM's claims system which is housed and maintained by ODM.
- The ODM system has controls in place to ensure that participants are Medicaid eligible and entitled to receive certain waiver services at a certain maximum cost for a given period of time; that providers are eligible to receive payment for those waiver services; and that providers are eligible to provide the certain waiver services.

After the PAA adjudicates the claim, the PAA sends the payment (check) to the provider. ODM's role is to adjudicate the ODA claim for federal reimbursement.

The regional entities are paid for administrative costs by ODM pursuant to the provisions in the Three-Party Agreements and pursuant to the standards of OMB Circular A-133. ODM performs audits of those costs as indicated in the three-party agreements at least once every 3 years. ODA performs fiscal audits every year to ensure the provider meets program and fiscal standards.

ODM may use the targeted review process, described in Appendix A, to determine whether ODA complies with financial accountability requirements for waiver enrollees. ODM selects a sample of enrollees and associated claims and verifies whether services were delivered within service limits as recorded in the ODA claims system. For enrollees with a recorded patient liability, claims data is reviewed to determine whether patient liability amounts were appropriately accounted for before claims were submitted to ODM for payment. Once patient liability is met, services are eligible for payment through Medicaid. To test the delivery of services in compliance with patient liability and assessed needs, PIMS service authorization and claims data is used for a sample of waiver enrollees. This data is used to review all authorized services for the selected enrollees to assure only those services were delivered. The data was tested to verify that patient liability was appropriately tracked and applied to claims and only authorized services were delivered within authorized limits and denied otherwise.

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:

Hospitals, local senior centers and social service agencies may provide waiver services if requirements contained in chapter 173-31 of the OAC are met.

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.

Ohio Department of Aging
Providers may request a change in the arrangement at any time.

ii. Organized Health Care Delivery System. Select one:

- No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.*
- The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.*

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.*
- This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.*
- If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.*

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

- Appropriation of State Tax Revenues to the State Medicaid agency**
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

[Empty text box]

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:

To the extent these funds are used by the state to fund waiver services, the source of funds is a horse racing excise tax (ORC 3769) and some moneys from a nursing facility franchise fee (ORC 5168). These moneys are appropriated directly to ODM via the biennial budget process.

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:

[Empty text box]

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:

[Empty text box]

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:

The Ohio Department of Medicaid collects an annual franchise permit fee from each Ohio nursing home based on the number of licensed and certified beds in each facility.

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:

Do not complete this item.

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: 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	8450.15	7755.79	16205.94	49364.34	12016.64	61380.98	45175.04
2	10933.37	8109.50	19042.87	50598.45	12377.14	62975.59	43932.72
3	11625.39	8446.29	20071.68	51863.41	12748.46	64611.87	44540.19
4	12411.20	8828.08	21239.28	53159.99	13130.91	66290.90	45051.62
5	13264.84	13264.84	26529.68	54488.99	13524.84	68013.83	41484.15

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: Nursing Facility	
Year 1	39807		39807
Year 2	39807		39807
Year 3	39807		39807

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:	
		Nursing Facility	
Year 4	39807		39807
Year 5	39807		39807

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay has been projected based on actual experience in the current waiver cycle through June 30, 2022 and reflects year-over-year increases during the new 5-year waiver period based on projected phase-in and phase-out assumptions. The actual ALOS for FY22 (July 1, 2021 through June 30, 2022) was approximately 255 days and represents a significant decrease from prior years due to a large number of participants phasing out of the waiver program in the beginning part of that waiver year. Therefore, the ALOS for the new 5-year waiver period represents increases from FY22 as participants phase-in to the waiver program, but these are lower than historical ALOS for 2019-2021 when there was a smaller amount of participant turnover.

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:

Base Year data reflects WY 4 of the current waiver period: July 1, 2021 through June 30, 2022. Factor D for current WY 5 (July 1, 2022 through June 30, 2023) and the new 5-year waiver period for the renewal (July 1, 2023 through June 30, 2028) was projected from WY 4 of the current renewal data in the following manner:

The number of projected users were adjusted based on total projected slots. Due to requirements by CMS to avoid an MOE violation, the total number of unduplicated participants must be held at or above the level listed in WY 5 of the current waiver (39,807). We projected growth in the covered services year over year based on actual recent experience. This results in an approximate 4% growth in users per year. Average units per user were projected to vary with average length of stay. Average cost per unit was increased by approximately 3.0% based on annual unit cost increases observed during the current waiver period. Combining these adjustments results in an annual growth for Personal Care expenditures of approximately 8.5% per year between WY 1 and WY 5.

ODM anticipates users of Choices-Home Care Attendant services to grow at 30% annually from WY 1 to WY 2 and for every year thereafter to reflect the Self-Direction allowed under this service. The ability for members to choose Self-Direction was being expanded and therefore ODM anticipates a large growth in the number of members opting to choose Self-Directed services leading to the projected changes for Choice-Home Care Attendant services.

• Services that were identified to have zero utilization in the historical claims experience were set at the current WY 5 utilization and cost for WY 1 and assumed to grow consistent with the growth in average length of stay.

** As a result of proposed budgetary changes effective January 1, 2024 the average cost per unit for Waiver Nursing, Personal Care, Home Care Attendant, Homemaker, Choice-Home Care Attendant Service, Adult Day Service, Home Delivered Meals, Enhanced Community Living Service and Home Modification Services were updated. These changes reflect additional funding specific for SFY 2024 and SFY 2025 which coincide with WY 1 and WY 2. We have held the average cost per unit constant for WY 3-5 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 Service – 13.2% for WY 1, 25.7% for WY 2
- Homemaker – 16.1% for WY 1, 39.9% for WY 2
- Personal Care – 16.1% for WY 1, 39.8% for WY 2
- Choices - Home Care Attendant – 10.6% for WY 1, 15.4% for WY 2
- Enhanced Community Living Service – 32.8% for WY 1, 61.2% for WY 2
- Home Care Attendant – 16.0% for WY 1, 39.8% for WY 2
- Home Delivered Meals – 10.3% for WY 1, 18.9% for WY 2
- Home Modification – 32.9% for WY 1, 61.2% for WY 2
- Waiver Nursing – 6.1% for WY 1, 11.2% for WY 2

These increases were based on legislative changes under Ohio House Bill 33 targeting the nursing services crisis and the ability to provide quality home and community based services. These noted increases were part of a planned provider rate increase of approximately 40% across the HCBS program. 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 \$43 million increase for SFY 2024 and an additional increase of approximately \$113 million for SFY 2025. As the changes will take effect January 1, 2024, the impact is only for a portion of WY 1 with the full effect of the changes noted in WY 2 and forward.

Added as part of September 2024 Amendment

Effective September 9, 2024, Structured Family Caregiving service will be offered as part of the HCBS program. It is estimated that this service will be utilized by approximately 500 individuals in WY2, with all of these individuals previously anticipated to utilize Personal Care services. The average units per user in WY2 has been prorated based on the September 3rd effective date. The WY2 estimated average cost per unit is based on a review of similar service offerings in other states' HCBS programs. Number of users 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 this service remains budget neutral to the HCBS program. It is anticipated that the Structured Family Caregiving service is budget neutral through shifting of users of the Personal Care services. With a small number of exceptions, providers will not be able to bill for Structured Family Caregiving Services and Personal Care services on the same day.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Base Year data reflects WY 3 of the current renewal: July 1, 2020 through June 30, 2021. The total Factor D' costs are inclusive of those reported in the WY 3 372 report in addition to the NEMT costs covered under the State Plan, but the unduplicated participant count was updated to be consistent with the new waiver period projections. The WY1 estimate for Factor D' represents the amount that was listed in the FY 2021 372 report (\$10,462) plus the estimated NEMT costs but divided by the required unduplicated participant count of 39,807. The adjustment for unduplicated participants materially reduced the Factor D' estimate from recent years. Factor D' for future waiver years was projected using a 3.0% annual trend rate in consideration of historical experience, budget forecast trends and general economic inflation. Incremental growth for the change in average length of stay was also incorporated.

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 the institutional population costs for the MyCare Ohio program in the period consistent with WY 4 of the current renewal: July 1, 2021 through June 30, 2022.

Factor G was projected using a 2.5% annual trend rate in consideration of historical experience, budget forecast trends and general economic inflation.

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 the institutional population costs for the MyCare Ohio program in the period consistent with WY 4 of the current renewal: July 1, 2021 through June 30, 2022. Factor G' was projected using a 3.0% annual trend rate in consideration of historical experience, budget forecast trends and general economic inflation. The value of Factor G' is higher than Factor D' due to the historical values being utilized in establishing these amounts. An unduplicated participant adjustment was not applied to the Factor G' values.

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 Service	
Homemaker	
Personal Care	
Alternative Meals Service	
Choices - Home Care Attendant Service (Participant Directed Home Care Attendant)	
Community Integration	
Community Transition	
Enhanced Community Living Service	
Home Care Attendant	
Home Delivered Meals	

<i>Waiver Services</i>	
<i>Home Maintenance and Chore</i>	
<i>Home Medical Equipment and Supplies</i>	
<i>Home Modification</i>	
<i>Non-medical Transportation</i>	
<i>Nutritional Consultation</i>	
<i>Out-of-Home Respite</i>	
<i>Personal Emergency Response System</i>	
<i>Social Work Counseling</i>	
<i>Structured Family Caregiving Services</i>	
<i>Waiver Nursing Service</i>	

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

<i>Waiver Service/Component</i>	<i>Unit</i>	<i># Users</i>	<i>Avg. Units Per User</i>	<i>Avg. Cost/ Unit</i>	<i>Component Cost</i>	<i>Total Cost</i>
Adult Day Service Total:						6336712.44
Adult Day Service	per day	657	412.00	23.41	6336712.44	
Homemaker Total:						6915744.36
Homemaker	1/4 hour	1764	889.00	4.41	6915744.36	
Personal Care Total:						265455908.00
Personal Care	1/4 hour	18415	2435.00	5.92	265455908.00	
Alternative Meals Service Total:						4690.00
Alternative Meals Service	per meal	7	67.00	10.00	4690.00	
Choices - Home Care Attendant Service (Participant Directed Home Care Attendant) Total:						11455390.32
Choices - Home Care Attendant Service (Participant Directed Home)	1/4 hour	636	4309.00	4.18	11455390.32	
GRAND TOTAL:						336375277.80
<i>Total Estimated Unduplicated Participants:</i>						39807
<i>Factor D (Divide total by number of participants):</i>						8450.15
<i>Average Length of Stay on the Waiver:</i>						264

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care Attendant)						
Community Integration Total:						8819.01
Community Integration	1/4 hour	27	89.00	3.67	8819.01	
Community Transition Total:						65995.60
Community Transition	per job	44	1415.00	1.06	65995.60	
Enhanced Community Living Service Total:						243968.36
Enhanced Community Living Service	1/4 hour	46	646.00	8.21	243968.36	
Home Care Attendant Total:						185519.18
Home Care Attendant	1/4 hour	22	1253.00	6.73	185519.18	
Home Delivered Meals Total:						28808906.94
Home Delivered Meals	per meal	14571	242.00	8.17	28808906.94	
Home Maintenance and Chore Total:						1166837.40
Home Maintenance and Chore	per job	729	1510.00	1.06	1166837.40	
Home Medical Equipment and Supplies Total:						3930514.80
Home Medical Equipment and Supplies	per item	7719	4.00	127.30	3930514.80	
Home Modification Total:						4260098.00
Home Modification	per job	850	1.00	5011.88	4260098.00	
Non-medical Transportation Total:						508833.20
Non-medical Transportation	per trip	677	8.00	93.95	508833.20	
Nutritional Consultation Total:						24942.40
Nutritional Consultation	1/4 hour	131	17.00	11.20	24942.40	
Out-of-Home Respite Total:						442224.00
Out-of-Home Respite	per day	222	10.00	199.20	442224.00	
Personal Emergency						5508630.63
GRAND TOTAL:						336375277.80
Total Estimated Unduplicated Participants:						39807
Factor D (Divide total by number of participants):						8450.15
Average Length of Stay on the Waiver:						264

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Response System Total:						
Personal Emergency Response System-monthly fee	1 month	1767	1.00	34.89	61650.63	
Personal Emergency Response System-Installation	1 install	18340	9.00	33.00	5446980.00	
Social Work Counseling Total:						691278.84
Social Work Counseling	1/4 hour	427	108.00	14.99	691278.84	
Structured Family Caregiving Services Total:						0.00
Structured Family Caregiving Services	per day	0	0.00	0.01	0.00	
Waiver Nursing Service Total:						360264.32
Waiver Nursing Service	1/4/hour	43	689.00	12.16	360264.32	
GRAND TOTAL:						336375277.80
Total Estimated Unduplicated Participants:						39807
Factor D (Divide total by number of participants):						8450.15
Average Length of Stay on the Waiver:						264

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 Service Total:						7665054.10
Adult Day Service	per day	685	418.00	26.77	7665054.10	
Homemaker Total:						9078449.60
Homemaker					9078449.60	
GRAND TOTAL:						435224790.58
Total Estimated Unduplicated Participants:						39807
Factor D (Divide total by number of participants):						10933.37
Average Length of Stay on the Waiver:						268

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	1/4 hour	1840	902.00	5.47		
Personal Care Total:						340870392.72
Personal Care	1/4 hour	19206	2418.00	7.34	340870392.72	
Alternative Meals Service Total:						4760.00
Alternative Meals Service	per meal	7	68.00	10.00	4760.00	
Choices - Home Care Attendant Service (Participant Directed Home Care Attendant) Total:						16277841.00
Choices - Home Care Attendant Service (Participant Directed Home Care Attendant)	1/4 hour	827	4374.00	4.50	16277841.00	
Community Integration Total:						9525.60
Community Integration	1/4 hour	28	90.00	3.78	9525.60	
Community Transition Total:						72001.04
Community Transition	per job	46	1436.00	1.09	72001.04	
Enhanced Community Living Service Total:						322752.00
Enhanced Community Living Service	1/4 hour	48	656.00	10.25	322752.00	
Home Care Attendant Total:						237266.16
Home Care Attendant	1/4 hour	23	1272.00	8.11	237266.16	
Home Delivered Meals Total:						33907850.34
Home Delivered Meals	per meal	15197	246.00	9.07	33907850.34	
Home Maintenance and Chore Total:						1269937.20
Home Maintenance and Chore	per job	760	1533.00	1.09	1269937.20	
Home Medical Equipment and Supplies Total:						4222064.00
Home Medical Equipment and Supplies	per item	8050	4.00	131.12	4222064.00	
GRAND TOTAL:						435224790.58
Total Estimated Unduplicated Participants:						39807
Factor D (Divide total by number of participants):						10933.37
Average Length of Stay on the Waiver:						268

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Modification Total:						5553302.99
Home Modification	per job	887	1.00	6260.77	5553302.99	
Non-medical Transportation Total:						546556.96
Non-medical Transportation	per trip	706	8.00	96.77	546556.96	
Nutritional Consultation Total:						26084.80
Nutritional Consultation	1/4 hour	137	17.00	11.20	26084.80	
Out-of-Home Respite Total:						462144.00
Out-of-Home Respite	per day	232	10.00	199.20	462144.00	
Personal Emergency Response System Total:						5917665.47
Personal Emergency Response System-monthly fee	1 month	1843	1.00	35.93	66218.99	
Personal Emergency Response System- Installation	1 month	19128	9.00	33.99	5851446.48	
Social Work Counseling Total:						755788.00
Social Work Counseling	1/4 hour	445	110.00	15.44	755788.00	
Structured Family Caregiving Services Total:						7612665.00
Structured Family Caregiving Services	per day	500	151.00	100.83	7612665.00	
Waiver Nursing Service Total:						412689.60
Waiver Nursing Service	1/4/hour	45	699.00	13.12	412689.60	
GRAND TOTAL:						435224790.58
Total Estimated Unduplicated Participants:						39807
Factor D (Divide total by number of participants):						10933.37
Average Length of Stay on the Waiver:						268

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 Service Total:						8073805.23
Adult Day Service	per day	713	423.00	26.77	8073805.23	
Homemaker Total:						9558234.24
Homemaker	1/4 hour	1916	912.00	5.47	9558234.24	
Personal Care Total:						357384600.00
Personal Care	1/4 hour	19476	2500.00	7.34	357384600.00	
Alternative Meals Service Total:						4830.00
Alternative Meals Service	per meal	7	69.00	10.00	4830.00	
Choices - Home Care Attendant Service (Participant Directed Home Care Attendant) Total:						21396262.50
Choices - Home Care Attendant Service (Participant Directed Home Care Attendant)	1/4 hour	1075	4423.00	4.50	21396262.50	
Community Integration Total:						10265.71
Community Integration	1/4 hour	29	91.00	3.89	10265.71	
Community Transition Total:						78059.52
Community Transition	per job	48	1452.00	1.12	78059.52	
Enhanced Community Living Service Total:						339787.50
Enhanced Community Living Service	1/4 hour	50	663.00	10.25	339787.50	
Home Care Attendant Total:						250307.04
Home Care Attendant	1/4 hour	24	1286.00	8.11	250307.04	
Home Delivered Meals Total:						35735137.89
Home Delivered					35735137.89	
GRAND TOTAL:						46271868.11
Total Estimated Unduplicated Participants:						39807
Factor D (Divide total by number of participants):						11625.39
Average Length of Stay on the Waiver:						271

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Meals	per meal	15823	249.00	9.07		
Home Maintenance and Chore Total:						1373176.00
Home Maintenance and Chore	per job	791	1550.00	1.12	1373176.00	
Home Medical Equipment and Supplies Total:						4527416.20
Home Medical Equipment and Supplies	per item	8381	4.00	135.05	4527416.20	
Home Modification Total:						5784951.48
Home Modification	per job	924	1.00	6260.77	5784951.48	
Non-medical Transportation Total:						586059.60
Non-medical Transportation	per trip	735	8.00	99.67	586059.60	
Nutritional Consultation Total:						27227.20
Nutritional Consultation	1/4 hour	143	17.00	11.20	27227.20	
Out-of-Home Respite Total:						482064.00
Out-of-Home Respite	per day	242	10.00	199.20	482064.00	
Personal Emergency Response System Total:						6346335.44
Personal Emergency Response System-monthly fee	1 month	1919	1.00	37.00	71003.00	
Personal Emergency Response System-Installation	1 install	19916	9.00	35.01	6275332.44	
Social Work Counseling Total:						817148.70
Social Work Counseling	1/4 hour	463	111.00	15.90	817148.70	
Structured Family Caregiving Services Total:						9560235.38
Structured Family Caregiving Services	per day	521	181.00	101.38	9560235.38	
GRAND TOTAL:						462771868.11
Total Estimated Unduplicated Participants:						39807
Factor D (Divide total by number of participants):						11625.39
Average Length of Stay on the Waiver:						271

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Waiver Nursing Service Total:						435964.48
Waiver Nursing Service	1/4/hour	47	707.00	13.12	435964.48	
GRAND TOTAL:						46271868.11
Total Estimated Unduplicated Participants:						39807
Factor D (Divide total by number of participants):						11625.39
Average Length of Stay on the Waiver:						271

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 Service Total:						8509888.53
Adult Day Service	per day	741	429.00	26.77	8509888.53	
Homemaker Total:						10079022.00
Homemaker	1/4 hour	1992	925.00	5.47	10079022.00	
Personal Care Total:						377012508.68
Personal Care	1/4 hour	20246	2537.00	7.34	377012508.68	
Alternative Meals Service Total:						4900.00
Alternative Meals Service	per meal	7	70.00	10.00	4900.00	
Choices - Home Care Attendant Service (Participant Directed Home Care Attendant) Total:						28234008.00
Choices - Home Care Attendant Service (Participant Directed Home Care Attendant)	1/4 hour	1398	4488.00	4.50	28234008.00	
Community Integration Total:						11040.00
GRAND TOTAL:						494052495.43
Total Estimated Unduplicated Participants:						39807
Factor D (Divide total by number of participants):						12411.20
Average Length of Stay on the Waiver:						275

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Integration	1/4 hour	30	92.00	4.00	11040.00	
Community Transition Total:						84697.50
Community Transition	per job	50	1473.00	1.15	84697.50	
Enhanced Community Living Service Total:						358709.00
Enhanced Community Living Service	1/4 hour	52	673.00	10.25	358709.00	
Home Care Attendant Total:						264588.75
Home Care Attendant	1/4 hour	25	1305.00	8.11	264588.75	
Home Delivered Meals Total:						37745684.79
Home Delivered Meals	per meal	16449	253.00	9.07	37745684.79	
Home Maintenance and Chore Total:						1486956.90
Home Maintenance and Chore	per job	822	1573.00	1.15	1486956.90	
Home Medical Equipment and Supplies Total:						4847356.80
Home Medical Equipment and Supplies	per item	8712	4.00	139.10	4847356.80	
Home Modification Total:						6016599.97
Home Modification	per job	961	1.00	6260.77	6016599.97	
Non-medical Transportation Total:						627457.92
Non-medical Transportation	per trip	764	8.00	102.66	627457.92	
Nutritional Consultation Total:						28369.60
Nutritional Consultation	1/4 hour	149	17.00	11.20	28369.60	
Out-of-Home Respite Total:						501984.00
Out-of-Home Respite	per day	252	10.00	199.20	501984.00	
Personal Emergency Response System Total:						6795285.66
Personal					76009.50	
GRAND TOTAL:					494052495.43	
Total Estimated Unduplicated Participants:					39807	
Factor D (Divide total by number of participants):					12411.20	
Average Length of Stay on the Waiver:						275

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Emergency Response System-monthly fee	1 month	1995	1.00	38.10		
Personal Emergency Response System-Installation	1 install	20704	9.00	36.06	6719276.16	
Social Work Counseling Total:						889758.61
Social Work Counseling	1/4 hour	481	113.00	16.37	889758.61	
Structured Family Caregiving Services Total:						10092733.76
Structured Family Caregiving Services	per day	542	181.00	102.88	10092733.76	
Waiver Nursing Service Total:						460944.96
Waiver Nursing Service	1/4/hour	49	717.00	13.12	460944.96	
GRAND TOTAL:					494052495.43	
Total Estimated Unduplicated Participants:					39807	
Factor D (Divide total by number of participants):					12411.20	
Average Length of Stay on the Waiver:						275

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 Service Total:						8954966.55
Adult Day Service	per day	769	435.00	26.77	8954966.55	
Homemaker Total:						10610618.48
Homemaker	1/4 hour	2068	938.00	5.47	10610618.48	
Personal Care Total:						397058650.56
GRAND TOTAL:					528033667.63	
Total Estimated Unduplicated Participants:					39807	
Factor D (Divide total by number of participants):					13264.84	
Average Length of Stay on the Waiver:						279

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care	1/4 hour	21016	2574.00	7.34	397058650.56	
Alternative Meals Service Total:						4970.00
Alternative Meals Service	per meal	7	71.00	10.00	4970.00	
Choices - Home Care Attendant Service (Participant Directed Home Care Attendant) Total:						37227604.50
Choices - Home Care Attendant Service (Participant Directed Home Care Attendant)	1/4 hour	1817	4553.00	4.50	37227604.50	
Community Integration Total:						11849.13
Community Integration	1/4 hour	31	93.00	4.11	11849.13	
Community Transition Total:						91671.84
Community Transition	per job	52	1494.00	1.18	91671.84	
Enhanced Community Living Service Total:						378040.50
Enhanced Community Living Service	1/4 hour	54	683.00	10.25	378040.50	
Home Care Attendant Total:						279178.64
Home Care Attendant	1/4 hour	26	1324.00	8.11	279178.64	
Home Delivered Meals Total:						39801654.25
Home Delivered Meals	per meal	17075	257.00	9.07	39801654.25	
Home Maintenance and Chore Total:						1606437.84
Home Maintenance and Chore	per job	853	1596.00	1.18	1606437.84	
Home Medical Equipment and Supplies Total:						5182362.44
Home Medical Equipment and Supplies	per item	9043	4.00	143.27	5182362.44	
Home Modification Total:						6248248.46
Home Modification	per job		1.00	6260.77	6248248.46	
GRAND TOTAL:					528033667.63	
Total Estimated Unduplicated Participants:					39807	
Factor D (Divide total by number of participants):					13264.84	
Average Length of Stay on the Waiver:						279

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		998				
Non-medical Transportation Total:						670814.56
Non-medical Transportation	per trip	793	8.00	105.74	670814.56	
Nutritional Consultation Total:						29512.00
Nutritional Consultation	1/4 hour	155	17.00	11.20	29512.00	
Out-of-Home Respite Total:						521904.00
Out-of-Home Respite	per day	262	10.00	199.20	521904.00	
Personal Emergency Response System Total:						7265161.25
Personal Emergency Response System-monthly fee	1 month	2071	1.00	39.23	81245.33	
Personal Emergency Response System- Installation	1 install	21492	9.00	37.14	7183915.92	
Social Work Counseling Total:						966937.25
Social Work Counseling	1/4 hour	499	115.00	16.85	966937.25	
Structured Family Caregiving Services Total:						10636635.14
Structured Family Caregiving Services	per day	563	181.00	104.38	10636635.14	
Waiver Nursing Service Total:						486450.24
Waiver Nursing Service	1/4/hour	51	727.00	13.12	486450.24	
GRAND TOTAL:					528033667.63	
Total Estimated Unduplicated Participants:					39807	
Factor D (Divide total by number of participants):					13264.84	
Average Length of Stay on the Waiver:						279