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 waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

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

1. Request Information

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

B. Program Title:
Transitions DD Waiver 1634 Amendment

C. Waiver Number:OH.0383
Original Base Waiver Number: OH.0383.

D. Amendment Number:OH.0383.R03.01

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

08/01/16

Approved Effective Date: 08/01/16
Approved Effective Date of Waiver being Amended: 07/01/15

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The renewal reflects the changes required to align with the Medicaid State Plan to convert from a section 209(b) state to a section 1634 state.

Main 8.B. Attachment Optional specifies the 1634 transition plan for the waiver

Appendix B-4 identifies the Medicaid State Plan eligibility groups that are served in the waiver, including changes to reflect the conversion to a section 1634 state.

Appendix B-5 makes revisions to State policies regarding post-eligibility treatment of income to reflect the conversion from a 209(b) to a 1634 state.

In addition, Appendix C-5 was updated to reflect Decemmber 2015 Public Input Process and Comment Summary for the Revised Draft of Statewide Transition Plan.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☑ Waiver Application	Main 6. I, Main 8.B.
☑ Appendix A – Waiver Administration and Operation	A-1-b, Att 2
☑ Appendix B – Participant Access and Eligibility	B-4-a-1, B-4-b , B-5-
☑ Appendix C – Participant Services	C-5
☑ Appendix D – Participant Centered Service Planning and Delivery	D-1-b
☐ Appendix E – Participant Direction of Services	
☐ Appendix F – Participant Rights	
☐ Appendix G – Participant Safeguards	
☐ Appendix H	
☐ Appendix I – Financial Accountability	
☐ Appendix J – Cost-Neutrality Demonstration	

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*):
Transitions DD Waiver 1634 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.0383
Waiver Number:OH.0383.R03.01
Draft ID: OH.013.03.01

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

E. **Proposed Effective Date of Waiver being Amended: 07/01/15**
Approved Effective Date of Waiver being Amended: 07/01/15

1. Request Information (2 of 3)

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

- [ ] **Hospital**

  Select applicable level of care

  - ( ) **Hospital as defined in 42 CFR §440.10**
    If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
  - ( ) **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**
- [ ] **Nursing Facility**

  Select applicable level of care

  - ( ) **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**
    If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
  - ( ) **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**
- [x] **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

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

1. Request Information (3 of 3)

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

Select one:

- (•) **Not applicable**
- ( ) **Applicable**

  Check the applicable authority or authorities:

  - [ ] **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
  - [ ] **Waiver(s) authorized under §1915(b) of the Act.**

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

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

    - [ ] **§1915(b)(1) (mandated enrollment to managed care)**
    - [ ] **§1915(b)(2) (central broker)**
    - [ ] **§1915(b)(3) (employ cost savings to furnish additional services)**
    - [ ] **§1915(b)(4) (selective contracting/limit number of providers)**
  - [ ] **A program operated under §1932(a) of the Act.**

    Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:
  - [ ] **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**
☐ **A program authorized under §1115 of the Act.**
Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:
☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The objective is to provide services to individuals with developmental disabilities who were enrolled on the Transitions - Developmental Disabilities Waiver as of January 1, 2013. These individuals would otherwise be eligible for Medicaid services in an intermediate care facility for individuals with intellectual disabilities (ICF/IID).

The organizational structure for this waiver includes the Ohio Department of Medicaid (ODM) as the Single State Medicaid Agency, the Ohio Department of Developmental Disabilities (DODD) as the day-to-day administrator of the waiver, and the County Boards as the local operating entity.

The two state departments operate in accordance with an interagency agreement. ODM retains final authority for the waiver, its administration and operation.

The traditional method of service delivery is used. Providers include County Boards, agency providers and independent providers, and for profits and not-for-profits.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

- (●) **Not Applicable**
- ( ) **No**
- ( ) **Yes**

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

- (●) **No**
- ( ) **Yes**

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

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

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

5. Assurances

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

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

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

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. **Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the

Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

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

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
Throughout the life of the waiver, DODD has engaged individuals enrolled in the Transitions DD waiver, including parents and other caregivers, providers, and other advocates in both a formal and informal capacity to discuss potential changes to the Transitions DD waiver.

April 2016 Public Input Process for the Waiver Amendment

Date of the formal public comment period: February 1, 2016 through March 2, 2016.

Active Link used to post the entire waiver application http://medicaid.ohio.gov/RESOURCES/PublicNotices.aspx

Electronic Methods: On 2/1/2016, Ohio posted a public notice, summary of the draft waiver, the draft waiver itself on the Ohio Department of Medicaid (ODM) website. The Ohio Department of Developmental Disabilities (DODD) posted public notices on their websites, which linked to the ODM website.

Non-electronic methods used for informing the public on the opportunity to provide comments on the proposed waiver amendments included:

The local County Department of Job and Family Services offices posted a copy of the Public Notice and Request for Comment announcement, which included information about how to obtain a non-electronic copy of the waiver and the proposed amendments.

DODD follows a protocol to advance-publish the changes in the waiver application and provide notice to inform the public including but not limited to individuals, families, County Boards, provider association, and advocates of changes incorporated in the Transitions DD waiver amendment application. These public notices include a mass distribution using multiple listservs via e-mail and updates to DODD's website. Individuals are able to obtain the waiver application which is available in both hard copies and online and requests may be through mail or phone request. By providing public notice it allows an opportunity for public input prior to submission of the Transitions DD waiver amendment application.

Ohio offered five methods for the public to provide input on the proposed waiver amendment and/or request a non-electronic copy of the plan:

E-mail: HCBSfeedback@medicaid.ohio.gov

Written comments sent to:
Ohio Department of Medicaid
P.O. Box 182709, 5th Floor
Columbus OH 43218

Fax: (614) 466-6945

Calling toll-free to leave a voicemail message at: 1 (800) 364-3153

Courier or in-person submission to:
Attn: BLTCSS, Lazarus Building, 50 W. Town St., Columbus OH 43218.

The state received submissions from seven unique commenters which were specific to the changes to the Disability Determination Redesign (aka 1634 conversion) during the formal public comment period held February 1st through March 2, 2016. Some submissions addressed more than one theme. The following is a summary of the comments received:

Comment: Request the state consider retaining some form of the spenddown option including providing a spend down option for those individuals with End Stage Renal Disease. (2)
Response: Most individuals who are aged, blind, or disabled and served by the Medicaid program will not notice a change in their coverage. All individuals impacted by the change will have a pathway to coverage. Most will transition from one type of Medicaid coverage to another. In some cases, individuals with income that exceeds the new, higher Medicaid eligibility limit will be referred to the Federal Marketplace to obtain subsidized health care coverage. No changes were made to the waiver amendment.

Comment: Concern about the elimination of the cost of care deduction from the special income level. Ohio could adopt a limited, targeted spend down for aged, blind and disabled individuals only. (2)
Response: Most individuals who are aged, blind, or disabled and served by the Medicaid program will not notice a change in their coverage. When an individual's income is over the Medicaid income limit for long term care services, he/she can deposit their excess income into a Qualified Income Trust to stay eligible for Medicaid services. ODM is committed to working with our partners to implement the required Qualified Income Trust process in order to insure that individuals enrolled on waiver or who reside in institutional settings do not lose coverage as a result of the need for a trust. ODM is working with case managers on developing a transition plan that insures there is no gap in coverage. Additionally, ODM is exploring the possibility of other flexibilities related to the QIT process. Additionally, ODM is in the process of developing education and outreach materials including an educational letter, fact sheet and informational video for individuals who will be effected by this change. As soon as this information is available it will be shared with stakeholders. No changes were made to the waiver amendment.

Comment: If spenddown is eliminated, request additional resources for outreach to people in the community with high medical needs who may need a waiver to stay on Medicaid. (1)
Response: The State's Aging and Disability Network partners across the system will continue to link individuals to access long term services and supports in a timely way. In addition, the State established a dedicated Disability Determination Redesign webpage to ensure all stakeholders have the same access the most current and accurate information. (http://www.medicaid.ohio.gov/INITIATIVES/DisabilityDeterminationRedesign.aspx) No changes were made to the waiver amendment.

Comment: Request information on the development of a waiver, as outlined in the Ohio Revised Code Section 516.32 and Am.Sub. HB. 64, to preserve a spenddown pathway for individuals with cystic fibrosis. (2)
Response: The State has a technical assistance call scheduled with the Centers for Medicare and Medicaid Services to discuss the options regarding preserving a spenddown option for individuals with cystic fibrosis. No changes were made to waiver

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: Donica

First Name: Kimberly J.

Title: Bureau Chief, Bureau of Long Term Care Services and Supports

Agency: Ohio Department of Medicaid

Address: 50 West Town Street, Suite 400

Address 2:

City: Columbus

State: **Ohio**

Zip: 43218-2709

Phone: (614) 752-3523 **Ext:** ☐ **TTY**

Fax: (614) 466-6945

E-mail: kimberly.donica@medicaid.ohio.gov

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

Last Name:

Horvath

First Name: Lori

Title: Deputy Director, Medicaid Development and Administration

Agency: Ohio Department of Developmental Disabilities

Address: 30 East Broad Street

Address 2: 13th Floor

City: Columbus

State: **Ohio**

Zip: 43215

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

Fax: (614) 752-5303

E-mail: lori.horvath@dodd.ohio.gov

8. Authorizing Signature

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

Signature: Sue Fredman

State Medicaid Director or Designee

Submission Date: Jun 23, 2016

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

Last Name: McCarthy

First Name: John B.

Title: Director

Agency: Ohio Department of Medicaid

Address: 50 West Town Street, Suite 400

Address 2: P.O. Box 182709

City: Columbus

State: **Ohio**

Zip: 43218

Phone: (614) 466-4443 **Ext:** ☐ **TTY**

Fax: (614) 752-3986

E-mail: john.mccarthy@medicaid.ohio.gov

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:

Background/Waiver Operation Transfer

The Ohio Department of Developmental Disabilities operates four 1915(c) waiver programs that serve Individuals with an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care which includes the Transitions DD waiver. The operation of the Transitions DD Waiver was transferred from the Ohio Department of Medicaid (ODM) to the Ohio Department of Developmental Disabilities (DODD) effective January 1, 2013. This transfer was part of a larger initiative set forth in House Bill 153, passed in July 2011, to have DODD administer all Medicaid-funded programs for individuals with developmental disabilities. The intent was to create a unified, efficient service delivery system.

At the time of the transfer to DODD the waiver was capped at 3200 unduplicated slots for WY's 3, 4, and 5 which included the 115 slots that were reserved for individuals who required at least one skilled nursing service daily, seven days a week. County Boards assumed case management functions and coordinated the scheduling of the reassessments. County Boards then assumed responsibility for conducting level of care reassessments, development of service plans, and monitoring implementation in accordance with Ohio Administrative Code rule 5123:2-1-11.

DODD formed a stakeholder group in 2013 for the purpose of identifying aspects of the Transitions DD waiver that may require enhancements or improvements to better meet the needs of those enrolled. This group is comprised of family members of individuals served, the ARC of Ohio, provider agencies, provider associations, County Boards, DODD, and the Ohio

Department of Medicaid. The stakeholder group outlined short term and long term strategies for improving alignment between the Transitions DD waiver and other waivers administered by DODD.

As part of the short-term strategy a waiver amendment was submitted and approved with an effective date 7/1/14, which involved modifications to the provider qualifications and service requirements in an effort to enhance the provider pool to allow greater access for individuals enrolled. Changes included in the amendment were:
•Allowing other agencies to be providers of Personal Care Aide services
•Aligning requirements for criminal history/background checks for independent providers of Personal Care Aide services with Section 5123.081 of the Ohio Revised Code
•Eliminating the requirement for Adult Day Health Centers to provide meals
•Allowing medical necessity for Home Modification services to be established through means other than an occupational or physical therapy evaluation
•Aligning the budget limitation for Home Modification and Supplemental Adaptive and Assistive Device services with calendar year, rather than rolling years
•Establishing an annual limitation of Out-of-Home Respite services to 90 calendar days per year

In addition to these changes, the stakeholder group began to discuss long term strategy of phasing out the Transitions DD Waiver at the time of the waiver renewal over the first two years of the waiver span. The workgroup's priority was to ensure the needs of individuals currently enrolled in the waiver would continue to be met through the opportunity to enroll in another waiver. Emphasis was placed on minimizing any disruption to the lives of individuals as enrollment in other waivers occurs.

DODD formed a stakeholder group in 2013 for the purpose of identifying aspects of the Transitions DD waiver that may require enhancements or improvements to better meet the needs of those enrolled. This group is comprised of family members of individuals served, the ARC of Ohio, provider agencies, provider associations, County Boards, DODD, and the Ohio Department of Medicaid. The stakeholder group outlined short term and long term strategies for improving alignment between the Transitions DD waiver and other waivers administered by DODD. The proposed phase out of Transitions DD was also included as part of the statewide HCBS Transition Plan. Public notice was posted for the HCBS transition plan on December 15, 2014 at:
http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=27gzh4u48iE%3d&tabid=125

In addition, the Transitions TDD phase-out proposal was shared during five regional forum plans during which the HCBS Transition Plan was discussed, as well as with DD Council on March 12, 2015.

Phase-out schedule of Transitions Developmental Disability Waiver

The phase-out of Transitions DD Waiver will occur over a two year period, beginning July 1, 2015 through June 30, 2017. Effective July 1, 2015, no new entrants will be enrolled in Transitions DD. It is presumed that most individuals enrolled in the Transitions DD Waiver will choose to enroll in the Individual Options (IO) Waiver (OH.0231) which offers the most robust array of services. However, individuals may choose to enroll in the SELF (OH.0877) or Level One (OH.0380) Waivers, as well.

During the initial year of the phase-out, from July 1, 2015 through, June 30, 2016, DODD will begin with voluntary enrollments for those individuals receiving Personal Care Aide (PCA) services only. County Board Service and Support Administrators (SSA) will assist individuals through this transition.
The final phase-out will occur July 1, 2016 through June 30, 2017 for individuals enrolled on Transitions DD who require and are receiving nursing services. In order to meet the needs of those requiring nursing services, Waiver Nursing is being added to the IO Waiver with an effective target date of July 1, 2016.

Summary of how the applicable waiver (IO, SELF and Level One)was updated/amended to accommodate those individual who are transitioning to the waiver from the Transitions DD Waiver:

INDIVIDUAL OPTIONS (OH.0231) WAIVER CHANGES
IO Waiver Amendment was submitted to CMS for proposed effective date of 7/1/15 to include reserved capacity of 3,000 to support the transfer of individuals enrolled on the Transitions DD Waiver to the Individual Options Waiver.

The IO Waiver will be amended with a submission date of 4/1/16 to add Waiver Nursing Services with an effective date of July 1, 2016 to allow for continuity of care.
SELF (OH.0877) and Level One (OH.0877) Waivers Changes

The SELF and Level One waiver applications do not need amended to accommodate those individuals who chose to transfer to

either of these waivers. SELF and Level One Waiver Capacity does not need to be increased to accommodate transfers since the State anticipates very few will chose the SELF or Level One Waivers.
HCBS CERTIFIED WAIVER PROVIDERS
All Transitions DD providers will be certified under the Individual Options, Level One and SELF waivers beginning July 1, 2015 to allow for continuity of care. This initial certification will be time-limited for one year. These providers will be required to submit renewal applications to DODD by July 1, 2016.

RULES
Rescission of Transitions DD authorization rule and rescission of Ohio Administrative Code 2-9-50 through 2-9-59 will be effective June 30, 2017. A new service rule related to the IO Waiver Nursing service will be effective July 1, 2016.

IMPACT OF PROPOSED PHASE-OUT OF THE TDD WAIVER
ODM and DODD are confident that by working in partnership, Ohio can accomplish undertaking the phase out Transitions DD and transitioning individuals into the Individuals Options, Level One and SELF Waivers in a manner that allows for the safe transfer of individuals, emphasizing continuity of care and minimizing service disruptions. Both Transitions DD and IO, Level One and SELF Waivers are administered by the same operational agencies promoting continuity of care. The Transitions DD waiver renewal included the new ICF/IID LOC process that is the same as the LOC process for IO, Level One and SELF waivers. Appendix A:7 Waiver Administration and Operation section aligns operation of all four DODD administered waivers.

CASE MANAGEMENT
The Transitions DD and Individual Options, Level One, and SELF waivers are presently administered by the same State agency. In addition, case management for both the Transitions DD and Individual Options, Level One and SELF Waivers is provided by local county boards of developmental disabilities. This provides continuity of care for the individuals transitioning to the IO, Level One and SELF waivers.

LEVEL OF CARE AND SERVICE PLANNING
The ICF/IID LOC will be the same for all waivers administered by DODD effective July 1, 2015. The new LOC rule of the Ohio Administrative Code 5123:2-8-01 will be effective for all waivers (Transitions DD, IO, Level One and SELF).
Service planning will remain with the same entity and SSA's will work with the individuals and their teams to develop a Person Centered Individual Service Plan.
COMMUNICATIONS
Ohio will communicate its plan to close the Transitions DD waiver and transfer eligible individuals to Individual Options Waiver with all affected parties. This will include, but not be limited to individuals enrolled on the Transitions DD Waiver, County Boards, Transitions DD providers, and other stakeholders. A communication strategy and timeline will be developed by DODD for this purpose. ODM and DODD will coordinate the issuance of an initial public notice about the phase-out and termination of the Transitions DD Waiver in a number of ways.
-DODD will have an announcement that will be posted on the department's respective website.
-Notice will be issued to the County Boards who are responsible for Case Management and provider oversight contractors, and they will be asked to disseminate the information to their local partners
-Notice will be issued to stakeholders on DODD's respective rule distribution lists (including but not limited to County Boards, the Ohio Olmstead Task Force, Disability Rights Ohio, Ohio County Board Association, the Ohio Provider Resource Association, the Ohio Waiver Network, Values and Faith Alliance, the Arc of Ohio, the Family Advisory Council, the Ohio Council of Home Care and Hospice).
-ODM and DODD will issue notice through their departmental advisory groups, including HCBS Policy
TIMELINE OF MAJOR MILESTONES

April 1, 2015 Transitions DD – Submit waiver amendment request to CMS proposing closure and phase-out (beginning July 1, 2015

April 1, 2015 Stakeholder Communications – Initial stakeholder communication commences

July 1, 201 Begin transfer of Transitions DD to another DD Waiver selected by the individual (IO, Level One, SELF) Transitions DD providers certified for Individual Options, Level One, and SELF Waivers for one year.

July 1, 2015-June 30, 2016 Transitions DD Quarterly Transfer Plan

July-Sept 2015	Oct-Dec 2015	Jan-March 2016	April-June 2016
410	293	452	511

July 1, 2016
Effective date of IO Waiver Nursing and initial transfer of individuals who require waiver nursing to IO Waiver
Transitions DD providers renew certification for Individual Options, Level One, and SELF Waivers

July 1, 2016-June 30, 2017 Transitions DD Quarterly Transfer Plan

July-Sept 2016	Oct-Dec 2016	Jan-March 2017	April-June 2017
313	242	315	318

February 1, 2017-March 3, 2017
Public Hearing regarding Transitions DD Waiver Amendment to terminated on June 30, 2017

April 1, 2017
Submit Waiver Amendment to CMS to close the Transitions DD Waiver with proposed effective date of June 30, 2017.

June 30, 2017
Rescind Ohio Administrative Code rules pertaining to Transitions DD Waiver

Quarterly progress reports to CMS should occur on 10/1/15, 1/1/16, 4/1/16, 7/1/16, 10/1/16, 1/1/17, 4/1/17, and final on 7/1/17.

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.

Under the umbrella of the Office of Health Transformation (http://www.healthtransformation.ohio.gov), an interagency project team, comprised of state staff from the Ohio Department of Aging (ODA), the Ohio Department of Developmental Disabilities (DODD), and the Ohio Department of Medicaid (ODM) developed a shared approach for developing the draft statewide transition plan. Compliance with the CMS rule creates different opportunities and challenges for the Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF-IID) waiver system and the Nursing-facility based level of care (NF-LOC) waiver system. As a result, the project team leveraged the existing resources and infrastructures of each waiver system to established system specific assessment methodologies to conduct a review of the applicable state statutes, administrative rules, approved waivers, provider licensing, qualifications and waiver certification requirements, service specifications, case management administrative and operational processes, person-centered planning processes, monitoring and operational oversight activities, and quality improvement strategies to determine the current level of compliance and identify areas for improvement and remediation to achieve and maintain full compliance.

A copy of the full draft transition plan was posted by Ohio's Office of Health Transformation from December 15, 2014 through January 23, 2015. Notice of public input was posted on DODD's website, included in DODD's Pipeline publication which is available in both hard copies and online, and distributed to all stakeholder mailing lists, including individuals served, families, county boards of developmental disabilities, and providers of HCBS. Stakeholders were afforded the opportunity to provide input through email, a mailing address, through voicemail, and through two public hearings. DODD participated in the state agency panel for public hearings that was held to obtain feedback from the public.

The results of the preliminary assessments for both residential and non-residential adult day services settings is described

below. In addition, the remediation strategies as outlined in the Ohio Statewide Transition Plan Appendix 2: ICF-IID Level of Care Waivers Setting Remediation Grid for each of the settings not in full compliance are specified below.

I. Residential Settings

The results of the state's preliminary assessment of the residential settings are described below.

A. Settings which currently do not meet HCBS characteristics

DODD began operating the Transitions DD Waiver in January 2013. This waiver was originally operated by the Ohio Department of Medicaid and was modeled after the Ohio Home Care Waiver which serves individuals with nursing facility levels of care. The Personal Care Aide service is limited in scope and is designed to provide hands-on assistance with activities of daily living and instrumental activities of daily living. Individuals enrolled in Transitions DD are not residing in a more traditional group home settings with twenty-four shifts and are not receiving services in settings of more than a one to three ratio. The majority of individuals enrolled in this waiver are children or young adults living with families or other caregivers. DODD presumed their homes met the requirements of HCB settings.

Service and Support Administrators (SSA) conduct home visits, in accordance with individual plans. Through the residential survey process, no county board identified a residential setting in which Transitions DD services are provided as non-compliant with the regulation. These residential settings will be monitored on an ongoing basis through SSA monitoring and the provider compliance process.

No remediation strategies noted at this time for settings not meeting HCBS characteristics for this waiver.

II. Non-Residential Adult Day Waiver Services

The results of the state's preliminary assessment of the non-residential adult day waiver service settings are described below.

A. Settings which currently do not meet HCBS characteristics

The Adult Day Health Center service offers only facility-based options and no employment supports to the individuals enrolled in the waiver, who are primarily young adults with an average age of 22.

Remediation Strategy: As part of this waiver renewal, a phase-out plan has been submitted to CMS that will include plans to migrate all individuals enrolled in the Transitions DD Waiver to another waiver operated by DODD, which will include the new adult day array services.

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

December 2015 Update: The Centers for Medicare and Medicaid Services (CMS) completed its initial review of Ohio's Statewide Transition Plan and issued the findings to the State on July 23, 2015. As a result of the initial CMS review of the draft statewide transition plan, the plan was revised and posted for public comment. During Ohio's second formal public comment period, a copy of the full draft transition plan was posted to the website of Ohio's Office of Health Transformation between October 15, 2015 and November 15, 2015.

Ohio submitted the revised draft statewide transition plan through the portal on December 3, 2015. The State awaits CMS approval of the revised plan. While the State is attaching the updated IO Waiver Transition plan, the State expects that language in the State's Transition Plan approved by CMS and related to the IO Waiver will take precedence over the language in the waiver transition plan.

December 2015: Public Input Process and Comment Summary for the Revised Draft Statewide Transition Plan

Dates of the formal public comment period for the revised draft statewide transition plan: October 15, 2015 through November 15, 2015.

Active Link used to post the entire plan:
http://www.healthtransformation.ohio.gov/CurrentInitiatives/ExpandandStreamlineHCBS.aspx.

Ohio used the following methods to announce the opportunity to review the revised draft statewide transition plan:

Electronic: Ohio posted the revised draft plan, a public notice, summary, and stakeholder feedback on the original draft plan on the Ohio Office of Health Transformation (OHT) website. The Ohio Department of Medicaid (ODM), the Ohio Department of Aging (ODA) and the Ohio Department of Developmental Disabilities (DODD) posted public notices on their websites, which linked to the OHT site.

Remittance advice. To reach the provider community, ODM placed a notice on provider "remittance advices" during the weeks of October 22 and 29, 2015, advising providers of the draft transition plan and listing website at which they could read the plan and submit comments. Home health agencies, personal care aides and home care attendants, and waiver services organizations were among the provider types notified.

Non-Electronic: The local County Department of Job and Family Services offices posted a copy of the Public Notice and Request for Comment announcement, which included information about how to obtain a non-electronic copy of the waiver and the proposed amendments.

During the public comment period, conversations between waiver case managers individuals served on Medicaid waivers, their family members, or any individuals who may be interested, included the opportunity to provide public comment on the Plan and how to obtain a non-electronic copy of the waiver and proposed amendments.
Announcements at meetings, e-mails and conference calls. Each agency took the opportunity to inform attendees of various Medicaid-related meetings and conference calls and stakeholder e-mail groups about the opportunity to review and comment on the HCBS draft transition plan. Combined, announcements were made at least 16 times through the various methodologies reaching almost 13,000 people, which included individuals receiving services, stakeholders, providers, advocates and professional associations. In the distribution of the e-mails, each agency asked recipients to further spread the opportunity to comment to their respective colleagues and distribution lists.

Stakeholder advisory groups. Announcements were issued to both DODD and ODM/ODA Stakeholder Advisory Groups regarding the formal public comment period with a request to disseminate the information to their respective colleagues and distribution lists.

Ohio provided five methods for the public to provide input on the draft transition plan and/or request a non-electronic copy of the plan:
E-mail - Ohio established a dedicated e-mail box named MCD-HCBSfeedback.
Written comments - Ohio also provided a U.S. Postal Service address, which was Ohio Department of Medicaid, ATTN: HCBS Transition Plan, P.O. Box 182709, 5th Floor, Columbus, OH 43218.
Fax - Ohio provided a fax number, which was (614) 466-6945.
Toll-free phone number - Ohio provided a toll-free number, 1 (800) 364-3153, with a recorded message advising callers they had reached the CMS HCBS draft transition plan phone message box and offering five minutes in which to leave a message.
Video. In response to a stakeholder request during the posting of the first draft transition plan, Ohio also accepted emailed .mov video submissions.

The state received 7 unduplicated comments on the revised draft statewide transition plan during the formal public comment period. Some submissions addressed a variety of themes. The following is a summary of the comments:

Assisted Living: 14% of the comments were on this topic. (1)

Comment: The personal needs allowance for individuals enrolled on the waiver is inadequate to promote community inclusion.
Response: The state acknowledges the value of the personal needs allowance in supporting community integration. The state will consider the personal need allowance policy in future waiver design. No change made to the plan.

Miscellaneous: 86% of comments received were not specific to any type of setting and some submissions addressed a variety of themes. One submission was specific to both systems, one submission was relevant only to the NF-based LOC system and four submissions were directed to the ICF-IID system. (6)

Comment: The principle that individuals and families determine what integration means must permeate the plan.

Response: The State agrees this is a basic principle of the transition plan. The plan provides opportunities for the experience of individuals to inform the implementation and ongoing assessment of compliance. No change made to the plan.

Comment: The on-site evaluations should include a broader sample of settings, not just those based on provider self-assessments.

Response: The State agrees the on-site evaluations should not be limited to those based on provider self-assessments. The ongoing provider oversight process does incorporate a review of the settings beyond those identified proposed plan, as appropriate. No change made to the plan.

Comment: Benchmarks and timelines are needed to make sure sufficient progress is made and process is transparent.

Response: The State acknowledges the importance of identified benchmarks and timelines. The plan outlines the proposed timelines for each component. The State will use existing stakeholder communication avenues to report on implementation progress. No change made to the plan.

Comment: Enforcement mechanism for individuals to challenge any setting not compliant.

Response: The State acknowledges the value of individual' assessment of initial and ongoing setting compliance. Using the existing complaint processes, individuals have the right to file a complaint regarding a specific setting and/or to report directly to the State any concerns with a setting's ability to comply. Upon receiving a report by an individual or another entity, the State will initiate a formal review, as appropriate. No change made to the plan.

Comment: Clarify the individual has a right to due process upon proposed modifications.

Response: Due process is currently afforded if individuals have concerns with the scope, duration, or frequency of services authorized in the person-centered service plan, including any modifications proposed to the plan. No change made to the plan.

Comment: Ongoing education is needed about the new rule and subsequent changes.

Response: The state will continue to share information about changes and status updates through the established stakeholder groups, routine publications, and websites. The design of the communication strategy included in the plan is underway as well as the development of "easy read" documents for individuals served by the ICF-IID system. No change made to the plan.

Comment: The Office of the State Ombudsman is supportive of the ombudsman's role in the education and relocation process. The Ombudsman recommends flexibility with timeframes for relocation, depending on the number of settings, to ensure smooth transition for individuals.

Response: The existing relocation team protocols will be used to ensure smooth transitions for individuals, including determining time frames for relocations. No change made to the plan.

Comment: The transition plan committee, which advised the development of the ICF-IID remediation plan, should be reassembled.

Response: The State acknowledges the importance of ongoing communication and opportunities to provide feedback on the implementation of the remediation plan for both systems. Ongoing communication will be provided and feedback will be solicited through existing stakeholder workgroups and publications, as well as through future public comment periods related to updates to the statewide transition plan and resulting waiver or rule amendments. No change made to the plan.

Comment: Additional Training and technical assistance is required to assist providers with complying with the regulation.

Response: The State acknowledges the value of ongoing education and technical assistance with plan implementation. Information regarding the requirements for all HCBS settings has been provided via regional forums, conferences, webinar presentations, and written publications. Since the characteristics of HCBS settings are determined through the experiences of individuals receiving supports, training efforts have been focused on the person-centered planning process. DODD has contracted with national experts to provide training and technical assistance to county board personnel and providers. In addition, local training sessions have been made available to individuals and families. Resources to support team members with person-centered planning are also available on DODD's website. To support providers who are transitioning from facility-based day services to integrated community supports, DODD has awarded project transformation grants and has fostered communities of practices for providers to share their experiences with transformation with one another. No change made to the plan.

Comment: Revised service definitions for adult day waiver services and new rate methodologies should be adopted prior to plan implementation.

Response: The State does not agree. Individuals should be afforded opportunities for access to the broader community in accordance with their person-centered plans. DODD continues to meet with stakeholders and respond to feedback regarding proposed service definitions and rates. The planned implementation date remains October 2016. Nothing in the current rules prevents or prohibits compliance. Many providers have already or are in the process of making necessary changes to increase individuals' access to the broader community. No change made to the plan.

Comment: County board personnel should be permitted to accompany DODD personnel during on-site visits.

Response: The State does not agree that it is necessary to include county board personnel in onsite reviews conducted by the State. County board personnel will receive training on the HCBS settings evaluation tool for use during the ongoing compliance process. No change made to the plan.

Comment: Empower SSAs in evaluating service setting compliance with integration mandate.

Response: County board personnel will receive training on the HCBS settings evaluation tool for use during the ongoing compliance process. No change made to the plan.

Comment: A question was raised about whether a formal strategic plan is required by providers of HCBS.

Response: No formal strategic plan is required. A provider's strategic plan, if available, is one possible indicator of the provider's commitment to supporting individuals with access to the broader community. No change made to the plan.

Comment: A question was raised about the role of protection and advocacy entities in the ongoing monitoring of site-specific settings.

Response: Involvement in ongoing compliance efforts by protection and advocacy entities is not duplicative of other compliance efforts by the State. Protection and advocacy entities are key partners in ongoing compliance by informing individuals of their right to file a complaint regarding a specific setting and/or to report directly to the State any concerns with a setting's ability to comply. Upon receiving a report by an individual or another entity, the State will initiate a formal review, as appropriate. No change made to the plan.

Comment: The State should conduct on-site reviews until county boards have resolved the conflict of interest.

Response: The State agrees that county boards should not conduct reviews of existing adult day waiver settings until they are no longer providers of service. All initial onsite reviews will be conducted by the State. County board personnel will receive training on the HCBS settings evaluation tool for use in the ongoing compliance process. Reviews by county board personnel will focus on residential settings, as long as boards continue to provide adult day waiver (non-residential) services. No change made to the plan.

Comment: Concern was expressed that the HCBS settings evaluation tool was developed by a group of stakeholders chosen by DODD.

Response: The State does not agree. DODD invited individuals, advocates, providers, and county board personnel who provided public input on the initial posting of the statewide transition plan. Representatives included those who submitted comments in support and in opposition to the plan. No change made to the plan.

Comment: Questioned how the public will be able to comment on the results of the onsite evaluations.

Response: The statewide transition plan will be updated to reflect the results of the on-site evaluations. Future public comment periods related to updates to the statewide transition plan and resulting waiver or rule amendments will be available. No change made to the plan.

Comment: State provider compliance reviews need to occur more often than once every 3 years.

Response: Routine reviews are conducted at least once every three years. However, special reviews may be conducted whenever concerns are reported. In addition to the formal provider compliance reviews conducted by DODD and county boards, service and support administrators conduct ongoing monitoring of service plan implementation. No change made to

the plan.

Comment: The HCBS settings evaluation tool should be posted to the website.

Response: The State agrees. A copy of the final HCBS evaluation tool will be posted to DODD's website. No change made to the plan.

Comment: Full inclusion requires enhanced literacy.

Response: The State acknowledges the importance of literacy. Case managers are responsible for linking individuals with supports necessary to support their desired outcomes. This may include referrals to literacy organizations, as appropriate. No change made to the plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

1634 Transition Plan

Ohio is sensitive to the magnitude of the proposed change to convert from a section 209(b) state to a section 1634 state. The objectives of the waiver transition plan are to ensure every individual potentially impacted by the conversion receives adequate notice of the conversion and potential impact on his or her Medicaid eligibility, is educated on his or her options, and has access to assistance to establish a Qualified Income Trust (QIT)/Miller Trust. All affected Medicaid beneficiaries will receive notification from Ohio Department of Medicaid (ODM) of the conversion to a section 1634 state.

Using information derived from the State's Medicaid eligibility system, the State has identified beneficiaries with income over the special income limit (300% of the SSI Federal Benefit Rate), by waiver program and county of residence. These individuals will have the option to continue their Medicaid eligibility and waiver services through the use of a QIT/Miller Trust.

At least 90 days prior to the conversion to a section 1634 state, ODM will send letters directly to each individual enrolled on the waiver with income over the special income limit. The letter will describe the option of continuing Medicaid eligibility and waiver services through the use of a QIT/Miller Trust. The letter will include the contact information for the vendor that will assist the individual with establishing a QIT/Miller Trust.

Information about the conversion to a section 1634 state will be posted on the ODM website. In addition, the sister agency websites (Ohio Department of Developmental Disabilities and the Ohio Department of Aging) will include a link to the ODM website.

The waiver case managers for the identified individuals will receive information regarding the conversion from a section 209 (b)state to a section 1634 state, and be directed to the ODM website for access to the state-developed QIT/Miller Trust education materials and templates. The State plans to engage a statewide vendor to contact each individual enrolled in the waiver with income over the special income limit to assist with establishing a QIT/Miller Trust. Using state-developed QIT/Miller Trust education materials and templates, the vendor will validate the status of individuals identified as having income over the special income limit, educate individuals on the QIT/Miller Trust option, assist with the creation of the QIT/Miller Trust, assist with the creation of a bank account for QIT/Miller Trust deposits, and ensure trust information is submitted to the local County Department of Job and Family Services.

Subsequent reminders will be mailed by ODM to individuals to encourage them to take the necessary actions in order to maintain Medicaid eligibility.

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 Developmental Disabilities (DODD)

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   The single State Medicaid Agency (ODM) assures the compliant performance of this waiver by: delegating specific responsibilities to the Operating Agency (DODD) through an interagency agreement; managing Medicaid provider agreements; establishing general Medicaid rules; approving the Operating Agency's program-specific rules related to Medicaid requirements; processing claims for federal reimbursement, conducting audits; conducting post-payment review of Medicaid claims; monitoring the compliance and effectiveness of the Operating Agency's operations; leading the development of quality improvement plans; and facilitating interagency data-sharing and collaboration.

   Responsibilities delegated to the Operating Agency include: assuring compliant and effective case management for applicants and waiver participants by County Boards; managing a system for participant protection from harm; certifying particular types of waiver service providers; assuring compliance of non-licensed providers; assuring that paid claims are for services authorized in individual service plans; setting program standards/expectations; monitoring and evaluating local administration of the waiver; providing technical assistance; facilitating continuous quality improvement in the waiver's local administration; and more

generally, ensuring that all waiver assurances are addressed and met for all waiver participants. These requirements are articulated in an interagency agreement which is reviewed and re-negotiated at least every two years.

The single State Medicaid Agency's (ODM) oversight of the Operating Agency's (DODD) performance occurs through a combination of reviews of performance data, interagency quality briefings, and fiscal reviews.

ODM monitors DODD's compliance and performance by:

1) Conducting the Continuous Review of DODD performance measure data (described below and in Appendix H);

2) Assuring the resolution of case-specific problems (describe below is the ODM Adverse Outcome and Alert Monitoring processes);

3) Assuring systemic remediation (Quality Improvement Plan) whenever a performance measure is not fully met, and falls below a threshold of 86% (described in Appendix H);

4) Convening operating agency Quality Briefings twice a year;

5) Convening interagency HCBS waiver Quality Steering Committee (QSC) approximately four times per year; and

6) Fiscal reviews and audits (described below and in Appendix I).

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

As part of the state's oversight strategy, each year ODM will host Quality Briefings between ODM and DODD to review and discuss both monitoring and oversight processes and quality data. In these meetings, which will occur approximately twice per year, the departments will include a discussion about opportunities for program improvement that were detected, what corrective measures are/or were taken, and how the operating agency verified, or intends to verify, that the actions were effective. The quality briefings will also serve as the forum for ODM and DODD to share and review the validity and/or usefulness of performance metrics identified in this application. Throughout this review process, if areas of non-compliance or opportunities to improve program performance are identified through this or other processes, ODM may require DODD to develop and implement quality improvement plans and monitor their effectiveness at achieving desired outcomes.

ODM also convenes the interagency HCBS waiver quality steering committee (QSC). The committee compares performance across Ohio's Medicaid HCBS waiver systems, to identify cross-system structural weaknesses, to support collaborative efforts to improve program performance, to identify best practices and to help Ohio move toward a more unified quality management system. In 2013, Ohio engaged with Truven to update and revise the performance measures used in the State's HCBS waivers. The QSC was instrumental in facilitating collaborative interaction across state agencies and with Truven to support the development of the "core measures" that are reflected in this waiver application.

In addition to the DODD's program review and compliance monitoring, fiscal reviews occur on a regular basis. This includes desk reviews of administrative costs and A-133 Audits, which occur at least every three years based on risk.

ODM Adverse Outcomes process-When ODM personnel have reason to believe that a waiver recipient(s)'s

health or welfare is or has been at substantial risk of being negatively affected, they will follow a protocol to assure timely reporting, intervention, and resolution in order that to the extent possible the person is made whole. These cases are managed through the Adverse Outcome (AO) Process. AOs are categorized into eight types based upon the level of harm severity: Imminent, Serious, Moderate, Failure to Report, Level of Care, Care Planning, Complaint and Financial Findings. Depending on the level of severity members will take immediate action; contact emergency response and protective service authorities as appropriate; coordinate intervention with providers, case managers, and other authorities; and report the finding to the Operating Agency. The Operating Agency is then required, within certain time frames, to describe and report the progress of their plan(s) for resolution and remediation (including at the systems level). ODM convenes an internal Adverse Outcomes committee to determine if the AO status is merited; make referrals and review responses/action of other mandated/interested parties (Attorney General, ODM's Surveillance/Utilization Review (SUR), Ohio Department of Health, Children/Adult Protective Services, etc.), determine if resolution/remediation plans are appropriate, and determine when the AO is resolved/remedied.

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

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:

       County Boards conduct waiver operational and administrative functions at the local level.
       These responsibilities include performing assessments and evaluations, assisting in the preparation and submission of prior authorization requests for waiver services, assisting individuals in exercising free choice of provider, monitoring services, investigations of abuse, neglect and major incidents, case management (known as service and support administration) and managing waiting lists in accordance with Section 5123.042 of the Ohio Revised Code.

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

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

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
In accordance with Section 5126.054 of the Ohio Revised Code, each County Boards develops a plan for Medicaid waiver administration. The plan includes the Planning Implementation Component Tracking document (known as the PICT).
DODD conducts the following activities:
* reviews and approves the County Boards plan for Medicaid waiver administration,
* reviews recommendations County Boards regarding whether an individual's application for HCBS waiver services should be approved or denied, including whether the individual meets an ICF-IID level of care,
* retains the authority to review any Individual Service Plan recommended by the County Boards for waiver services, and
* provides communication, technical assistance and training to County Boards regarding their role as local operators for waivers.

Appendix H provides further discussion of the oversight of County Boards by the DODD.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
The Operating Agency (DODD): 1) accredits each County Boards for a period of one to five years, with better performing boards granted the longer accreditation terms, 2) conducts tiered reviews every 1-3 years (based on performance) of each county board of dd to evaluate Prevention from Harm Systems, and 3) on an ongoing basis , investigates Major Unusual Incidents that may be considered a conflict of interest for the local county board of dd to investigate. The tools used for accreditation contain questions, probes, and requests for evidence that tie directly to federal assurances, including assurances for: service planning & consumer free choice of provider; level of care determination; health and welfare; and hearing rights. The health and welfare sections of the accreditation tool are used for the tiered Protection from Harm evaluations. The Operating Agency produces regular reports on participant-specific Major Unusual Incidents, including county-specific data, and monitors to detect trends and patterns.

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. **Performance Measures**

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
PM A1: Number and percentage of Quality Briefings conducted between Ohio Department of Medicaid (ODM) to review the operating agency's (Ohio Department of Developmental Disabilities (DODD)) performance data as specified in the waiver application. Numerator: Number of conducted Quality Briefings between ODM. Denominator: Total number of Quality Briefings specified in the waiver.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ODM/DODD Quality Briefing Meeting Minutes/Performance Measure Data

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

Data Aggregation and Analysis:

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

Performance Measure:

PM A2: Number and percent of performance measures required to be reported as specified in the waiver application that were submitted on time and in the correct format. Numerator: Number of performance measures required to be reported submitted timely and in the correct format. Denominator: Total number of performance measures required to be reported as specified in the waiver application.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD Performance Measures submitted to ODM

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

Data Aggregation and Analysis:

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

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

Performance Measure:
PM A3: Number and percent of County Board of DD Accreditations that DODD completed timely. Numerator: Number of County Board of DD Accreditations completed timely. Denominator: Total number of County Board of DD Accreditations due for review.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
PM A4: Number and percent of County Boards of DD Major Unusual Incidents Quality Tier Site reviews that DODD completed timely. Numerator: Number of County Boards of DD Major Unusual Incidents Quality Tier Site reviews completed timely. Denominator: Total number of County Boards of DD due for review.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD's Office of Major Unusal Incidents and Investigations Reviews

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

Data Aggregation and Analysis:

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

Performance Measure:
PM A5: Number and percent of the Office of Medicaid Development and Administration (MDA)Division Operating Plan reports that were submitted timely to ODM. Numerator: Number of MDA Operating Plan reports that were submitted timely to ODM. Denominator: Total number of MDA Operating Plan reports due to be submitted to ODM.

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

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Data for specific waivers will be presented to each operating agency in Quality Briefings twice a year. These Quality Briefings will also be informed by data presented by the operating agencies to report oversight activities conducted in the period, and including descriptions of any compliance or performance problems, actions taken to remedy those problems, and how the operating agency verified, or intends to verify,that the actions were effective. The Quality Briefings will also serve as the forum for ODM and DODD to
share and review performance metrics identified in this application.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
ODM conducts activities for: 1) case-specific remediation, and 2) system-level remediation.
Activities by ODM for addressing individual problems include:
1) ODM Adverse Outcomes process - during the course of any review conducted by ODM, when staff encounter a situation in which a waiver recipient's health seems to be at risk, the staff follow a protocol to report these observations. Adverse outcomes are prioritized based upon seven reporting levels: Imminent, Serious, Moderate, Failure to Report, Level of Care, Care Planning and Complaint. Depending on the severity of the situation, the staff will take immediate action, coordinate intervention with providers or case managers,or report the finding to ODM staff in Columbus. ODM staff in Columbus communicate findings to the Operating Agency for review and/or 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 appropriate assure resolution. ODM convenes an internal Adverse Outcomes committee to determine when an Adverse Outcome is fully resolved and can be closed.
2) Alert Monitoring – ODM Protection from Harm Unit monitors both prevention and outcome activities performed by DODD to protect Medicaid consumers on HCBS waivers from significant incidents impacting their health and safety. ODM staff review incident alerts, track and monitor them until, resolution has been reached, the individual is healthy and safe, the cause has been identified and remedied, and preventive measures have been taken. The discovery of potential Incident Alerts may occur through the following means: may be notified by DODD via Director's Alert e-mail or other means; by ODM Protection from Harm Unit; by

DODD; through ODM monitoring of DODD Incident Tracking System (ITS); through other service delivery systems; media; or complaints received directly by ODM.

Activities by ODM geared to support systems level remediation include:
1) Performance Measures data reports submitted to ODM by DODD on a quarterly basis. DODD is able to address individual remediation as they are discovered and provide technical assistance that may include plans of corrective action.
2) Quality Briefings - ODM convenes a bi-annual Quality Briefing with DODD in which the agencies share and review performance measures data. In addition, data may include performance data reflecting DODD monitoring activities, including how many particular monitoring activities were completed in the period, what areas of non-complaints were identified, and what corrective actions were initiated. This Quality Improvement process is described in greater detail in Appendix H.

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

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

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

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

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

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

Target Group	**Included**	**Target SubGroup**	**Minimum Age**	**Maximum Age**	
				Maximum Age Limit	**No Maximum Age Limit**
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐

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

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

Individuals who were enrolled on the Ohio Home Care Waiver who were determined to have an ICF-IID level of care at their annual redetermination, using the revised ICF-IID criteria specified in Ohio Administrative Code Rule 5123:2-8-01.

* Individuals enrolled on the Ohio Home Care Waiver whose intermediate or skilled level of care is reevaluated to be an ICF-IID level of care.

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

◉ **Not applicable. There is no maximum age limit**

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

○ **A level higher than 100% of the institutional average.**

Specify the percentage:

◉ **Other**

Specify:

At the time of an individual's enrollment on the Transitions DD Waiver and throughout one's enrollment, individual's monthly waiver costs shall not exceed $14,700.

○ **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's health and welfare must be met within the $14,700 per month cost limit. If health and welfare cannot be assured, the individual will be disenrolled from the Transitions DD Waiver. All individuals disenrolled from the waiver will be provided information on fair hearing rights and processes.

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)*:

- [x] **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:

- [x] **Other safeguard(s)**

Specify:

The individual may be referred to another HCBS waiver, may receive applicable state plan services, and/or may receive services supplemented by local, non-Medicaid funds. In addition, the individual will be afforded the opportunity for placement in an ICF-IID if he or she so chooses.

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	3000
Year 2	2000
Year 3	1
Year 4	1
Year 5	1

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).**

Appendix B: Participant Access and Eligibility

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

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

- ( ) **The waiver is not subject to a phase-in or a phase-out schedule.**
- (●) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. **Allocation of Waiver Capacity.**

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

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

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

In the event an individual is determined to no longer meet the eligibility criteria for the Transitions DD Waiver, the individual shall be disenrolled and afforded fair hearing rights. The individual will also be referred for alternative services including, but not limited to, other Medicaid HCBS services, State Plan services, or local non-Medicaid-funded services, as appropriate.

Appendix B: Participant Access and Eligibility

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

Waiver Phase-In/Phase-Out Schedule
Based on Waiver Proposed Effective Date: 07/01/15

a. **The waiver is being** (select one):

- ○ **Phased-in**
- ◉ **Phased-out**

b. **Phase-In/Phase-Out Time Schedule.** *Complete the following table:*

Beginning (base) number of Participants: 3000

Phase-In/Phase-Out Schedule

Waiver Year 1
Unduplicated Number of Participants: 3000

Month	Base Number of Participants	Change	Participant Limit
Jul	3000	0	3000
Aug	3000	0	3000
Sep	3000	423	2577
Oct	2577	0	2577
Nov	2577	0	2577
Dec	2577	298	2279
Jan	2279	0	2279
Feb	2279	0	2279
Mar	2279	460	1819
Apr	1819	0	1819
May	1819	0	1819
Jun	1819	530	1289

Waiver Year 2
Unduplicated Number of Participants: 2000

Month	Base Number of Participants	Change	Participant Limit
Jul	1289	0	1289
Aug	1289	0	1289
Sep	1289	341	948
Oct	948	0	948
Nov	948	0	948
Dec	948	264	684
Jan	684	0	684
Feb	684	0	684
Mar	684	335	349
Apr	349	0	349
May	349	0	349
Jun	349	349	0

Waiver Year 3
Unduplicated Number of Participants: 1

Month	Base Number of Participants	Change	Participant Limit
Jul	0	0	0
Aug	0	0	0
Sep	0	0	0
Oct	0	0	0
Nov	0	0	0
Dec	0	0	0
Jan	0	0	0
Feb	0	0	0
Mar	0	0	0
Apr	0	0	0
May	0	0	0
Jun	0	0	0

Waiver Year 4
Unduplicated Number of Participants: 1

Month	Base Number of Participants	Change	Participant Limit
Jul	0	0	0
Aug	0	0	0
Sep	0	0	0
Oct	0	0	0
Nov	0	0	0
Dec	0	0	0
Jan	0	0	0
Feb	0	0	0
Mar	0	0	0
Apr	0	0	0
May	0	0	0
Jun	0	0	0

Phase-In/Phase-Out Schedule

Waiver Year 5
Unduplicated Number of Participants: 1

Month	Base Number of Participants	Change	Participant Limit
Jul	0	0	0
Aug	0	0	0
Sep	0	0	0
Oct	0	0	0
Nov	0	0	0
Dec	0	0	0
Jan	0	0	0
Feb	0	0	0
Mar	0	0	0
Apr	0	0	0
May	0	0	0
Jun	0	0	0

c. Waiver Years Subject to Phase-In/Phase-Out Schedule

Year One	Year Two	Year Three	Year Four	Year Five
☑	☑	☐	☐	☐

d. Phase-In/Phase-Out Time Period

	Month	Waiver Year
Waiver Year: First Calendar Month	Jul	
Phase-in/Phase-out begins	Sep	1
Phase-in/Phase-out ends	Jun	2

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - ◉ **§1634 State**
   - ○ **SSI Criteria State**
   - ○ **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ○ **No**
   - ◉ **Yes**

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

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

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

Select one:

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

Specify percentage:

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

Specify:

Sec. 1902(a)(10)(A)(i)(l) - Children with Title IV-E Adoption assistance or Foster Care payments
Sec. 1902(a)(10)(A)(i)(VIII) - Adult Expansion
Sec.1902(a)(10)(A)(i)(IX) - Former Foster Children
Sec.1902(a)(10)(A)(ii)(VIII) - Children with Non-IV-E Adoption Assistance
Sec.1902(a)(10)(A)(ii)(XVII) - Independent foster care adolescents
42 CFR 435.110-Parents/Caretaker Relatives
42 CFR 435.116 - Pregnant Women
42 CFR 435.118 - Infants and children under age 19
42 CFR 435.210-SSI look alike

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:

- [x] **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 spenddown 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 five-year period beginning January 1, 2014, 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.

- [x] **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 December 31, 2018.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (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 Federal Benefit Rate (SSI/FBR).

○ **Other**

Specify:

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

◉ **Not Applicable**

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

Specify:

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

○ **SSI standard**

○ **Optional State supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

○ **The amount is determined using the following formula:**

Specify:

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

○ **Not Applicable (see instructions)**

◉ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

Specify percentage:

- ○ **The following dollar amount:**

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

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

  Specify formula:

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

- ( ) **Other**

  Specify:

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

Select one:

- (●) **Allowance is the same**
- ( ) **Allowance is different.**

  Explanation of difference:

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

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

Select one:

- ( ) **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- (●) **The State does not establish reasonable limits.**
- ( ) **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

- ( ) **Directly by the Medicaid agency**
- (●) **By the operating agency specified in Appendix A**
- ( ) **By an entity under contract with the Medicaid agency.**

Specify the entity:

- ( ) **Other**

Specify:

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

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

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

As a condition of waiver eligibility, applicants must meet an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) Level of Care as defined in OAC rule 5123:2-8-01.
Criteria for ICF-IID level of care:

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

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

(b) In the absence of individually planned supports, the individual has a high probability of having substantial functional limitations in at least three areas of major life activities set forth in OAC 5123:2-8-01 later in life:
(i) Self-care;
(ii) Receptive and expressive communication;
(iii) Learning;
(iv) Mobility;
(v) Self- direction;
(vi) Capacity for independent living; and
(vii) Economic self-sufficiency.

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

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

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

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

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

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

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

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

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

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

For reevaluations the County Board will submit an ICF-IID level of care redetermination to DODD within twelve months of the previous level of care determination and whenever the individual experiences a significant change of condition as described in paragraph (D) (5)(a-b) in OAC rule 5123:2-8-01.

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

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**
  Specify the other schedule:

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

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

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

DODD staff receive alerts from the LOC system which gives the waiver particpants names (by county), their LOC due date 90 days prior and 15 days prior to the redetermination due date. A Prior Notice letter (named such as it provides the individual their rights to a prior notice for a pending action) is issued to the individual and/or guardian and to the County Board alerting them of the pending timelines, and encourages collaboration with the County Board to ensure all necessary documentation is submitted to DODD prior to the due date. The information generated from these reports is entered into an excel spreadsheet and is monitored by DODD staff (at two levels) for the purpose of working with the external customers to ensure the timely submittal of the redetermination.

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3

years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
PM B1: Number and percent of new enrollees who had a LOC indicating need for institutional LOC prior to receipt of services. Numerator: Number of new enrollees who had a LOC indicating need for institutional LOC prior to receipt of services. Denominator: Total number new enrollees.

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
PM B2: Number and percent of level of care redetermination completed within 12 months of the previous level of care determination. Numerator: Number of level of care redetermination completed within 12 months of the previous level of care determination. Denominator: Total number of waiver participants with redetermination needed.

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

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

Data Aggregation and Analysis:

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

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

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:
PM B3: Number and percent of participants that initial LOC determinations reviewed were completed using the process required by the approved waiver. Numerator: Number of participants with initial LOC determinations that were completed using the process required by the approved waiver. Denominator: Total number of participants with initial LOC determinations.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DODD becomes aware of problems through a variety of mechanisms including, but not limited to, formal & informal complaints, technical assistance requests, and routine & special regulatory review processes (accreditation, licensure, provider compliance, quality assurance, etc). As problems are discovered, the County Board is notified and technical assistance is provided using email, phone contact and/or letters to the County Board of DD Superintendent. During the DODD regulatory review process citations may be issued and plans of correction required as needed and appropriate. When issues are noted that are systemic, DODD will provide statewide training and additional technical assistance and monitor for improvement during subsequent monitoring cycles.

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

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

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

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

At the time the individual requests HCBS waiver services, the County Board in the county in which the individual resides is responsible for explaining the services available under the Transition DD waiver and the alternative of services delivered in an ICF-IID.
The County Boards “use the Freedom of Choice” form to document that the individual has chosen to enroll on the waiver as an alternative to services in an ICF-IID. When the “Freedom of Choice” form is signed by the individual, the county board shall provide a copy of the Medicaid Fair Hearings Right to the individual using the Ohio Department of Jobs and Family Services (ODJFS) 4074.The "Freedom of Choice" form can be made available to ODM upon request.

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

The completed Freedom of Choice forms are maintained by the 88 County Boards.

Appendix B: Participant Access and Eligibility

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

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

Individuals with limited English proficiency have access to a range of supportive services at the time of application and throughout their participation in the waiver program. The need for language accommodation is determined by the County Boards. Both will make arrangements for the individuals to receive interpretation services as needed to ensure individuals can access services. DODD will monitor access to services by persons with limited English proficiency through its ongoing monitoring and technical assistance process.

ODM makes interpretation services available at the county and state levels. A variety of ODJFS forms have been translated into Spanish and Somali, including the HCBS Waiver Guide; the Medicaid Consumer Guide, information about Healthy Start, Healthchek, and Food Stamps, and state hearing forms. The County Departments of Job and Family Services (CDJFS) also make interpreter services available to individuals when needed during the eligibility determination process.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Adult Day Health Center Services		
Statutory Service	Personal Care Aide Services		
Other Service	Emergency Response Service		
Other Service	Home Delivered Meal Services		
Other Service	Home Modification Services		
Other Service	Out-of-Home Respite		
Other Service	Supplemental Adaptive and Assistive Device Services		
Other Service	Supplemental Transportation Services		
Other Service	Waiver Nursing Services		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Health Center Services

HCBS Taxonomy:

Category 1: 04 Day Services

Sub-Category 1: 04050 adult day health

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

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

Service Definition *(Scope)*:
Adult Day Health Center Services (ADHCS) are regularly scheduled services delivered at an adult day health center to individuals age eighteen or older who have a need for this service as identified on the individual's service plan. A qualifying adult day health center must be a freestanding building or a space within another building that is used solely for the provision of ADHCS. The services that the adult day health center must make available are waiver nursing or personal care aide services, and recreational and educational activities. The services the adult day health center may also make available are skilled therapy services, social work/counseling services and transportation of the individual to and from ADHCS. The requirement that the adult day health center must provide no more than two meals per day that meet the individual's dietary requirement was eliminated effective July 1, 2014 in accordance with rule 5123:2-9-51 of the Ohio Administrative Code.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
*ADHCS are reimbursable at a full-day rate when five or more hours are provided to an individual in a day.
*ADHCS are reimbursable at a half-day rate when less than five hours are provided to an individual in a day.
*None of the services provided by the adult day health center are reimbursable separately.
*The ADHCS provider must be identified as the provider, and have specified on the individual's service plan, the number of hours for which the provider is authorized to furnish ADHCS to the individual.
*Services performed by a provider must not exceed the monthly dollar amount allocated to that specific provider on the individual's service plan.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicare-certified HHA, an agency accredited by ACHC, CHAP or the Joint Commission or another national accrediting organization approved by CMS, adult day health centers

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Medicare-certified HHA, an agency accredited by ACHC, CHAP or the Joint Commission or another national accrediting organization approved by CMS, adult day health centers
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify):*
OAC Chapter 5123:2-9-51

Verification of Provider Qualifications

Entity Responsible for Verification:
ODM/DODD

Frequency of Verification:
Provider compliance reviews will be conducted within one year of the provider's initial billing for provision of TDD services. Thereafter, routine compliance reviews of providers shall be conducted so that each provider is reviewed at least once every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Personal Care

Alternate Service Title (if any):
Personal Care Aide Services

HCBS Taxonomy:

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

Service Definition *(Scope):*
Personal Care Aide Services are services provided pursuant to the individual's service plan that assist the individual with activities of daily living (ADL) and instrumental activities of daily living (IADL) impairments. Personal Care Aide Services consists of the following:
*Bathing, dressing, grooming, nail care, hair care, oral hygiene, shaving, deodorant application, skin care, foot care, feeding, toileting, assisting with ambulation, positioning in bed, transferring, range of motion exercises, and monitoring intake and output;
*General homemaking activities including, but not limited to: meal preparation and cleanup, laundry, bed-making, dusting, vacuuming and waste disposal;
*Household chores including, but not limited to washing floors, windows and walls, tacking down loose rugs and tiles; and moving heavy items to provide safe access and egress;

*Paying bills and assisting with personal correspondence as directed by the individual; and
*Accompanying or transporting the individual to Transitions DD Waiver services, medical appointments, other community services, or running errands on behalf of the individual.

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

This service specification reflects the inclusion of non-legally responsible family members as individual providers. Related legal guardians of individuals over the age of 18 are permitted to be personal care aide providers.

Personal care services that can be covered under the State Plan should be furnished to waiver participants under the age of 21 as services required under EPSDT.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
*The provider must be identified as the provider, and have specified on the individual's service plan, the number of hours for which the provider is authorized to furnish services to the individual.
*Personal Care Aide Services do not include services performed in excess of what is approved pursuant to the individual's service plan.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicare-certified HHA, an agency accredited by ACHC, CHAP or the Joint Commission or another national accrediting organization approved by CMS, other personal care aide agencies
Individual	Non-agency personal care aide

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Medicare-certified HHA, an agency accredited by ACHC, CHAP or the Joint Commission or another national accrediting organization approved by CMS, other personal care aide agencies
Provider Qualifications
License *(specify):*
Medicare-certified HHA, accreditation by ACHC, CHAP or the Joint Commission or another national accrediting organization approved by CMS
Certificate *(specify):*
Personal care aide agencies that meet the certification standards listed in OAC rule 5123:2-9-56
Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DODD
Frequency of Verification:
Provider compliance reviews will be conducted within one year of the provider's initial billing for provision of TDD services. Thereafter, routine compliance reviews of providers shall be conducted so that each provider is reviewed at least once every three years.

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Non-agency personal care aide
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Certificate of completion within the last 24 months for either the nurse aide competency evaluation conducted by the Ohio Department of Health or the Medicare competency evaluation program for HHAs, or another equivalent training program that includes personal care aides, basic home safety and universal precautions for infection control.

First aid certification.
Other Standard *(specify):*
OAC Chapter 5123:2-9-56
Verification of Provider Qualifications
Entity Responsible for Verification:
DODD
Frequency of Verification:
Provider compliance reviews will be conducted within one year of the provider's initial billing for provision of TDD services. Thereafter, routine compliance reviews of providers shall be conducted so that each provider is reviewed at least once every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Emergency Response Service

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:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Emergency Response Services (ERS) are in-home, twenty-four hour communication connection systems that enable an individual to secure immediate assistance during a medical, physical, emotional or environmental emergency. ERS can meet the needs of individuals who live alone, are alone for significant parts of the day, or have no regular caregiver for extended periods of time and would otherwise require extensive routine supervision. The response center is staffed by trained professionals and available 24 hours per day, 7 days per week.
The State pays for installation, testing and monthly maintenance of ERS equipment. There are separate billing codes for each under the waiver.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
*The provider must be identified as the provider, and have specified on the individual's service plan, the number of hours for which the provider is authorized to furnish services to the individual. *Services performed by a provider must not exceed the monthly dollar amount allocated to that specific provider on the individual's service plan.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicare-certified HHA, an agency accredited by ACHC, CHAP or the Joint Commission or another national accrediting organization approved by CMS; other ERS agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Emergency Response Service

Provider Category:
Agency
Provider Type:

Medicare-certified HHA, an agency accredited by ACHC, CHAP or the Joint Commission or another national accrediting organization approved by CMS; other ERS agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OAC chapter 5123:2-9-52

Verification of Provider Qualifications

Entity Responsible for Verification:

DODD

Frequency of Verification:

Provider compliance reviews will be conducted within one year of the provider's initial billing for provision of TDD services. Thereafter, routine compliance reviews of providers shall be conducted so that each provider is reviewed at least once every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Delivered Meal Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
06 Home Delivered Meals	06010 home delivered meals

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope):*

Home Delivered Meal Services is defined as the provision of individual meals to individuals. The service includes the provider's preparation and home delivery of safe and nutritious meals. The meals must be planned by a dietician in consultation with the individual, taking into consideration the individual's cultural and ethnic

background, and dietary preferences and/or restrictions. The provider must be in compliance with all applicable federal, state, county and local laws and regulations concerning the preparation, handling and transportation of food.

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

*Home delivered meal services are limited to up to two meals per day per individual.

*The provider must be identified as the provider, and have specified on the individual's service plan, the number of hours for which the provider is authorized to furnish services to the individual.

*Services performed by a provider must not exceed the monthly dollar amount allocated to that specific provider on the individual's service plan.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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 provider
Agency	Agency, e.g., Meals on Wheels, a food vendor, etc.

Appendix C: Participant Services

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

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

Provider Category:
Individual

Provider Type:
Non-agency provider

Provider Qualifications

License *(specify)*:
Valid Food Vendor's License and Valid Driver's License

Certificate *(specify)*:

Other Standard *(specify)*:
OAC chapter 5123:2-9-53

Verification of Provider Qualifications

Entity Responsible for Verification:
DODD

Frequency of Verification:
Provider compliance reviews will be conducted within one year of the provider's initial billing for provision of TDD services. Thereafter, routine compliance reviews of providers shall be conducted so that each provider is reviewed at least once every three years.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Delivered Meal Services

Provider Category:
Agency
Provider Type:
Agency, e.g., Meals on Wheels, a food vendor, etc.
Provider Qualifications
License *(specify):*
Valid Food Vendor's License and Valid Driver's License for food delivery personnel
Certificate *(specify):*

Other Standard *(specify):*
OAC chapter 5123:2-9-53
Verification of Provider Qualifications
Entity Responsible for Verification:
DODD
Frequency of Verification:
Provider compliance reviews will be conducted within one year of the provider's initial billing for provision of TDD services. Thereafter, routine compliance reviews of providers shall be conducted so that each provider is reviewed at least once every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Home Modification Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

Home Modification Services are environmental accessibility adaptations to structural elements of the interior or exterior of an individual's home, required in the individual's service plan, that are necessary to ensure health and safety, or which enable the individual to function with greater independence in the home and remain in the community. Excluded are those modifications to the home that are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Modifications that add to the total square footage of the home are excluded from this benefit. Home modifications shall be provided in accordance with applicable state or local building codes.

This service specification reflects the inclusion of non-legally responsible family members as individual providers. Services provided via a legal guardian must also be in accordance with the guardianship requirements found in OAC rule 5123:2-9-54.

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

*Home modification services are limited to $10,000 calendar year per individual, and are outside of the individual funding level.

*The provider must be identified as the provider, and have specified on the individual's service plan, the number of hours for which the provider is authorized to furnish services to the individual.

*Services performed by a provider must not exceed the monthly dollar amount allocated to that specific provider on the individual's service plan.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modification Services

Provider Category:
Individual

Provider Type:
Non-agency providers, e.g., independent contractors

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
OAC Chapter 5123:2-9-54

Verification of Provider Qualifications

Entity Responsible for Verification:
DODD

Frequency of Verification:
Provider compliance reviews will be conducted within one year of the provider's initial billing for provision of TDD services. Thereafter, routine compliance reviews of providers shall be conducted so that each provider is reviewed at least once every three years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modification Services

Provider Category:
Agency
Provider Type:
Agencies, e.g., home improvement companies and general contractors, etc.
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
OAC chapter 5123:2-9-54
Verification of Provider Qualifications
Entity Responsible for Verification:
DODD
Frequency of Verification:
Provider compliance reviews will be conducted within one year of the provider's initial billing for provision of TDD services. Thereafter, routine compliance reviews of providers shall be conducted so that each provider is reviewed at least once every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Out-of-Home Respite

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home

Category 2:	Sub-Category 2:

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

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

Service Definition *(Scope):*
Out-of-Home Respite Services are services delivered to individuals in an out-of-home setting that include an overnight stay in order to provide respite for caregivers normally providing care. Out-of-Home Respite Service providers must make available waiver nursing and personal care aide services and 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:
*None of the services delivered by an Out-of-Home Respite Service provider are reimbursable separately.
*The provider must be identified as the provider, and have specified on the individual's service plan, the number of hours for which the provider is authorized to furnish services to the individual.
*Services performed by a provider must not exceed the monthly dollar amount allocated to that specific provider on the individual's service plan.
*Out-of-home respite is limited to 90 days of services per waiver eligibility span.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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 other institutional providers (e.g., hospitals, etc.)

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
ICF-IID, NF or other institutional providers (e.g., hospitals, etc.)
Provider Qualifications
License *(specify):*
ICF-IID or NF per OAC rules 5160-3-02 and 5160-3-02.3, respectively.
Certificate *(specify):*

Other Standard *(specify):*
OAC Chapter 5123:2-9-55
Verification of Provider Qualifications
Entity Responsible for Verification:

DODD
Frequency of Verification:
Provider compliance reviews will be conducted within one year of the provider's initial billing for provision of TDD services. Thereafter, routine compliance reviews of providers shall be conducted so that each provider is reviewed at least once every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Supplemental Adaptive and Assistive Device Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope):*
Supplemental Adaptive and Assistive Device Services are medical equipment and supplies, and vehicle modifications to a vehicle owned by the individual or the individual's legally responsible family member, that are not otherwise available through any other funding source and that are suitable to enable the individual to function with greater independence, avoid institutionalization, and reduce the need for human assistance.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
*Reimbursement for medical equipment and supplies, and vehicle modifications, shall not exceed $10,000 calendar year per individual, and are outside of the individual's individual funding level.
*DODD will not approve the same type of medical equipment and supplies for the same individual within the same calendar year period unless there is a documented need for requiring replacement of medical equipment and/or supplies.
*DODD will not approve the same type of vehicle modification for the individual within a three-year period unless there is a documented change in the individual's medical and/or physical condition requiring the replacement.
*The provider must be identified as the provider, and have specified on the individual's service plan, the number of hours for which the provider is authorized to furnish services to the individual.

*Services performed by a provider must not exceed the monthly dollar amount allocated to that specific provider on the individual's service plan.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
Agency, e.g., DME providers

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
OAC Chapter 5123:2-9-57

Verification of Provider Qualifications

Entity Responsible for Verification:
DODD

Frequency of Verification:
Provider compliance reviews will be conducted within one year of the provider's initial billing for provision of TDD services. Thereafter, routine compliance reviews of providers shall be conducted so that each provider is reviewed at least once every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

HCBS Taxonomy:

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

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope)*:
Supplemental Transportation Services are those transportation services not otherwise covered by the Ohio medicaid program that enable an individual to access waiver services and other community resources specified on the individual's service plan. Supplemental Transportation Services include assistance in transferring the individual from the point of pick-up to the vehicle and from the vehicle to the destination point.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
*The provider must be identified as the provider, and have specified on the individual's service plan, the number of hours for which the provider is authorized to furnish services to the individual.
*Services performed by a provider must not exceed the monthly dollar amount allocated to that specific provider on the individual's service plan.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supplemental Transportation Services

Provider Category:

Agency

Provider Type:
Agency, e.g., ambulette companies, senior centers and community action organizations, etc.
Provider Qualifications
License *(specify):*
Valid Driver's License
Certificate *(specify):*

Other Standard *(specify):*
OAC chapter 5123:2-9-58
Verification of Provider Qualifications
Entity Responsible for Verification:
DODD
Frequency of Verification:
Provider compliance reviews will be conducted within one year of the provider's initial billing for provision of TDD services. Thereafter, routine compliance reviews of providers shall be conducted so that each provider is reviewed at least once every three years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supplemental Transportation Services

Provider Category:
Individual
Provider Type:
Non-agency provider
Provider Qualifications
License *(specify):*
Valid Driver's License
Certificate *(specify):*

Other Standard *(specify):*
OAC chapter 5123:2-9-58
Verification of Provider Qualifications
Entity Responsible for Verification:
DODD
Frequency of Verification:
Provider compliance reviews will be conducted within one year of the provider's initial billing for provision of TDD services. Thereafter, routine compliance reviews of providers shall be conducted so that each provider is reviewed at least once every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

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

HCBS Taxonomy:

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

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope)*:
Waiver nursing services are defined as services provided to individuals who require the skills of a registered nurse (RN) or licensed practical nurse (LPN) at the direction of an RN. All nurses providing waiver nursing services to individuals enrolled on the Transitions DD Waiver shall provide services within the nurse's scope of practice as set forth in Chapter 4723. of the Revised Code (Ohio's Nurse Practice Act) and Administrative Code rules adopted there under, and shall possess a current and valid license in good standing with the Ohio Board of Nursing.

Waiver nursing services provide needed nursing services up to the individual's approved individual budget that are not otherwise available. Waiver nursing provides part-time, intermittent and/or continuous nursing services. It is different than state plan nursing because its approved provider pool is not limited to Medicare-certified home health agencies. Waiver nursing services that can be covered under the State Plan should be furnished to waiver participants under the age of 21 as services required under EPSDT.

This service specification reflects the inclusion of non-legally responsible family members as individual providers. Related legal guardians of individuals over the age of 18 are permitted to be providers.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
*The provider must be identified as the provider, and have specified on the individual's service plan, the number of hours for which the provider is authorized to furnish services to the individual.
*Services may be performed by a legally responsible family member as long as that individual is employed by an approved agency provider.
*Services performed by a provider must not exceed the monthly dollar amount allocated to that specific provider on the individual's service plan.
*Waiver nursing does not include services delegated in accordance with Chapter 4723. of the Revised Code and to be performed by individuals who are not licensed in accordance with Chapter 4723. of the Revised Code, services that require the skills of a psychiatric nurse, and visits performed for the sole purpose of meeting the supervisory requirements for LPNs at the direction of an RN.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [x] **Legally Responsible Person**

☑ **Relative**
☑ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Waiver Nursing Services

Provider Category:
Individual
Provider Type:
Non-agency RN, non-agency LPN
Provider Qualifications
License *(specify)*:
RN/LPN
Certificate *(specify)*:
Other Standard *(specify)*:
OAC Chapter 5123:2-9-59
Verification of Provider Qualifications
Entity Responsible for Verification:
DODD
Frequency of Verification:
Provider compliance reviews will be conducted within one year of the provider's initial billing for provision of TDD services. Thereafter, routine compliance reviews of providers shall be conducted so that each provider is reviewed at least once every three years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Waiver Nursing Services

Provider Category:
Agency
Provider Type:
Medicare-certified HHA, an agency accredited by ACHC, CHAP or the Joint Commission or another national accrediting organization approved by CMS
Provider Qualifications
License *(specify)*:
RN/LPN
Certificate *(specify)*:
Other Standard *(specify)*:
OAC chapter 5123:2-9-59
Verification of Provider Qualifications

Entity Responsible for Verification:
DODD
Frequency of Verification:
Provider compliance reviews will be conducted within one year of the provider's initial billing for provision of TDD services. Thereafter, routine compliance reviews of providers shall be conducted so that each provider is reviewed at least once every three years.

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.*

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

County Boards conduct targeted case management activities (TCM) through Service and Support Administrators(SSA) who are certified or registered through DODD.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

At the time of initial enrollment DODD requests that every independent provider and every agency have a report sent to the Department as part of their application requirements. Certification will not be granted without this document, which must be sent directly from the Bureau of Criminal Identification and Investigation (BCII) to DODD.

DODD does not enroll an applicant who provides direct services to individuals with developmental disabilities as a Transitions DD waiver provider until a background check has been satisfactorily completed.

Criminal history/background checks are conducted for all providers having direct contact with waiver participants. Background investigations follow the requirements listed in Section 5123.081 of the Ohio Revised Code.

A report is submitted by the Ohio's Bureau of Criminal Identification and Investigation (BCII) directly to DODD regarding an applicant's criminal record. If the applicant who is the subject of a background investigation does not present proof that he/she has been a resident of Ohio for the five-year period immediately prior to the date of the background investigation, a request that BCII obtain information regarding the applicant's criminal record from the federal bureau of investigation (FBI) shall be made. If the applicant presents proof that he/she has been a resident of Ohio for that five-year period, a request may be made that BCII include information from the FBI in its report.

An individual provider is required to report to DODD if he or she is ever formally charged with, convicted of, or pleads guilty to any of the disqualifying offenses listed or described in divisions (A)(3)(a) to (e) of section 109.572 of the Revised Code. The individual provider shall make such report, in writing, no later than fourteen calendar days after the date of such charge, conviction or guilty plea.

An agency provider shall require any employee in a direct services position to report, in writing, to the agency provider if the employee is every formally charged with , convicted of, or plead guilty to any of the disqualifying offenses listed or described in divisions (A)(3)(a) to (e) of section 109.572 of the Revised Code no later than fourteen calendar days after the date of such charge, conviction, or guilty plea.

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

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

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; 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):

The requirements for the abuser registry are contained in Sections 5123.50 through 5123.54 of the Ohio Revised Code. DODD maintains an abuser registry and screens provider applicants for waiver services that have direct contact with waiver participants against the abuser registry. Certification as an independent waiver provider who is engaged in a direct services position shall not be approved until the screening has been satisfactorily completed. Agency providers must assure that all employees or contractors who are engaged in a direct services position have been screened against the abuser registry. Agency providers will not hire or employ anyone engaged in a direct services position who is on the abuser registry.

Certification shall be denied to any applicant whose name appears on the abuser registry. For waiver providers who previously have been certified, DODD regulations require the revocation of all providers' certifications whose names have been placed on the registry. If a provider is employing someone in a direct services position that is on the registry, DODD would immediately require the person on the registry to be removed from contact with any person with a developmental disability. The provider would be sanctioned for violating the abuse registry guidelines, which may involve revocation of the provider's certification.

Additionally, contact is made with the Ohio Department of Health to inquire whether the nurse aide registry established under section 3721.32 of the Revised Code reveals that its director has made a determination of abuse, neglect, or misappropriation of property of a resident of a long-term care facility or residential care facility by the applicant. The Ohio Department of Developmental Disabilities will deny certification to an applicant whose name appears on the nurse aide registry with regard to abuse, neglect or misappropriation.

For employees, subcontractors of the applicant, and employees of subcontractors who provide specialized services to an individual with a developmental disability as defined in division (G) of section 5123.50 of the Revised Code, the applicant shall provide to DODD written assurance that, as of the date of the application, no such persons are listed on the abuser registry established pursuant to sections 5123.50 to 5123.54 of the Revised Code.

DODD compliance reviews verify whether the provider has checked the registry to ensure none of the employees have been placed on the registry.

Appendix C: Participant Services

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

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- (●) **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ( ) **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

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.*

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.

Legally-responsible family members are permitted to provide waiver nursing services if they are employed by an approved agency provider.

Non-legally responsible family members are permitted to provide personal care aide services, waiver nursing, home modification services and supplemental transportation services as long as they meet the provider requirements for the service in question. Related legal guardians of individuals over the age of 18 are permitted to provide personal care aide and waiver nursing services.

As a condition of reimbursement, the provider must be identified as the provider, and have specified on the service plan, the number of hours for which the provider is authorized to furnish the service to the individual. This ensures that payment is made to the non-legally responsible family member as a provider only in return for specific services rendered.

Additionally, both the monitoring of service plan implementation performed by the County Board Service and Support Administrator, and provider compliance reviews conducted by DODD, include a review of whether services were actually delivered in accordance with the individual's service plan. This will include assuring that appropriate providers are furnishing authorized services.

○ **Other policy.**

Specify:

f. **Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The documents required for enrollment as a waiver provider, along with information regarding the enrollment process, are posted on DODD's website. Prospective providers may call or email DODD for information about the requirements or assistance with the application process.

Once DODD verifies applicants meet all requirements and service specifications for the service they wish to furnish, the Medicaid Provider application is forwarded to ODM for review and assignment of a Medicaid provider number.

County Boards also assist in the open enrollment of providers by passing along information regarding the waiver services and the provider application process to potential providers. DODD has an online Provider Certification Wizard which has streamlined the process potential providers use to become enrolled as waiver service providers.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. **Methods for Discovery: Qualified Providers**

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
PM C1: Number and percent of new independent personal care aids that meet initial certification requirements prior to providing waiver services. Numerator: Total number of new independent personal care aids that meet initial certification requirements prior to providing waiver services. Denominator: Total number of new independent personal care aids enrolled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD's Provider Certification Wizard

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

Data Aggregation and Analysis:

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

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

Performance Measure:
PM C2: Number and percent of enrolled independent personal care aids for which an appropriate background and registry checks were conducted timely. Num: Number of enrolled independent personal care aids for which an appropriate background and registry checks were conducted timely. Den: Total number of enrolled independent personal care aids due for a background check and registry checks.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD's Provider Certification Wizard

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

Data Aggregation and Analysis:

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

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:
PM C3: Number and percent of non-licensed/non-certified providers that meet requirements. Numerator: Number of non-licensed/non-certified providers that meet requirements. Denominator: Total number of non-licensed/non-certified providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD's Provider Certification Wizard

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

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

Data Aggregation and Analysis:

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

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:

PM C4: Number and percent of providers as a result of provider compliance review were determined to have met training requirements. Numerator: Number of providers as a result of a provider compliance review was determined to have met training requirements. Denominator: Total number of providers due for a review.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD's Provider Compliance Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Records Review-Sample selected based on regulatory review schedule and number of members receiving services
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
All Transitions – Developmental Disabilities waiver provider applicants must receive approval from the ODM before providing services to an individual enrolled on the Transitions – Developmental Disabilities waiver. ODM will make available to DODD information regarding any newly enrolled providers for the Transitions DD waiver.

DODD ongoing provider compliance reviews are scheduled at least once every three years for each provider who has actively billed during the last calendar year and is providing services in an unlicensed setting. Special reviews for each review process are conducted based on requests and/or complaints received from individuals and family members, advocates, other stakeholders, and concerned citizens.

DODD and ODM shall regularly communicate with one another regarding all provider reviews involving Transitions DD Waiver service providers that are conducted.

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

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

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

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

- (●) **No**
- ( ) **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- ( ) **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- (●) **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☑ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

(a) Waiver services to which the limit applies:

*Home modification services are limited to $10,000 per calendar year per individual.

*Under Supplemental Adaptive and Assistive Device Services, reimbursement for medical equipment and supplies, and vehicle modifications shall not exceed $10,000 per calendar year per individual. DODD will not approve the same type of medical equipment, supplies or devices for the same individual in the same calendar year unless there is a documented need for ongoing medical supplies or a documented change in the individual's medical and/or physical condition requiring the replacement.

*Under Supplemental Adaptive and Assistive Device Services, DODD will not approve the same type of vehicle modification for the same individual within a three-year period unless there is a documented change in the individual's medical and/or physical condition requiring the replacement.

(b) Basis of limit: The limits that are being established for these services are set forth in OAC rule 5123:2-9-54 and 5123:2-9-57 and are identified in (a) above. The limit on vehicle modifications is extended to three

years to avoid unnecessary replacement of vehicles, upgrades, etc.

(c) Adjustment of the limit: Home modifications and supplemental adaptive and assistive devices must be prior-approved. Supplemental adaptive and assistive devices in excess of the limit can be approved by DODD when there is a documented need for ongoing medical supplies, or a documented change in the individual's medical and/or physical condition requiring replacement.

(d) Provision of exceptions: Any exceptions to either vehicle modifications and/or supplemental adaptive and assistive device services must be brought to DODD's attention for review and prior-approval.

(e) Safeguards: Service and Support Administrators are responsible for monitoring the adequacy of services provided to individuals through routine monitoring. Individuals can request home modification and/or supplemental adaptive and assistive device services from their Service and Support Administrator at any time. A skilled therapist may be consulted to ascertain whether the modification and/or device will enable the individual to function in the home with greater independence and thereby avoid institutionalization.

(f) Notification of amount: Service and Support Administrators must notify the individual of the approval of the request for and amount of home modification and/or adaptive and assistive device services, and must update the individual's service plan accordingly.

Hearing rights: Service and Support Administrators must also notify individuals of their right to request a hearing subsequent to a denial of the individual's request for initial or subsequent home modification and/or supplemental adaptive and assistive device services.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☑ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

a) Waiver services to which the limit applies: Funding ranges are applied to the total monthly cost of waiver services (excluding home modification services and supplemental adaptive and assistive device services) received by each individual. Upon completion of the service plan, an individual is assigned a funding range based on their individual funding level. The individual funding level is determined by the total cost of their services (excluding home modification services and supplemental adaptive and assistive device services. The Service and Support Administrator is responsible for determining the individual funding level and the funding range, but they may be subject to review and approval by DODD when they are over certain threshholds. Individuals are notified by the Service and Support Administrator in writing of their hearing rights related to service changes which affect their funding levels and funding ranges.

(b) Basis of limit: Funding ranges up to the waiver cost cap.

(c) Adjustment of the limit: Individual funding ranges will be determined at the time of entry onto the waiver, with changes occurring subsequent to changes in the individual's condition or circumstances.

(d) Provisions for exceptions: Individuals whose service needs are considered by the individual and/or Service and Support Administrator to be greater than the funding level or funding range may request an increase in one or the other, or both. DODD has developed a process through which County Boards of DD submit all payment authorizations that exceed a certain threshold. DODD will ensure that services authorized are the most efficient to ensure health and welfare, and that alternate funding sources such as State plan services have been explored.

(e) Safeguards: Service and Support Administrators are responsible for monitoring the adequacy of services provided to individuals through routine monitoring. Individuals can request an increase in their assigned funding level at any time.

(f) Notification of amount: Service and Support Administrators will notify the individual of the funding

allocation limit at the time of service plan development.

Hearing rights: Service and Support Administrators notify individuals of their right to request a hearing, and hearing rights are generated subsequent to denial of the individual's request for a change or increase in their funding level.

☐ **Other Type of Limit.** The State employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Individuals enrolled in Transitions DD are not residing in a more traditional group home settings with twenty-four shifts and are not receiving services in settings of more than a one to three ratio. The Transitions DD Waiver transition plan assumes the Residential Supports are compliant since the majority of individuals enrolled in this waiver are children or young adults living with families or other caregivers. Service and Support Administrators (SSA) conduct home visits, in accordance with individual plans. Through the residential survey process, no county board identified a residential setting in which Transitions DD services are provided as non-compliant with the regulation. These residential settings will be monitored on an ongoing basis through SSA monitoring and the provider compliance process.

Remediation Strategies/Action Steps/Timelines as outlined in the Ohio Statewide Transition Plan Appendix1: ICF-IID Level of Care Waivers System Remediation Grid that will provide for ongoing monitoring of HCB setting requirements in the future:

1. Implement new Home and Community-Based Services Administration rule that describes the characteristics required of all settings in which HCBS is provided and recognizes the individual's opportunity to choose among services/settings that address assessed needs in the least restrictive manner, promote autonomy and full access to the community, and minimize dependency on paid supports. Including the requirements specific to provider owned or controlled settings.
Action Steps:
a. Developed content with the sub-committee with equal representation from advocates/self-advocates, county boards, and providers of HCBS.
b. Formal clearance for draft rule.
c. Final file. Complete by January 2016.

2. Revise service definition of Homemaker/Personal Care under the Individual Options and Level One Waivers to include language that supports the use of this service to promote individuals' integration in and access to the greater community.
Action Steps:
a. Submit waiver amendments to CMS.
b. Formal clearance for draft rule.
c. Final file. Complete by October 2016.

3. Implement a new HCBS settings evaluation tool utilized to conduct compliance reviews of providers of HCBS to include prompts for ensuring HCBS are provided in settings that comport with the regulation.
Action Steps:
a. Convene workgroup with broad cross-section of individuals/families, providers of HCBS, and county board personnel.

b. Develop draft tool.
c. Share draft with stakeholders for feedback.
d. Provide training on new tool. Complete by January 2016.

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:

- [x] **Other**

  Specify the individuals and their qualifications:

  Service and support administrators (SSA) are responsible for service plan development and revision (ORC 5126.15 and rule 5123:2-1-11 of the Administrative Code). A service and support administrator must be, regardless of title, employed by or under subcontract with a County Board to perform the functions of service and support administration, and must hold the appropriate certification in accordance with rule 5123:2-5-02 of the Administrative Code. The minimum qualifications for certification are an associate's degree from a college or university and the successful completion of following:

  (1) The Ohio Alliance of Direct Support Professionals Professional Advancement Through Training and Education in Human Services (PATHS) Certificate of Initial Proficiency program; OR
  (2) An orientation program of at least eight hours that addresses: Organizational background of the county board or contracting entity. Components of quality care for individuals served including Person-centered philosophy. Health and safety. Positive behavior support. Services that comprise service and support administration.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. **Service Plan Development Safeguards.** *Select one:*

- ( ) **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- (•) **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

County Boards currently serve as the single provider of case management through Ohio's Targeted Case Management(TCM)services. County boards may also provide direct services to some individuals receiving 1915

(c) waiver services. In many cases, people have been receiving their direct services from the county board for a long period of time. The state reports that there are not enough providers and the state needs time to develop a broader provider pool.

In the past 7 years, the state has reduced the percentage of adult day services provided by the boards from 92% to 52%. This was accomplished through a combination of expanding the private provider pool, expecting boards to actively recruit providers in counties where options are minimal, and carefully planned transitions of individuals from county boards to other providers.

Ohio is in the process of redesigning the adult day services. It is anticipated that these new services will be available in 2016, they will not be available in segregated facilities. County boards providing TCM will not be eligible to provide any of the new adult day services, unless no other qualified provider is available in the geographic area. It is anticipated that all individuals will be safely transitioned from their existing adult day services, many of which are operated by county boards, to the newly designed services according to Ohio's Transition Plan.

Under the newly designed adult day services model, the county boards' role will be to assist individuals with navigating the various employment services available through the waiver, as well as through other community organizations, such as Ohio's vocational rehabilitation vendors and the county departments of job and family services. This employment navigation will be provided as a function of TCM.

Case management shall not be assigned responsibilities for implementing other services for individuals and shall not be employed by or serve in other administrative functions for any other entity that provides programs or services to individuals with developmental disabilities in accordance with section 5126.15 of the Ohio Revised Code.

So long as a county board is a provider of home and community-based services, the county board shall: (1) Ensure administrative separation between county board staff doing assessments and service planning and county board staff delivering direct services; and (2) implement a process and establish annual benchmarks for recruitment of sufficient providers of adult day support and employment services. The state monitors for this administrative separation during the county board accreditation reviews as outlined under OAC 5123:2-1-02 (P) Administration and Operation of County Boards of Developmental Disabilities. Through the accreditation process county boards are reviewed as a provider of service, if applicable, and as the administrative entity overseeing service delivery and waiver programs. Based on the results of an accreditation review, a County Board is awarded an accreditation term of from one to three years.

Personnel providing TCM shall inform individuals, at least annually, of the right to choose from among all qualified providers and shall provide assistance, as needed, with the provider selection process in accordance with section OAC 5123:2-9-11. Individuals who wish to appeal a decision related to their HCBS services may request a state hearing in accordance with section 5101.35 of the Revised Code and Chapters 5101:6-1 to 5101:6-9 of the Administrative Code.

By March 1, 2020 no more than 30% of the individuals receiving case management through the county boards will also receive direct services through the county boards. To achieve this goal, the County Boards will continue to phase out their provision of direct services.

Annual benchmarks will be established for recruitment of sufficient providers in each county to safely meet the needs of all individuals requiring day services and for reducing the census of county board day programs. Annual benchmarks will be established in accordance with paragraph (D) of OAC 5123:2-9-11 for the recruitment of sufficient adult day, employment, and non-medical transportation providers. The county board shall establish and implement annual benchmarks for reducing the number of individuals for whom the county board provides adult day support, employment services, and non-medical transportation. Benchmarks are subject to approval by DODD. The county board shall report progress on achieving benchmarks to the department twice per year in accordance with the schedule and format established by the department.

The Ohio Department of Developmental Disabilities shall require county boards to establish annual benchmarks as outlined in OAC 5123:2-9-11 (D) no later than September 1, 2015. County boards shall submit progress reports on achieving benchmarks to the department twice per year, starting June 30, 2016 reflecting the number of individuals who have selected another qualified provider and are no longer receiving day services from the county board. The Ohio Department of Developmental Disabilities will work closely with county boards to ensure

compliance with established benchmarks. County boards that fail to comply will no longer be permitted to provide Targeted Case Management or to develop individuals' person-centered plans.

County Boards are prohibited from providing direct services to new individuals, unless no other qualified and willing provider is available. County boards shall submit progress reports on achieving benchmarks to the department twice per year, starting June 30, 2016 reflecting the number of individuals who have selected another qualified provider and are no longer receiving day services from the county board.

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.

Each individual receives information and support from the Service and Support Administrator (SSA) to direct and be actively engaged in the service plan development process in accordance with OAC 5123:2-1-11. The DODD website publishes a variety of handbooks and brochures to assist participants and family members to understand HCBS waivers and the service planning process.

OAC 5123:2-1-11 states that an individual shall be responsible for making all decisions regarding the provision of services, and that even individuals with guardians have the right to participate in the decisions that affect their lives. The rule also requires that the service planning process occurs with the active participation of the individual to be served and other persons selected by him/her; that the service plan shall be reviewed and/or revised at the request of the individual; and that the individual will receive a complete copy of the service plan.

Services and supports are planned and implemented in accordance with each individual's needs, expressed preferences, and decisions concerning his/her life in the community. To that end,
Individuals participate in the development of their service plans and plans of care and choose the providers from whom they would like to receive services. Those providers may be traditional agency providers or non-agency providers approved by ODM, including non-legally responsible family members.

If an individual elects to receive all or a portion of their waiver services from non-agency providers, the SSA must assure that the individual/guardian is able to direct the waiver services. This includes training the providers to meet the individual's health care needs, and/or specifying additional training the provider must successfully complete prior to furnishing waiver services; establishing an approved back-up plan to be followed when the provider is unable to furnish services at the scheduled time and location; and approving timesheets after waiver services have been furnished and prior to a submission of a claim to ODM.

The SSA must assure the health and welfare of the individual. The SSA will assist the individual, as needed, with directing waiver services by non-agency providers, including assistance with communicating health care needs to non-agency providers, identifying provider performance issues, and resolving conflicts with non-agency providers.

If the SSA cannot assure the individual's health and welfare through the individual's direction of waiver services by non-agency providers, with or without support, then the SSA may require the individual only receive services from agency providers.

Individuals have the right to request a state hearing anytime they disagree with an action that has been taken by the county board, DODD, or ODM.

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):

Service Planning Process Overview--Service planning under the Transitions DD Waiver is a multi-dimensional, participant-centered function that involves the ongoing coordination of Medicaid and other formal and informal supports and services an individual receives. It includes authorizing and arranging for waiver services that support and enhance, but do not replace, what is already furnished by the family and/or informal caregivers. Service planning addresses the changing circumstances and medical and physical conditions of an individual over time. Inherent in the process is the desired outcome that services and supports are planned and effectively implemented in accordance with each individual's unique needs, expressed preferences and decisions concerning his or her life in the community.

The SSA is responsible for developing and revising the service plan and ensuring that this process occurs with the active participation of the individual to be served, the guardian of the individual, as applicable, other persons selected by the individual, and the provider(s) selected by the individual. The SSA is also responsible for ensuring the service plan addresses the results of the assessment process and results from service monitoring, that the plan focuses on the individual's strengths, interests and talents; and that the plan integrates all services and supports, regardless of funding, available to meet the needs and desired outcomes of the individual. The SSA is responsible for informing the individual of all the services available under the waiver. Staff who are responsible for writing an individual's plan do not provide any direct services to the individual. SSA's are prohibited from providing direct service to individuals. DODD compliance reviews verify that entities responsible for plan development do not provide services to individuals.

Input from the individual, the individual's guardian, other advocates, and team members determines the types of assessments that are included in the assessment process. Assessments and evaluations by certified and/or licensed professionals shall be completed as dictated by the needs of the individual. Assessments shall also include evaluation of the individual's likes, dislikes, priorities, and desired outcomes, as well as what is important to and for the individual, including skill development, health, safety, and welfare needs, as applicable.

The service plan shall include services and supports that prevent institutionalization and assist the individual to engage in meaningful, productive activities and develop community connections. All services and activities indicated shall include the provider type, the frequency, and the funding source; and specify how services will be coordinated among providers and across all settings for the individual. The service plan is to be reviewed and, as appropriate, revised at the request of the of the individual or a member of the individual's team; whenever the individual's assessed needs,circumstances or status changes, when the individual chooses a new provider; or as a result of ongoing monitoring of service plan implementation, and/or identified trends and patterns of unusual incidents or major unusual incidents. Revisions to the ISP must occur within thirty calendar days of a request by the individual or a team member. At a minimum, all service plans are updated annually.

Changes to service plans that result in a decrease in services or changes that result in an increase in the cost of services within the individual's funding range are approved by the SSA. Changes to plans that result in an increase in the cost of an individual's services in excess of their funding range are approved by DODD. In addition, ODM monitors service planning activity through the quality performance measures.

Back-up providers are identified by the individual and their team and are named in the individual's service plan as such. On those occasions when the primary provider is not able to provide services, the primary provider must notify the back-up provider per the process identified in the individual's service plan. If the back-up provider cannot be reached, the primary provider will notify the SSA, who will make arrangements for coverage so that the individual is not left without needed services.

The SSA is responsible for ensuring that services are effectively coordinated by facilitating communication with the individual and among providers across all settings and systems. Such communication includes service plan revisions; relocation plans of the individual; changes in individual status that result in suspension or disenrollment from services; and coordination activities to ensure that services are provided to individuals in accordance with their service plans and desired outcomes.

The SSA is responsible for monitoring the implementation of the service plan in order to verify the health, safety and welfare of the individual; consistent implementation of services; achievement of the desired outcomes for the individual as stated in the service plan; and that services received are those reflected in the plan. This monitoring includes, but is not limited to, behavior support plan implementation; emergency intervention; identified trends and

patterns of unusual incidents and major unusual incidents and the development and implementation of prevention and/or risk management plans; results of quality assurance reviews; and other individual needs determined by the assessment process. (OAC 5123:2-1-11)

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The SSA is required to coordinate assessments to determine the health, safety and welfare needs of the individual as part of the service planning process. Assessments shall be completed by licensed and/or certified professionals as dictated by the needs of the individual. The SSA is also required to monitor incident trends and the development and implementation of prevention and/or risk management plans as needed for the participant.

In developing the proposed service plan, County Boards generally assess all areas of the individual's life, such as housing, community membership, health, safety and personal satisfaction. The SSA shall incorporate in the service plan any known or perceived risk and/or safety considerations identified through the assessment and/or monitoring processes.

Back-up providers are identified by the individual and their team and are named in the individual's service plan. On those occasions when the primary provider is not able to provide services, the primary provider must notify the back-up provider per the process identified in the individual's service plan. If the back-up provider cannot be reached, the primary provider will notify the SSA, who will make arrangements for coverage so that the individual is not left without needed services. The primary provider or the individual may also contact the county board's emergency contact for assistance 24 hours a day.

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.

DODD ensures individuals have Free Choice of Provider through interviews and documentation reviews conducted during the accreditation review process. In accordance with OAC 5123:2-9-11 DODD assures the free choice of provider processes are adhered to and is intended to emphasize the right of individuals to choose any qualified provider of home and community-based services.

DODD creates and maintains on its website lists of all qualified providers that are certified by DODD to provide home and community-based services and who has a medicaid agreement with ODM. The lists are updated by DODD at least monthly. The SSA utilizes the lists of providers created by DODD to assist the individual in identifying potential providers, in accordance with OAC 5123:2-9-11. Individuals have the ability to search for providers using DODD's provider search portal.

If an individual wants to select a friend, neighbor or non-legally responsible family member as a non-agency provider, or if the individual would like to select a provider who is certified by DODD and is not currently enrolled as a Medicaid provider for the Transitions DD waiver, the individual may direct the provider to ODM for assistance with enrollment.

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):

SSAs will develop services plans in accordance with OAC 5123:2-1-11. Changes to plans that result in a decrease in services or changes that result in an increase in the cost of services within the individual's funding range are approved by the service and support administrator. Changes to plans that result in an increase in the cost of an individual's services in excess of their funding range are approved by DODD. In addition, ODM monitors service planning activity through the quality performance measures. ODM also retains the right to review and modify service plans at any time.

ODM oversees the operation and performance of DODD to ensure the waiver program is operated in accordance with the approved waiver, and to assess the effectiveness of DODD's oversight of the County Boards operating the waiver locally. Operation of the waiver is delegated by ODM to DODD through an interagency agreement between ODM and DODD. This agreement includes language authorizing ODM to perform oversight activities to establish the program's compliance with federal and state laws and regulations as well as auditing and fiscal compliance. ODM will employ a multifaceted monitoring and oversight process which is outlined in Appendix H.

Under the Continuous Review process, ODM will regularly review, monitor, and dialogue with DODD about data generated quarterly through the approved waiver's performance measures to gauge performance and compliance with federal waiver assurances including service planning, care management, free choice of provider, level of care, health and welfare, and validation of service delivery. Through its review of this data, ODM may request additional information as well as remediation and/or quality improvement strategy as appropriate.

ODM in conjunction with DODD will review the effectiveness of the State's Quality Oversight Strategy including DODD performance data, case-specific resolutions data, quality improvement plans and technical assistance provided. These discussions will occur through quality briefings as outlined in Appendix H.

Requirements to comply with federal assurances are also codified in state statute and administrative rules, and clarified in procedure manuals. While some rules and guidelines apply narrowly to specific programs administered by the operating agency, other rules promulgated by ODM authorize those rules or guidelines, establish overarching standards for Medicaid programs, and further establish the authority and responsibility of ODM to assure the federal compliance of all Medicaid programs.

Participants can request a State Hearing regarding plans of care and ODM has general authority to provide oversight of the Operating Agency actions regarding the waiver, which includes plans of care.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☑ **Other**

Specify:

Copies of service plans are maintained by the county boards of developmental disabilities.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan 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 SSA is responsible for monitoring the implementation of the service plan in accordance with OAC 5123:2-1-11 in order to verify the health, safety and welfare of the individual; consistent implementation of services; achievement of the desired outcomes for the individual as stated in the service plan; and individual's service plan is reviewed at least annually and more often should the needs of the individual change. This on-going monitoring is tailored to the individual and occurs through regular interaction with the individual and his or her provider(s). The scope, type, and frequency of reviews are specified in the individual serivce plan.

DODD monitors service plan implementation through the provider compliance and accreditation review processes. Reviewing service plan documentation and the corresponding service plans is one component of the accreditation and provider compliance review processes conducted by DODD field review staff.

Reviewing service plans and the monitoring activities of SSAs is one component of the accreditation review process. Accreditation reviews are scheduled at least once every three years based on the term of the county board's accreditation award. A county board may be accredited for one to three years based on the outcome of their review.

Provider compliance reviews are scheduled at least once every three years for each provider who has actively billed during the last calendar year and is providing services in an unlicensed setting. County Boards cannot complete compliance reviews of day services while providing day services. This function can only be performed by DODD. Special reviews for each review process are conducted based on requests and/or complaints received from individuals and family members, advocates, other stakeholders, and concerned citizens. DODD and ODM shall regularly communicate with one another regarding all Transitions DD Waiver provider reviews that are conducted.

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 State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Service Plan Assurance/Sub-assurances**

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. **Sub-Assurances:**

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
PM D1. Number and percent of participants whose service plans address their assessed needs, including health and safety risk factors, and personal goals. Numerator: Number of participants whose service plans address their assessed needs, including health and safety risk factors, and personal goals. Denominator: Total number of participants reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Records Review-Sample selected based on regulatory review schedule and number of members receiving services through that provider.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

Performance Measure:
PM D2. Number and percent of service plans that were developed according to policies and procedures as described in the approved waiver. Numerator: Number of service plans that were developed according to policies and procedures as described in the approved waiver. Denominator: Total number of participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Records Review-Sample selected based on regulatory review schedule and number of members receiving services through that provider.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's 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:
PM D3. Number and percent of service plans reviewed that were updated at least annually. Numerator: Number of service plans reviewed that were updated at least annually. Denominator: Total number of service plans reviewed that an annual update were due.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Records Review-Sample selected based on regulatory review schedule and number of members receiving services through that provider.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
PM D4. Number and percent of service plans reviewed that were updated when the participant's needs changed. Numerator: Number of service plans reviewed that were updated when the participant's needs changed. Denominator: Total number of service plan reviewed for whom participants experienced a change in need.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

		review schedule and number of members receiving services through that provider.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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:
D5. Number and percent of participants reviewed who received services in the type,scope,amount, duration and frequency specified in the service plan. Numerator: Number of participants reviewed who received services in the type, scope, amount, duration and frequency specified in the service plan. Denominator: Total number of participants reviewed.

Data Source (Select one):
Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Records Review-Sample selected based on regulatory review schedule and number of members receiving services through that provider.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and 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:
D6. Number and percent of participants notified of their right to choose among waiver services and/or providers. Numerator: Number of participants notified of their rights to choose among waiver services and/or providers. Denominator: Total number of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD County Board/Provider Compliance Reviews

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

		selected based on regulatory review schedule and number of members receiving services through that provider.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Records Review-Sample selected based on regulatory review schedule and number of members receiving services through that provider.
It is the responsibility of the SSA to ensure that the individual's service plan is compiled correctly and timely. During the DODD regulatory review process in the areas of Service Plan Development and Service Plan Implementation the following are reviewed 1) the service plan meets the assessed needs and wants of the individual, 2) it is developed according to the required processes, 3) it is developed utilizing the correct forms, 4) it is updated at least annually, 5) it updated when the needs of the individual change, and 6) the individual receives services in the type, scope, amount, duration, and frequency identified in the service plan. When non-compliance in an area is identified, a citation is issued to the County Board and the County Board will be required to submit a plan of correction by the specified due date. Verification of the plan of correction will be

done to ensure that the plan of correction has been implemented to correct the area of non-compliance. When issues are noted that are systemic, DODD will provide statewide training and additional technical assistance and monitor for improvement during subsequent monitoring cycles.

During the DODD regulatory review process, the individual's SSA is asked to complete a questionnaire which asks for copies of the Freedom of Choice. When non-compliance in this area is identified, a citation is issued to the County Board . The County Board will be required to submit a plan of correction by the specified due date. Verification of the plan of correction will be done to ensure that the plan of correction has been implemented to correct the area of non-compliance. When issues are noted that are systemic, DODD will provide statewide training and additional technical assistance and monitor for improvement during subsequent monitoring cycles.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**

○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

At the time of application for benefits, the individual or authorized representative is informed, in writing of the right to a state hearing, of the method by which a state hearing may be requested and that the case may be presented by an authorized representative, such as legal counsel, relative, friend, or other spokesperson. Individuals receive an "Explanation of State Hearing Procedures," JFS 04059(rev 4/2005), or its computer-generated equivalent, to provide this notice in accordance with rule 5101:6-2-01 of the Ohio Administrative Code.

Applicants for Transition DD enrollment and waiver enrollees who are affected by any decision made to approve, reduce, suspend deny or terminate enrollment or to deny the choice of a qualified and willing provider or to change the level and/or type of waiver service delivered, including any changes made to the individual service plan, shall be afforded medicaid due process. All waiver enrollees receive prior notice for any adverse action proposed. This notice includes the right to a state hearing and an explanation of the hearing procedures and is either generated manually by county boards or electronically by county departments of job and family services. Each agency retains copies of notices issued.

The individual must call or write their local county agency or write the Ohio Department of Job and Family Services (ODJFS), Office of Legal Services, Bureau of State Hearings (BSH). A hearing request must be received within 90 days of the mailing date of the notice of action

DODD assures participation through an agency representative (DODD and/or County Boards pursuant to OAC 5101:6-6-02 at hearings requested by applicants, enrollees and individuals disenrolled from the Transitions DD Waiver. Individuals who request hearings are notified about the action to be taken regarding the hearing request and are informed of the date, time, and location of the hearing at least ten days in advance. Services proposed to be reduced or terminated must be continued at the same level when the hearing is requested within ten days of the mailing date on the notice. Hearing decisions are rendered no later than 90 days after the hearing request. When agency compliance with a hearing decision is required, it must be acted upon within 15 calendar days of the decision or within 90 days of request for hearing, whichever is first.

Individuals who request hearings are notified about the action to be taken regarding the hearing request and are informed of the date, time, and location of the hearing at least ten days in advance. Services proposed to be reduced or terminated must be continued at the same level when the hearing is requested within fifteen days of the mailing date on the notice. Hearing decisions are rendered no later than 90 days after the hearing request. When agency compliance with a hearing decision is required, it must be acted upon within fifteen calendar days of the decision or within 90 days of request for hearing, whichever is first.

Individuals are informed in writing of the hearing decision and are notified of the right to request an administrative appeal if they disagree with the hearing decision. The administrative appeal process is defined in rule 5101:6-8-01 of the Ohio Administrative Code.

As an alternative dispute resolution process that does not involve a decision by the SSA or County Board, Individuals who wish to appeal a decision related to their Home and Community-based services may request a state hearing in accordance with section 5101.35 of the Revised Code and Chapters 5101:6-1 to 5101:6-9 of the Administrative Code.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

The Ohio Department of Developmenal Disabilities (DODD).

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).

DODD receives and acts upon complaints in a variety of ways. DODD's Major Unusual Incident/Registry Unit receives complaints through a toll-free number for reporting abuse/neglect and other MUIs. Complaints are also received via email and U.S. mail. Each complaint received is logged and acted upon the same or next day and followed up until the issue is resolved. Some calls result in MUIs while other calls are assorted complaints which are referred to other department staff, county boards, or outside entities such as the Department of Health. These include medical, behavior, environmental and other miscellaneous subjects. Managers in the MUI/Registry Unit recommend closure when the issue has been resolved. The case is then closed by unit supervisors.

DODD employs a Family Advocate who works with families to provide technical assistance, including addressing complaints.

DODD Provider Standards and Review will follow up on any complaints regarding County Boards or certified waiver providers. This could result in citations being issued. Citations require a plan of correction that must be approved by DODD. Individuals may also contact their SSA to voice any concerns or complaints. Each County Board is required to have a complaint resolution process.

None of the above complaint resolution processes may be used in place of or to delay a Medicaid state hearing. As an alternative dispute resolution process that does not involve a decision by the SSA or County Board, Individuals who wish to appeal a decision related to their Home and Community-based services may request a state hearing in accordance with section 5101.35 of the Revised Code and Chapters 5101:6-1 to 5101:6-9 of the Administrative Code.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- ◉ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*
If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

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).

Reportable Incidents
"Major Unusual Incident" or "MUI" means the alleged, suspected, or actual occurrence of an incident when there is reason to believe the health or safety of an individual may be adversely affected or an individual may be placed at a reasonable risk of harm as listed in this paragraph, if such individual is receiving services through the DD service delivery system or will be receiving such services as a result of the incident. MUIs include the following:
1. Accidental or Suspicious death
2. Attempted Suicide
3. Death other than accidental or suspicious death
4. Exploitation
5. Failure to report
6. Law enforcement
7. Medical emergency
8. Misappropriation
9. Missing individual
10. Neglect
11. Peer-to-peer acts
12. Physical abuse
13. Prohibited sexual relations
14. Rights code violation
15. Significant injury
16. Sexual abuse
17. Unapproved behavior support
18. Unscheduled Hospitalization
19. Verbal abuse

Required Reporters:
County Boards of Developmental Disabilities
Ohio Department of Developmental Disabilities
DODD operated Developmental Centers
All DD Waiver providers
All DD licensed or certified providers
DD employees providing specialized services

Reporting Methods and Timeframes
The timeframe for reporting abuse, neglect, misappropriation, exploitation, and suspicious or accidental death is immediate to four (4) hours. The remaining MUIs must be reported no later than 3:00 p.m. the next working day. DODD is notified by the county board through the Incident Tracking System by 3:00 p.m. on the working day following notification by the provider or becoming aware of the MUI. Immediate action to protect the individual(s) is taken by the provider and ensured by the county board. Notifications are made immediately to law enforcement for alleged criminal acts and to the Children's Services agency if the individual is under 22.

Reference Rule: OAC 5123:2-17-02

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including

how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

DODD's home page lists the Hotline complaint telephone number for reporting of abuse, neglect, and MUIs.

DODD and county boards of DD conduct annual trainings on reporting and investigation of MUIs for county boards, DODD employees, providers, and families.

DODD sends out Field Alerts on health and safety issues through an on-line newsletter that goes to families, providers, and county boards. The Alerts also go through a listserve to all county boards and certified and licensed providers and those with agreements with ODM to provide Transitions DD Waiver services.

DODD and county boards have Hotlines/Help Lines for receiving reports that have been communicated to providers and families.

DODD letterhead includes the Hotline telephone number for reporting abuse, neglect, and MUIs.

DODD developed a Family Handbook on MUIs which was distributed through the County Boards and placed on the Department's website.

DODD, in addition to the hotline for reporting abuse and neglect, lists each County Boards after-hours number for reporting MUIs on its website.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The County Boards MUI Unit receives reports of critical incidents from providers, families, and county board operated programs. This Unit is responsible for determining if it meets the criteria of an MUI, ensuring immediate actions have been taken to protect the individual(s), making notifications, and initiating the investigation for all MUIs. Investigations into allegations of abuse, neglect, misappropriation, exploitation,suspicious or accidental deaths, failure to report, peer to peer acts, and rights code violation are initiated within 24 hours. For all other MUIs the investigation is initiated within a reasonable amount of time based on the initial information received and consistent with the health and safety of the individual(s) but no later than three (3) working days. All investigations are to be completed within 30 working days unless extensions are granted by DODD based upon established criteria.

Reference Rule: OAC 5123: 2-17-02.

ODM Protection from Harm Unit

Alert Process Summary
One way ODM assures that the health and safety needs of individuals enrolled on DODD HCBS waivers are adequately addressed is by ODM Protection from Harm Unit monitoring the progress and contributing to the investigatory process by mandated state agencies for certain incidents that impacted those individuals. Those incidents include but are not limited to incidents of alleged neglect or abuse resulting in hospitalization or removal by law enforcement; suspicious, unusual, accidental deaths, and misappropriations valued at over $500.

ODM is made aware of these incidents through various means, including: notification by DODD, discovered during other ODM oversight activities, contacted by other agencies, media sources, stakeholders and citizens.

The monitoring is completed by viewing the report and all investigation updates recorded in DODD's Incident Tracking System (ITS) and other DODD and ODM electronic sources. Inquires and concerns by ODM regarding any aspect of the investigation process/progress are added to the report by DODD with timelines for responses included.

Prior to ODM considering a case closed, members ensure if the steps taken to assure the immediate health and safety of the individual(s) involved in the incident are and adequate; that appropriate notification was made to law enforcement, children's services, guardians, other appropriate agencies and parties; that all of the causes and contributing factors are identified, and are adequately remedied and/or addressed in the prevention plans; that all questions by all parties have been answered, and that the recommendations and prevention plans have been implemented/completed.

After the initial review, the progress of the incident investigations is evaluated through a monthly review. If during the process of getting a Director's Alert MUI case to closure it becomes apparent the efforts to provide for the waiver recipient(s)'s health or welfare are not being assured for any reason, ODM will address those issues through the Adverse Outcome process described in Appendix A-2-b.

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.

Reference Rule OAC 5123:2-17-02

DODD has a web-based Incident Tracking System (ITS), which is a DODD application tasked with tracking the Major Unusual Incidents (MUIs) across all of Ohio's 88 counties and be each waiver. This application aids local and state developmental disability employees in ensuring the health and safety of individuals.

DODD reviews all initial MUI/Registry Unit incident reports to ensure the health and safety of individuals. All substantiated reports of abuse, neglect, and misappropriation involving staff are reviewed. Other incidents are reviewed as deemed necessary to ensure the health and safety of individuals.

DODD MUI/Registry Unit conducts assessments of county boards to ensure the following:
• Appropriate reporting
• Immediate actions
• Appropriate notifications
• Thorough investigations
• Preventative measures to address the cause and contributing facts
• Trend and Pattern analysis and remediation
• Appropriate reporting of unusual incidents (local reporting)
• Training requirements

MUI Assessments are conducted based on the performance of the county board but at least on a three (3) year cycle. Triggers are identified which could result in the assessment being done sooner.

There is an MUI assessment that is part of the Accreditation review; however, the MUI division also conducts their own 3-year performance-based cycle of reviews (which are separate from the Accreditation reviews) based on the MUI division's assessment of a county board's performance. For example: If, in 2013, the MUI assesses the county board and the county board is eligible for a 3-year MUI review based on their performance, but there is an Accreditation review scheduled in 2014, the MUI team would still return in 2014 for another assessment along with the Accreditation team.

MUI Trend and Pattern analyses and remediation is done twice a year by agency providers and county boards. DODD reviews all analyses completed by county boards and samples those completed by agency providers.

County boards are responsible for reviewing the analyses for agency providers in their county. DODD MUI/Registry Unit flags serious or egregious incidents as Director's Alerts. These cases are closely monitored for a thorough investigation and good prevention planning. Examples include accidental or suspicious deaths, neglect or physical abuse resulting in serious injuries or death, missing persons with high risk, serious unknown injuries and others as deemed appropriate.

DODD holds a quarterly Mortality Review Committee compiled of stakeholders, including ODM, to review deaths for the purpose of identifying trends, possible Alerts, notification to other jurisdictional entities or licensing boards. In addition, the committee looks at causes of deaths and what steps might be taken to educate the field on the causes.

A statewide Trend and Pattern Committee, made up of stakeholders, including ODM, meets twice a year to review statewide trends and patterns along with activities and initiatives being taken by DODD in regard to health and safety.

DODD's MUI/Registry Unit conducts annual, in-depth analysis on abuse, neglect, and misappropriation to determine who, what types, root causes, and provides interventions to reduce reoccurrences. This is communicated through Alerts and during annual trainings.

DODD's MUI/Registry Unit notifies the county board of individual trends and requires the county board to identify

what action will be implemented to address the trends.

DODD works in conjunction with Provider Compliance and Accreditation when trends and patterns are noted with a particular provider.

ODM Protection from Harm Unit Additional Oversight Responsibilities:

1. Participate in DODD's semi-annual Trends and Patterns Committee
2. Participate in DODD's quarterly Mortality Review Committee

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. **Use of Restraints.** *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The State of Ohio has in place a "Behavioral Support Strategies that Include Restrictive Measures" (OAC 5123:2-2-06) (Behavior Support Rule) that regulates the use of all restraints (including manual, mechanical, and chemical).
Safeguards and protocols in the rule include:
•Behavior support strategies that include restrictive measures (including restraint) may only be used as a last resort when necessary to keep people safe and with informed consent of the person and prior approval by a human rights committee;
•A list of prohibited measures, including: prone restraint; use of manual or mechanical restraint that causes pain or harm; using any restrictive measure for punishment, retaliation, instruction or teaching, convenience of providers, or substitute for services;
•A comprehensive assessment process that takes into consideration a person's: interpersonal, environmental, medical, mental health, and emotional needs and other motivational factors;
•Requirements for people who are conducting and developing behavior support strategies that include restrictive measures;
•Behavior support strategies that include restrictive measures shall be designed in a manner that promotes healing, recovery, and emotional well-being; be data-driven; recognize the role of environment; capitalize on strengths; delineate measures to be implemented and those responsible for implementation; specify steps to be taken to ensure the safety of the individual and others;
•Behavior support strategies that include restrictive measures shall be implemented with sufficient safeguards and supervision to ensure the health, welfare and rights of individuals receiving specialized services and anyone serving the individual must be trained on the strategy prior to serving;
•Shall be reviewed at least every 90 days;
•All County Boards must have a human rights committee to safeguard individual's rights and protect individuals from physical, emotional, and psychological harm – their role and responsibility is clearly defined in the Behavior Support Rule;
•Use of restrictive measures without prior approval by the human rights committee must be reported as an

"unapproved behavior support";
•DODD must be notified after approval of the human rights committee and prior to implementation of all behavior support strategies that include restrictive measures;
•All County Boards must collect and analyze data regarding behavior support strategies that include restrictive measures and furnish data to their human rights committee.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

DODD is responsible for overseeing the use of restraints. The following specifies how the oversight is conducted:

•After approval by the human rights committee and prior to implementation, a County Board must complete and submit the "Restrictive Measure Notification" form electronically to DODD (Note: DODD does not use the notification system as a means to approve plans, the approval of plans that include restrictive measures occurs at the local level. The notification system is used to collect and monitor data for trends and patterns, provide oversight, and to identify cases where technical assistance may be needed.) The notification must be submitted initially, when revised or renewed, and (optionally) when discontinued.

• DODD may select a sample of behavior support strategies for additional review to ensure that the strategies are developed and implemented, and monitored in accordance with this rule.
• DODD shall take immediate action, as necessary, to protect the health and safety of individuals served.
• DODD shall compile and analyze data regarding the use of behavior support strategies throughout the state for the purposes of determining methods for enhancing risk reduction efforts and outcomes, reducing the frequency of restrictive measures, and identifying technical assistance and training needs.
• DODD conducts both MUI, and regular regulatory reviews (Accreditation, Licensure, & Provider Compliance Reviews) to ensure consistent and routine reviews of behavior support policies and procedures that are in place for individuals.

The rule Addressing Major Unusual Incidents and Unusual Incidents to Ensure Health, Welfare and Continuous Quality Improvement, and the Behavior Support Rule requires an MUI to be filed when there is an unapproved behavior support. The system has required fields that must be completed plus the intake staff at DODD follow-up on any reports that are incomplete. If an unreported incident is identified during the course of the review or as a part of a complaint received, an MUI is filed, a citation is issued, and a plan of correction is required.

When ODM discovers a case of the improper or unauthorized use of restraint(s) and restrictive intervention (s) that have not yet been reported through DODD ITS system the case is reported to the proper DODD parties. Additionally, that case will be processed through the Adverse Outcome process described in Appendix A in order to ensure that the waiver recipient's health or welfare are being assured.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The State of Ohio has in place a "Behavioral Support Strategies that Include Restrictive Measures" (OAC 5123:2-2-06) (Behavior Support Rule) that regulates the use of all restrictive measures.
Safeguards and protocols in the rule include:

•Behavior support strategies that include restrictive measures may only be used as a last resort when necessary to keep people safe, and in the case of rights restrictions, when an individual's actions may result in legal sanction. The strategies require informed consent of the person and prior approval by a human rights committee;
•A list of prohibited measures, including: prone restraint; use of manual or mechanical restraint that causes pain or harm; using any restrictive measure for punishment, retaliation, instruction or teaching, convenience of providers, or substitute for services;
•A comprehensive assessment process that takes into consideration a person's: interpersonal, environmental, medical, mental health, and emotional needs and other motivational factors;
•Requirements for people who are conducting and developing behavior support strategies that include restrictive measures;
•Behavior support strategies that include restrictive measures shall be designed in a manner that promotes healing, recovery, and emotional well-being; be data-driven; recognize the role of environment; capitalize on strengths; delineate measures to be implemented and those responsible for implementation; specify steps to be taken to ensure the safety of the individual and others;
•Behavior support strategies that include restrictive measures shall be implemented with sufficient safeguards and supervision to ensure the health, welfare and rights of individuals receiving specialized services and anyone serving the individual must be trained on the strategy prior to serving;
•Shall be reviewed at least every 90 days;
•All County Boards must have a human rights committee to safeguard individual's rights and protect individuals from physical, emotional, and psychological harm – their role and responsibility is clearly defined in the Behavior Support Rule;
•Use of restrictive measures without prior approval by the human rights committee must be reported as an "unapproved behavior support";
•DODD must be notified after approval of the human rights committee and prior to implementation of all behavior support strategies that include restrictive measures;
•All County Boards must collect and analyze data regarding behavior support strategies that include restrictive measures and furnish data to their human rights committee.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

DODD is responsible for overseeing the use of restrictive interventions. The following specifies how the oversight is conducted:

•After approval by the human rights committee and prior to implementation, a County Board must complete and submit the "Restrictive Measure Notification" form electronically to DODD (Note: DODD does not use the notification system as a means to approve plans, the approval of plans that include restrictive measures occurs at the local level. The notification system is used to collect and monitor data for trends and patterns, provide oversight, and to identify cases where technical assistance may be needed.) The notification must be submitted initially, when revised or renewed, and (optionally) when discontinued.

•DODD may select a sample of behavior support strategies for additional review to ensure that the strategies are developed and implemented, and monitored in accordance with this rule.
•DODD shall take immediate action, as necessary, to protect the health and safety of individuals served.
•DODD shall compile and analyze data regarding the use of behavior support strategies throughout the state for the purposes of determining methods for enhancing risk reduction efforts and outcomes, reducing the frequency of restrictive measures, and identifying technical assistance and training needs.
•DODD conducts both MUI, and regular regulatory reviews (Accreditation, Licensure, & Provider Compliance Reviews) to ensure consistent and routine reviews of behavior support policies and procedures that are in place for individuals.

The rule on Addressing Major Unusual Incidents and Unusual Incidents to Ensure Health, Welfare and Continuous Quality Improvement and the Behavior Support Rule requires an MUI to be filed when there is an unapproved behavior support. The system has required fields that must be completed plus the intake staff at DODD follow-up on any reports that are incomplete. If an unreported incident is identified during the course of the review or as a part of a complaint received, an MUI is filed, a citation is issued, and a plan of correction is required.

When ODM discovers a case of the improper or unauthorized use of restraint(s) and restrictive intervention (s) that have not yet been reported through DODD ITS system the case is reported to the proper DODD parties. Additionally, that case will be processed through the Adverse Outcome process described in Appendix A in order to ensure that the waiver recipient's health or welfare are being assured.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

○ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

◉ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The State of Ohio has in place a “Behavioral Support Strategies that Include Restrictive Measures” (OAC 5123:2-2-06) (Behavior Support Rule) that regulates the use of all restrictive measures, including “Time Out.”
Safeguards and protocols in the rule include:

•Behavior support strategies that include restrictive measures (including Time Out) may only be used as a last resort when necessary to keep people safe and with informed consent of the person and prior approval by a human rights committee;
•A list of prohibited measures, including: prone restraint; use of manual or mechanical restraint that causes pain or harm; using any restrictive measure for punishment, retaliation, instruction or teaching, convenience of providers, or substitute for services;
•Time Out may not exceed 30 minutes for any incident or 1 hour in a 24 hour period; may not be key-locked; shall be adequately lighted and ventilated and provide a safe environment for the person;
•An individual in a time-out room or area must be protected from hazardous conditions, shall be under constant visual supervision, and time out shall cease immediately once risk of harm has passed or the individual engages in self-abuse, becomes incontinent, or shows other signs of illness;
•A comprehensive assessment process that takes into consideration a person’s: interpersonal, environmental, medical, mental health, and emotional needs and other motivational factors;
•Requirements for people who are conducting and developing behavior support strategies that include restrictive measures;
•Behavior support strategies that include restrictive measures shall be designed in a manner that promotes healing, recovery, and emotional well-being; be data-driven; recognize the role of environment; capitalize on strengths; delineate measures to be implemented and those responsible for implementation; specify steps to be taken to ensure the safety of the individual and others;

•Behavior support strategies that include restrictive measures shall be implemented with sufficient safeguards and supervision to ensure the health, welfare and rights of individuals receiving specialized services and anyone serving the individual must be trained on the strategy prior to serving;
•Shall be reviewed at least every 90 days;
•All County Boards must have a human rights committee to safeguard individual's rights and protect individuals from physical, emotional, and psychological harm – their role and responsibility is clearly defined in the Behavior Support Rule;
•Use of restrictive measures without prior approval by the human rights committee must be reported as an "unapproved behavior support";
•DODD must be notified after approval of the human rights committee and prior to implementation of all behavior support strategies that include restrictive measures;
•All County Boards must collect and analyze data regarding behavior support strategies that include restrictive measures and furnish data to their human rights committee.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

DODD is responsible for overseeing the use of restrictive interventions, including seclusion ("time out"). The following specifies how the oversight is conducted:

•After approval by the human rights committee and prior to implementation, a County Board must complete and submit the "Restrictive Measure Notification" form electronically to DODD (Note: DODD does not use the notification system as a means to approve plans, the approval of plans that include restrictive measures occurs at the local level. The notification system is used to collect and monitor data for trends and patterns, provide oversight, and to identify cases where technical assistance may be needed.) The notification must be submitted initially, when revised or renewed, and (optionally) when discontinued.

•DODD may select a sample of behavior support strategies for additional review to ensure that the strategies are developed and implemented, and monitored in accordance with this rule.
•DODD shall take immediate action, as necessary, to protect the health and safety of individuals served.
•DODD shall compile and analyze data regarding the use of behavior support strategies throughout the state for the purposes of determining methods for enhancing risk reduction efforts and outcomes, reducing the frequency of restrictive measures, and identifying technical assistance and training needs.
•DODD conducts both MUI, and regular regulatory reviews (Accreditation, Licensure, & Provider Compliance Reviews) to ensure consistent and routine reviews of behavior support policies and procedures that are in place for individuals.

The rule on Addressing Major Unusual Incidents and Unusual Incidents to Ensure Health, Welfare and Continuous Quality Improvement and the Behavior Support Rule requires an MUI to be filed when there is an unapproved behavior support. The system has required fields that must be completed plus the intake staff at DODD follow-up on any reports that are incomplete. If an unreported incident is identified during the course of the review or as a part of a complaint received, an MUI is filed, a citation is issued, and a plan of correction is required.

When ODM discovers a case of the improper or unauthorized use of restraint(s) and restrictive intervention (s) that have not yet been reported through DODD ITS system the case is reported to the proper DODD parties. Additionally, that case will be processed through the Adverse Outcome process described in Appendix A in order to ensure that the waiver recipient's health or welfare are being assured.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. **Applicability.** Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Medical professionals who prescribe medications have "first-line" responsibility for monitoring participant medication regimens, the methods for conducting monitoring and the frequency of monitoring.

While conducting initial and ongoing assessments for planning, the SSA reviews and updates, as necessary, the list of all medications. The SSA includes this information, as well as the person (individual, unpaid support, nurse, etc.) responsible for medication administration. Ongoing monitoring of medication management occurs during routine contacts and visits by the SSA.

Medication errors posing an adverse impact to an individual's health and welfare are reported via the unusual or major unusual incident reporting processes described in OAC 5123:2-17-02.

Plans that incorporate medication for behavior control are prohibited unless the medications are prescribed by and the under the supervision of a licensed physician who is involved in the interdisciplinary planning process.

The following protocols must be followed if medication for behavior control is used:

Methods are employed with sufficient safeguards and supervision to ensure that the safety, welfare, due process, and civil and human rights of individuals receiving County Board services are adequately protected. A human rights committee reviews and prior approves or rejects all behavior support plans using aversive methods, including chemical and physical restraint and time-out, and those which involve potential risks to the individual's rights and protections. Prior documented informed consent is obtained from the individual receiving services from the County Board program, or guardian if the individual is eighteen years old or older, or from the parent or guardian if the individual is under eighteen years of age.

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.

DODD monitors medication administration through review staff and potentially through the MUI Investigators if the error rises to the level of neglect. When an unusual incident is reported, that incident is initially investigated by local County Board personnel and the results of the investigation forwarded to the state for review. The investigation is completed by the review of records and face-to-face interviews with staff working with the individual. DODD may do random quality assurance reviews but also may follow-up on situations secondary to findings from a review completed by each County Board.

The County Board's Investigative Agent or DODD's Investigators complete investigations in situations where there is a reasonable risk of harm to an individual due to medication management or administration issues. When a report of suspected harmful practice is reported to the DODD, the review of records and interview of staff would also be completed.

A special review (one not scheduled) could be conducted by the DODD if the individual, parent or guardian requested such or if there was suspicion of abuse, neglect, non¬compliance with laws or rules especially those related to medication administration.

The OAC rule 2153:2-17-02 on Incidents Affecting Health and Safety require medication errors to be filed when there is a reasonable risk of harm or harm to the individual. At times this may result in allegations of neglect under certain circumstances.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

A self-medication assessment is done to determine if an individual is not capable of self-medicating. This must be reviewed annually and completely re-done at least every 3 years if an individual does not meet the criteria for self medication. This can be done more frequently than every 3 years if there is a change in the individual's medication condition or if a problem with self medication is observed. (OAC 5123:2-6-02)

Administration of medication is limited to medical personnel who are professionally licensed to do so in accordance with the Revised Code (e.g., a physician licensed to practice in the State of Ohio, and a nurse licensed to practice in Ohio in accordance with Section 4723. of the Revised Code, etc.). Unlicensed providers shall not administer medications, but personal care aides may, pursuant to Chapter 4723-13 of the Administrative Code, help the individual self-administer medications by:

*Reminding the individual when to take the medication, and observing to ensure the individual follows the directions on the container;

*Assisting the individual by taking the medication in its container from where it is stored and handing the container to the individual;

*Opening the container for a individual who is physically unable to open the container;

*Assisting an individual who is physically impaired, but mentally alert, in removing oral or topical medication from the container and in taking or applying the medication; and

*Assisting a consumer who is physically unable to place a dose of medication in his or her mouth without spilling or dropping it by placing the dose in another container and placing that container to the mouth of the consumer.

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:

Medication errors are required to be reported to the local County Board or DODD depending upon whether errors are considered an "unusual" or a "major unusual" incident.

(b) Specify the types of medication errors that providers are required to *record:*

"Prescribed medication error" means the administration of the wrong prescribed medication (which includes outdated prescribed medication and prescribed medication not stored in accordance with the instructions of the manufacturer or the pharmacist), administration of the wrong dose of prescribed

medication, administration of prescribed medication at the wrong time, administration of prescribed medication by the wrong route, or administration of prescribed medication to the wrong person. All of these are reported.

(c) Specify the types of medication errors that providers must *report* to the State:

Per 5123:2-17-02 (C) (8) "...administration of incorrect medication or failure to administer medication as prescribed" is an unusual incident unless additional circumstances warrant it to be classified as an MUI in accordance with OAC 5123:2-17-02(C) (6)(iii)(c) &(d)
(Neglect or death, by any cause, of an individual.)

○ **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.

DODD monitors performance of waiver providers through review of various County Board reports and County Board reviews. Incidents or issues that may be questioned can also be reported to the County Board or the DODD at times other than when a report is filed or a Quality Assurance review is completed. When reported directly to DODD, DODD will complete an investigation to determine necessary action.

When ODM discovers non-compliance with laws or rules governing medication administration without an occurrence or potential of harm which has not been discovered or is not adequately being addressed by DODD that case will be processed through the Adverse Outcome Reporting and Tracking Process described in Appendix A-2-b.

When ODM discovers an instance of harm occurring or where there is a reasonable risk of harm to an individual due to medication management or administration issues, the case is reported to the proper DODD parties and processed through the Adverse Outcome Reporting and Tracking Process described in Appendix A-2-b.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
PM G1: Number and percent of substantiated cases of abuse, neglect, exploitation and misappropriation of funds where recommended actions to protect health and welfare were implemented. Num: Number of substantiated cases where recommended actions to protect health and welfare were implemented. Denom: Total number of substantiated cases were recommended actions to protect health and welfare.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD's Incident Tracking System (ITS)

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

Data Aggregation and Analysis:

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

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

Performance Measure:
PM G2: Number and percent of deaths with a determined need for investigation that were investigated. Numerator: Number of deaths with a determined need for investigation that were investigated. Denominator: Total number of deaths with a determined need for investigation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD's Incident Tracking System (ITS)

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
PM G3: Number and percent of critical incidents that were reported within the required time frames as specified in the waiver application. For all incidents of Abuse;Neglect;Exploitation;and Misappropriation of Funds. N: Number of critical incidents reported in the required time frames as specified in the waiver app. D: Total number of reported critical incidents in the specified areas.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:
PM G4: Number and percent of critical incident reviews/investigations that were completed as specified in the approved waiver. Critical incidents related to Abuse; Neglect; Exploitation; and Misappropriation of Funds. Num: Number of critical incident reviews/investigations that were completed as specified approved waiver. Denominator: Total number of critical incident reviews/investigations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD's Incident Tracking System (ITS)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
PM G5: Number and percent of participants with a critical incident who had a plan of prevention/documentation of a plan, developed as a result of the incident. Num: Number of participants with a critical incident who had a plan of prevention/ documentation of a plan, developed as a result of the incident. Denom: Total number of participants with a critical incident in the specified areas.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD's Incident Tracking System (ITS)

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

Data Aggregation and Analysis:

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

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

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:
PM G6: Number and percent of instances of unapproved restraint, seclusion or other restrictive interventions with a prevention plan developed as a result of the incident. Numerator: Number of instances with a prevention plan developed as a result of the incident. Denominator: Total number of instances that required development of a prevention plan developed as a result of the incident.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DODD's Incident Tracking System (ITS)

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

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
PM G7: Number and percent of participants reviewed with an identified need for medication administration whose service plan includes a plan for medication administrative. Numerator: Total number of participant records reviewed with an identified need for medication administration. Denominator: Total number of provider medication administration service documentation reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Less than 100% Review, records review sample based on regulatory review schedule and number of participants receiving services through that provider.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. 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 DODD and the County Boards to assure that all prevention, investigation and resolution protocols are followed through to completion. ODM meets regularly with DODD and works collaboratively to identify and observe trends, propose changes to rules and protocols, and support ongoing improvement to systems intended to assure prevention and adequate response to incidents of abuse.

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

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 2)

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;
- 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 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The State's quality oversight strategy for this waiver relies on the collaborative efforts of staff at ODM and DODD to generate and analyze both data and other performance related information to measure compliance with federal waiver assurances and to assure participant health and welfare.

Role of the State Medicaid Agency (ODM)
ODM oversees the operation and performance of DODD to ensure the waiver program is operated in accordance with the approved waiver, and to assess the effectiveness of DODD's oversight of the County Boards operating the waiver locally. Operation of the waiver is delegated by ODM to DODD through an interagency agreement between ODM and DODD. This agreement includes language authorizing ODM to perform oversight activities to establish the program's compliance with federal and state laws and regulations as well as auditing and fiscal compliance. ODM will employ a multifaceted monitoring and oversight process that includes the following activities:

Continuous Review of DODD Performance Data- Under the Continuous Review process, ODM will regularly review, monitor, and dialogue with DODD about data generated quarterly through the approved waiver's performance measures to gauge performance and compliance with federal waiver assurances including service planning, care management, free choice of provider, level of care, health and welfare, and validation of service delivery. Through its review of this data, ODM may request additional information as well as remediation and/or quality improvement strategy as appropriate.

Quality Briefings - Twice per year, ODM and DODD will meet to dialogue about data generated through the departments' quality processes. In these meetings, the departments' will review performance data generated and discuss remediation and/or quality improvement strategy. These Quality Briefings will also be informed by data presented by DODD on the oversight activities conducted by that department including but not limited to problems detected, corrective measures taken, and how the operating agency verified, or intends to verify, that the actions were effective.

Quality Improvement Plan- Whenever a performance measure is not fully met, and falls below a threshold of 86%, a systemic remediation (Quality Improvement Plan (QIP) would be conducted to determine the cause. A QIP must be implemented once the cause is found unless the state provides justification accepted by CMS that a QIP is not necessary. A QIP may take any of several forms. It may be training, revised policies/procedures, additional waiver services, etc. Each QIP must measure the impact to determine whether it was effective.

Case Specific Resolution – ODM will continue to assure case-specific resolution through "Alert Monitoring" and its "Adverse Outcomes" process.

Quality Steering Committee - ODM convenes the multi-agency HCBS waiver Quality Steering Committee (QSC). The committee collects, compiles, and reports aggregate waiver-specific performance data. The committee uses this data as a means to assess and compare performance across Ohio's Medicaid waiver systems to identify cross-waiver structural weaknesses, support collaborative efforts to improve waiver systems, and to help move Ohio toward a more unified quality management system.

Fiscal Reviews – ODM staff perform regular desk reviews of administrative costs, with A-133 Audits being performed every one to three years based on risk. On a biennial basis, ODM staff conduct audits of County Boards prepared cost reports. Additional detail about Ohio's practice for maintaining fiscal oversight of the waiver can be found in Appendix I.

Open Lines of Communication - ODM and DODD schedule mid-level managers meetings in which the departments discuss issues related to program operations including but not limited to: participant health and safety, program administration, budgeting, enrollment, providers and provider enrollment, provider reimbursement, issues pertaining to Medicaid state plan services, pending legislation, statute and rule changes etc.

Role of the Operating Agency
Through an interagency agreement, ODM delegates to DODD responsibility for the administration of the wavier program. These responsibilities include managing and monitoring the waiver program to assure compliance and quality improvement.
Monitoring by DODD is primarily focused on: 1) assuring compliant and effective case management for applicants and waiver participants by County Boards; 2) managing a system to assure prevention and effective response to incidents of participant abuse and neglect; 3) assuring the qualifications and compliance of particular waiver service providers; 4) assuring that paid claims are for services authorized in individual service plans; 5) setting program standards/expectations; 6) compliance and performance of County Boards which administer the program locally; 7) providing technical assistance; 8) facilitating continuous quality

improvement in the waiver's local administration; and more generally, 9) ensuring that all waiver assurances are addressed and met for all waiver participants.

DODD's Office of Provider Standards and Review (OPSR), conducts compliance reviews in licensed waiver funded settings, unlicensed waiver funded settings, and County Boards settings. In order to ensure consistency, the review process and tools used are the same in all settings to determine compliance with administrative rules and waiver assurances. A standardized review tool is used to determine if health, safety and individual satisfaction criteria are met.

DODD uses the Participant Experience Survey (PES) when interviewing individuals/families as part of the department's regulatory review processes.

Compliance Review – regularly scheduled reviews of a provider are conducted prior to the end of the provider's term license, accreditation term or at least once every 3 years for non-licensed waiver settings. The review is conducted utilizing a single review tool. A report is issued to the County Board and/or provider identifying areas of deficiencies and requiring a plan of compliance (POC). The POC is reviewed and approved by the OPSR and follow-up visits are conducted to verify that the appropriate corrections have been made. In cases where an immediate risk to health or safety is identified, the OPSR reviewer remains onsite until corrective action is taken.

Special Compliance Review – an unscheduled review, which occurs due to identified concerns such as complaints, Major Unusual Incidents, reports of fraud, or adverse outcomes identified by other entities such as the Ohio Department of Health or the ODM. A report is issued to the county board and/or provider identifying areas of deficiencies and requiring a plan of compliance (POC). The findings are reported to appropriate State agency.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Quality Improvement Committee**	☐ **Annually**
☑ **Other** Specify: County Boards and Transition DD Provider	☑ **Other** Specify: Semi-annually

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

ODM monitoring and oversight responsibilities include ensuring that DODD is exercising its authority for the day-to-day operation of the waiver in accordance with federal Medicaid requirements. ODM supports and facilitates qualitative improvements in the systems, procedures, and protocols DODD employs to ensure conformity of providers, recipients, and other entities with federal Medicaid requirements. ODM will work with DODD to assess the root cause and develop and implement an appropriate course of action to remedy the program.

DODD monitoring and oversight responsibilities include ensuring that the local County Boards are establishing and implementing systems, procedures and protocols to ensure conformity of providers, recipients, staff, or other entities with federal Medicaid requirements. The DODD supports and facilitates qualitative improvements in the systems, procedures, and protocols at the County Board level. When a program component is determined to be out of compliance with federal Medicaid requirements, ODM will work with DODD to assess the root cause and develop and implement an appropriate course of action to remedy the program.

ODM is responsible for ensuring DODD and County Boards are in compliance with federal regulations, including the amount, duration and scope of services, free choice of providers, timeliness of delivery of services to waiver eligible participant and the availability of services statewide and conducts A-133 audits at least once every three years based on risk.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

ODM in conjunction with DODD will review the effectiveness of the State's Quality Oversight Strategy including DODD performance data, fiscal reviews results, case-specific resolutions data, quality improvement plans, and technical assistance provided. These discussions will occur through quality briefings outlined in this appendix.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Ohio Department of Developmental Disabilities (DODD), Division of Fiscal Administration – Audit Office performs waiver reviews utilizing a risk-based approach. The risk-based approach covers a wide range of providers, individuals and transactions. A risk analysis is performed for each waiver cycle to identify riskier providers. Risk factors used in the analysis include, but are not limited to: dollar amount of claims paid; number of individuals served; complexity of services provided; prior noncompliance issues; prior findings; referrals from Office of Provider Standards and Review (OPSR); and changes in compliance requirements to services provided.
Once the selection of higher risk providers is determined, we limit our review to a set number of individuals to be reviewed for each provider selected. Once the individuals are selected for review, a selection of claims paid to each provider for those selected individuals is selected for testing, depending on the number of individuals served, types of services provided, and/or number of and dollar amount of claims paid. Additionally, some of the required Ohio Administrative Code (OAC)compliance testing is performed on a statewide basis to achieve increased coverage across the State and increase the number of County Boards of DD reviewed.

Additionally, the DODD Audit Office performs audits of the County Boards of DD Cost Reports. The audits consist of program monitoring for allowable costs, activities allowed, and cash management. The cost report audits also include a review of program revenues and expenditures and other reporting requirements.

The Auditor of the State of Ohio conducts an annual Single State Audit of the Ohio Department of Medicaid (ODM) in accordance with the requirements of the Single Audit Act (31 U.S.C. 7501-7507) as amended by the Single Audit Act Amendments of 1996 (P.L. 104- 146).

In accordance with Ohio Administrative Code rule 5160-1-29, ODM is required to have in effect a program to prevent and detect fraud, waste, and abuse in the Medicaid program. The definition of fraud, waste, and abuse incorporates the concept of payment integrity. ODM, the Auditor of the State of Ohio, and/or the Ohio Office of Attorney General may recoup any amount in excess of that legitimately due to the provider based on review or audit.

The Department of Medicaid's Surveillance Utilization Review Section (SURS) primary function is to conduct audit and review activities to assure the allowability of claims paid to Medicaid providers. The scope of providers subjected to audit and review activities includes claims paid through sister state agencies which administer Medicaid programs on behalf of ODM.

DODD recovers any overpayments pursuant to Section 5164.58 of the Ohio Revised Code. DODD notifies the provider of the overpayment and requests voluntary repayment. If DODD is unable to obtain voluntary repayment, it shall give the provider notice of an opportunity for a hearing in accordance with Chapter 119 of the Ohio Revised Code. DODD shall conduct the hearing to determine the legal and factual validity of the overpayment. DODD shall submit the hearing officer's report and recommendation and a complete record of the proceedings, including all transcripts to the Director of

Ohio Department of Medicaid. The Director of ODM may issue a final adjudication order in accordance with Chapter 119 of the Ohio Revised Code.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(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:
PM I1: Number and percent of paid waiver claims submitted that were authorized.
Numerator: Total number of paid waiver claims submitted that were authorized.
Denominator: Total number of submitted waiver claims.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Information Technology Systems (MITS)

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

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

Data Aggregation and Analysis:

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

Performance Measure:
PM I2: Number and percent of waiver claims paid for individuals who were enrolled on the waiver on the date of services. Numerator: Total number of waiver claims paid for individuals who were enrolled on the waiver on the date of services. Denominator: Total number of submitted waiver claims.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Information Technology Systems (MITS)

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

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

Data Aggregation and Analysis:

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

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:

PM I3: Number and percent of waiver claims that were paid using the correct rate as specified in Chapters 5123:2-9 of the Ohio Administrative Code. Numerator: Total number of paid claims that were paid using the correct rate. Denominator: Total number of approved waiver claims.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Information Technology System (MITS)

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

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Findings included in the State of Ohio Single State Audit are reviewed by the Ohio Department of Medicaid (ODM). Findings related to the Department of Developmental Disabilities (DODD) and Medicaid are communicated to DODD through the single audit. ODM reviews DODD related findings and determines whether a Plan of Correction (POC) proposed by DODD will correct the finding(s). ODM may issue a Management Decision Letter (MDL) to DODD as a means to approve the POC. Compliance with the MDL is reviewed as part of monitoring conducted by ODM.

DODD monitors claim rejections and denials on a quarterly basis by county and by rejection/denial reason code. If there is a large negative change for a county or if a county continuously has a large number of claims rejected or denied, DODD staff will contact the county and offer technical assistance to the county board and their providers. Similarly, if a rejection or denial reason code spikes up in a certain quarter, claims staff will research the reason.

DODD initiates an investigation into rejected or denied claims within two business days of becoming aware that the problem exists. The length of time required to resolve a claim depends on the nature of the claim and the complexities around the issue.

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: As required in relation to any relevant audit findings.

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).

DODD is responsible for the development of statewide rates for waiver services through an Interagency Agreement with ODM, Ohio's single state Medicaid agency. The rate development process includes input from stakeholders. Once developed by DODD, ODM is responsible for the final review and approval of all rates. Once approved by ODM, all reimbursement rates are incorporated into Ohio's Administrative Code, which includes a period for public comment as well as a public hearing process that allows for public testimony before Ohio's Joint Commission on Agency Rule Review (JCARR), a body compromised of representatives from the Ohio Senate and the Ohio House of Representatives. Public Comments are solicited during the Public Hearing phase for any new/amended/to be rescinded Administrative rules in Ohio. Information about payment rates is made available to the individual during the Individual Service Planning process.

Rate models typically begin with an examination of the most relevant Ohio-specific information available from Bureau of Labor Statistics (BLS) as means to identify basic parameters for specific types of services rendered by particular types of providers. Similar information may also be gathered through a salary survey. Independent rate models typically take into account factors such as average wages, reimbursement for employee related expenses, administrative overhead, and non-billable work time. A preliminary statewide rate may be further refined by taking into account variation in the cost of doing business in different regions of the state.

Establishing a rate for a new service, or changing an existing rate, requires initiating or amending administrative rules. DODD and ODM follow a protocol to advance-publish, and invite public comment on, proposed new rules and rule amendments. Final rules are approved by a special committee comprised of Ohio legislators. Besides this formal public input process, ODM may engage affected stakeholders, in advance, to seek input and support for an intended change. Rates may also be affected by statute resulting from the State's legislative budget process. The Governor can also change rates on an emergency basis; however, rule changes made on an emergency basis are required to be subsequently re-filed through the standard rule promulgation process.

After state rates are established, claims are reimbursed at the lower of: 1) the rate established using the rate setting model, or 2) the provider’s usual and customary charge for the service (i.e., if the provider’s usual and customary charge is lower than the state rate).

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:

Provider billings flow directly from certified providers to the ODM Medicaid payment system.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Claims for waiver services are processed through the Ohio Department of Medcaid's Medicaid Information Technology System (MITS). As part of claims processing, MITS edits to assure that: 1) the claim is for a service provided to a Medicaid eligible individual on the date of service, 2) the claim amount does not exceed the maximum rate approved for service, 3) the service was rendered by a provider who is certified for Medicaid on the date of service, and 4) there is no evidence of third party insurance that is responsible to cover the cost of the service.

MITS also exerts controls to ensure that waiver partcipants are eligible to receive certain types of waiver services, that total costs do not exceed pre-established limits for a given time period, and that providers are eligible to provide, and to recieve payment for, particular services.

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*):

- [x] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [ ] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [ ] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

  Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- [ ] **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

  Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- (●) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ( ) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- (●) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

County Boards of DD receive payments as certified adult day health center service providers.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. **Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- (●) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the**

State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. **Additional Payment Arrangements**

i. **Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. **Organized Health Care Delivery System.** *Select one:*

- (●) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ( ) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. **Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

- (●) **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.**

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**
- [x] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

  If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

  The DODD provides the non-federal share of the computable waiver costs through funds appropriated in its budget. ODM shall utilize funds through a vouchering process established by the Office of Budget and Management (OBM) for claims payment purposes.

- [ ] **Other State Level Source(s) of Funds.**

  Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

Check each that applies:

- [ ] **Appropriation of Local Government Revenues.**

  Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

  Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ( ) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**

◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Only one Transitions DD Waiver service is offered in a residential setting. Out-of-home respite services falls under the exception listed in 42 CFR 441.310 (a)(2). It is reimbursed at a daily rate and that rate does not include room and board.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**

○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

◉ **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**

○ **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

☐ **Nominal deductible**
☐ **Coinsurance**
☐ **Co-Payment**
☐ **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	13742.77	51463.40	65206.17	96238.27	7934.50	104172.77	38966.60
2	13746.09	53007.30	66753.39	99022.42	8172.54	107194.96	40441.57
3	7890.08	54597.52	62487.60	101993.09	8417.72	110410.81	47923.21
4	7890.08	56235.45	64125.53	105052.88	8670.25	113723.13	49597.60
5	7890.08	57922.51	65812.59	108204.47	8930.36	117134.83	51322.24

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	3000		3000
Year 2	2000		2000
Year 3	1		1
Year 4	1		1
Year 5	1		1

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 was estimated based on the historical length of stay of individuals on the Transitions DD waiver. The average length of stay is estimated at 262 days for Waiver Year 1 and 190 days for Waiver Year 2. In addition, the proposed phase-out schedule has been used.

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 for these estimates is as follows:

The basis for the Factor D Derivation is the actual costs for fiscal year 2014 with adjustments for individuals that are projected to phase-out of the waiver.

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:

Projected service utilization for non-waiver services is based on actual utilization of the Transitions DD waiver population during State Fiscal Year (SFY) 2014. Eligibility data was used to identify dual eligibles. Drug

expenditures were then removed for the dual eligibles. An annual inflation factor of 3% was applied to the historical expenditures to project costs for future waiver years.

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:

The control group includes individuals of any age who were institutionalized in an ICF/IID facility during State Fiscal Year (SFY) 2014. The institutional costs were obtained using claims data and they include the ICF/IID facility expenditures for the individuals in the control group. Institutional costs were projected using calendar year 2014 expenditures as the baseline and applying an annual inflation factor of 3%.

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:

The control group is specified in c.iii. The G prime estimates includes an analysis of non-institutional claims for dates of service during State Fiscal Year (SFY)2014. Eligibility data was used to identify dual eligibles. Drug expenditures were then removed for the dual eligibles. An annual inflation factor of 3% was applied to the historical expenditures to project costs for future waiver years.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Adult Day Health Center Services	
Personal Care Aide Services	
Emergency Response Service	
Home Delivered Meal Services	
Home Modification Services	
Out-of-Home Respite	
Supplemental Adaptive and Assistive Device Services	
Supplemental Transportation Services	
Waiver Nursing Services	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Center Services Total:						**1361314.08**
Adult Day Health Center Services	1 day	436	49.00	63.72	**1361314.08**	
				GRAND TOTAL:		**41228324.82**
				Total Estimated Unduplicated Participants:		**3000**
				Factor D (Divide total by number of participants):		**13742.77**
				Average Length of Stay on the Waiver:		252

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Aide Services Total:						**31206910.02**
Personal Care Aide Services	15 minutes	1879	4665.24	3.56	**31206910.02**	
Emergency Response Service Total:						**37677.62**
Emergency Response, Installation and Testing	1 installation	4	0.60	44.91	**107.78**	
Emergency Response, Service Fee	1 month	44	19.00	44.94	**37569.84**	
Home Delivered Meal Services Total:						**42019.60**
Home Delivered Meal Services	1 meal	43	140.00	6.98	**42019.60**	
Home Modification Services Total:						**1433497.50**
Home Modification Services	1 item	270	1.00	5309.25	**1433497.50**	
Out-of-Home Respite Total:						**297446.76**
Out-of-Home Respite	1 day	117	13.00	195.56	**297446.76**	
Supplemental Adaptive and Assistive Device Services Total:						**258946.74**
Supplemental Adaptive and Assistive Device Services	1 item	90	1.30	2213.22	**258946.74**	
Supplemental Transportation Services Total:						**6610.50**
Supplemental Transportation Services	1 mile	6	2825.00	0.39	**6610.50**	
Waiver Nursing Services Total:						**6583902.00**
Waiver Nursing	15 minutes	1290	676.00	7.55	**6583902.00**	
				GRAND TOTAL:		**41228324.82**
				Total Estimated Unduplicated Participants:		**3000**
				Factor D (Divide total by number of participants):		**13742.77**
				Average Length of Stay on the Waiver:		252

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Center Services Total:						**908583.48**
Adult Day Health Center Services	1 day	291	49.00	63.72	**908583.48**	
Personal Care Aide Services Total:						**20810142.76**
Personal Care Aide Services	15 minutes	1253	4665.24	3.56	**20810142.76**	
Emergency Response Service Total:						**24842.78**
Emergency Response, Installation and Testing	1 installation	3	0.60	44.91	**80.84**	
Emergency Response, Service Fee	1 month	29	19.00	44.94	**24761.94**	
Home Delivered Meal Services Total:						**28338.80**
Home Delivered Meal Services	1 meal	29	140.00	6.98	**28338.80**	
Home Modification Services Total:						**955665.00**
Home Modification Services	1 item	180	1.00	5309.25	**955665.00**	
Out-of-Home Respite Total:						**198297.84**
Out-of-Home Respite	1 day	78	13.00	195.56	**198297.84**	
Supplemental Adaptive and Assistive Device Services Total:						**172631.16**
Supplemental Adaptive and Assistive Device Services	1 item	60	1.30	2213.22	**172631.16**	
Supplemental Transportation Services Total:						**4407.00**
Supplemental Transportation Services	1 mile	4	2825.00	0.39	**4407.00**	
Waiver Nursing Services Total:						**4389268.00**
Waiver Nursing	15 minutes	860	676.00	7.55	**4389268.00**	
				GRAND TOTAL:		**27492176.82**
				Total Estimated Unduplicated Participants:		**2000**
				Factor D (Divide total by number of participants):		**13746.09**
				Average Length of Stay on the Waiver:		190

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Center Services Total:						**63.72**
Adult Day Health Center Services	1 day	1	1.00	63.72	**63.72**	
Personal Care Aide Services Total:						**3.56**
Personal Care Aide Services	15 minutes	1	1.00	3.56	**3.56**	
Emergency Response Service Total:						**89.85**
Emergency Response, Installation and Testing	1 installation	1	1.00	44.91	**44.91**	
Emergency Response, Service Fee	1 month	1	1.00	44.94	**44.94**	
Home Delivered Meal Services Total:						**6.98**
Home Delivered Meal Services	1 meal	1	1.00	6.98	**6.98**	
Home Modification Services Total:						**5309.25**
Home Modification Services	1 item	1	1.00	5309.25	**5309.25**	
Out-of-Home Respite Total:						**195.56**
Out-of-Home Respite	1 day	1	1.00	195.56	**195.56**	
Supplemental Adaptive and Assistive Device Services Total:						**2213.22**
Supplemental Adaptive and Assistive Device Services	1 item	1	1.00	2213.22	**2213.22**	
Supplemental Transportation Services Total:						**0.39**
Supplemental Transportation Services	1 mile	1	1.00	0.39	**0.39**	
Waiver Nursing Services Total:						**7.55**
Waiver Nursing	15 minutes	1	1.00	7.55	**7.55**	
				GRAND TOTAL:		**7890.08**
				Total Estimated Unduplicated Participants:		**1**
				Factor D (Divide total by number of participants):		**7890.08**
				Average Length of Stay on the Waiver:		1

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Center Services Total:						**63.72**
Adult Day Health Center Services	1 day	1	1.00	63.72	**63.72**	
Personal Care Aide Services Total:						**3.56**
Personal Care Aide Services	15 minutes	1	1.00	3.56	**3.56**	
Emergency Response Service Total:						**89.85**
Emergency Response, Installation and Testing	1 installation	1	1.00	44.91	**44.91**	
Emergency Response, Service Fee	1 month	1	1.00	44.94	**44.94**	
Home Delivered Meal Services Total:						**6.98**
Home Delivered Meal Services	1 meal	1	1.00	6.98	**6.98**	
Home Modification Services Total:						**5309.25**
Home Modification Services	1 item	1	1.00	5309.25	**5309.25**	
Out-of-Home Respite Total:						**195.56**
Out-of-Home Respite	1 day	1	1.00	195.56	**195.56**	
Supplemental Adaptive and Assistive Device Services Total:						**2213.22**
Supplemental Adaptive and Assistive Device Services	1 item	1	1.00	2213.22	**2213.22**	
Supplemental Transportation Services Total:						**0.39**
Supplemental Transportation Services	1 mile	1	1.00	0.39	**0.39**	
Waiver Nursing Services Total:						**7.55**
Waiver Nursing	15 minutes	1	1.00	7.55	**7.55**	
				GRAND TOTAL:		**7890.08**
				Total Estimated Unduplicated Participants:		**1**
				Factor D (Divide total by number of participants):		**7890.08**
				Average Length of Stay on the Waiver:		1

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Center Services Total:						**63.72**
Adult Day Health Center Services	1 day	1	1.00	63.72	**63.72**	
Personal Care Aide Services Total:						**3.56**
Personal Care Aide Services	15 minutes	1	1.00	3.56	**3.56**	
Emergency Response Service Total:						**89.85**
Emergency Response, Installation and Testing	1 installation	1	1.00	44.91	**44.91**	
Emergency Response, Service Fee	1 month	1	1.00	44.94	**44.94**	
Home Delivered Meal Services Total:						**6.98**
Home Delivered Meal Services	1 meal	1	1.00	6.98	**6.98**	
Home Modification Services Total:						**5309.25**
Home Modification Services	1 item	1	1.00	5309.25	**5309.25**	
Out-of-Home Respite Total:						**195.56**
Out-of-Home Respite	1 day	1	1.00	195.56	**195.56**	
Supplemental Adaptive and Assistive Device Services Total:						**2213.22**
Supplemental Adaptive and Assistive Device Services	1 item	1	1.00	2213.22	**2213.22**	
Supplemental Transportation Services Total:						**0.39**
Supplemental Transportation Services	1 mile	1	1.00	0.39	**0.39**	
Waiver Nursing Services Total:						**7.55**
Waiver Nursing	15 minutes	1	1.00	7.55	**7.55**	

GRAND TOTAL:	**7890.08**
Total Estimated Unduplicated Participants:	**1**
Factor D (Divide total by number of participants):	**7890.08**
Average Length of Stay on the Waiver:	1