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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

## 1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

The State is not proposing any significant changes to the waiver design, administration, operations, or quality strategy with this renewal.

Changes proposed through this waiver renewal application:
General
-Modified language in performance measures to simplify descriptions and ensure boxes checked accurately reflect program processes and procedures. Modifications made do not change waiver assurance reporting or measurements.
-Updated terms throughout the application for consistency (ex: OMA/ODM; consumer/waiver participant).
-General clean-up, reformatting and simplification of language throughout to waiver application.
-Updated outdated website URLs, Federal and State regulatory references, and grammar.
-Updated methods for remediation/fixing individual problem process description throughout the application.
-Modified language throughout the waiver application to align language with similarly administered 1915(c) waiver programs

Appendix A
-Addition of measures reflective of the Ohio Department of Medicaid's administrative oversight responsibilities.

Appendix B
-Updated eligibility groups (other specified groups) with additional CFR references.
-Updated unduplicated enrollment projections.
-Updated waiver reserve capacity.
-Updated case management qualifications to allow licensed practical nurses to perform assessment and care management activities.

Appendix C
-Updated service specifications for all services to better align with and refer to waiver service requirements described in Ohio administrative code.
-Updated to incorporate home and community-based settings requirements described in Ohio Administrative Code 5160-44-01. This includes the addition of an assurance measure.
-Proposed changes maintain maintenance of effort requirements.
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Appendix D
-Updated to incorporate person-centered planning requirements described in Ohio Administrative Code 5160-44-02.

Appendix G
-Modified to incorporate reference to incident management requirements described in Ohio Administrative Code 5160-44-05.

Appendix I
-Addition of critical access assisted living rate.

Appendix J
-Modified slot and service projections.

# 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*):

Assisted Living Renewal July 1, 2024

**C. Type of Request: renewal**

**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.0446**
**Draft ID: OH.009.04.00**

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

Regular Waiver

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

07/01/24

**PRA Disclosure Statement**

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

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

## 1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☒ **Nursing Facility**

Select applicable level of care

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

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

n/a

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

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

**§440.150)**
If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

## 1. Request Information (3 of 3)

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

- ◉ **Not applicable**
- ○ **Applicable**

Check the applicable authority or authorities:

- ☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
- ☐ **Waiver(s) authorized under §1915(b) of the Act.**
  Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

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

The goals and objectives of the waiver include:

1. Serving individuals meeting the following eligibility criteria:
- Eligible for medicaid in accordance with Chapters 5160:1-3 to 5160:1-6 of the Administrative Code.
- Has an intermediate or skilled level of care in accordance with rule 5160-3-08 of the Administrative Code. If the individual requires skilled nursing care beyond supervision of special diets, application of dressings, or administration of medication, it must be provided in accordance with rule 3701-16-09.1 of the Administrative Code.
- Age twenty-one years old or older at the time of enrollment.
- Participates in the development of a person-centered services plan in accordance with the process and requirements set forth in rule 5160-44-02 of the Administrative Code.
- Has the ability to make room and board payments calculated at the current supplemental security income (SSI) federal benefit level minus fifty dollars.
- Health and safety related needs are able to be met, as determined by the Ohio department of aging's (ODA) designee.

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

3. Maintaining cost neutrality.

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

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

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

The 13 regional entities PAAs are located across the state and are responsible for the day-to-day operation and management of the waiver, including the following activities:
- disseminating information concerning the waiver to potential enrollees
- assisting individuals in waiver enrollment,
- conducting level of care determinations,
- providing administrative case management, and
- recruiting providers.

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

The Assisted Living waiver provides participants access to two waiver services.
Available services include:
- assisted living service (base, memory care and critical access)

- community transition service

## 3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

## 4. Waiver(s) Requested

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

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

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

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

- ◉ **No**
- ○ **Yes**

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

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver

only to individuals who reside in the following geographic areas or political subdivisions of the state.
*Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

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

## 5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## 6. Additional Requirements

***Note: Item 6-I must be completed.***

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

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

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

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

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

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

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

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

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

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

•Electronic: Ohio posts a public notice, summary of the draft waiver, the draft waiver itself on the ODM website. ODA and the 13 PAAs post public notices on their websites, which link to the ODM website. The public has the ability to submit electronic comments via email to a mailbox designated by the state. The public may also submit written comments to the state at a mailing address designated to receive written comments.

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

•The Area Agencies on Aging, as the lead agency for the state’s Aging and Disability Network, posts a copy of the Public Notice and Request for Comment announcement in their offices, which includes information about how to obtain a non-electronic copy of the waiver and a summary of the proposed revisions to the draft statewide transition plan.

•Stakeholder advisory groups. Announcements are issued to ODA Stakeholder Advisory Groups regarding the formal public comment period with a request to disseminate the information to their respective colleagues and distribution lists, which link to the electronic documents.

Active Link used to post the entire waiver applications: https://medicaid.ohio.gov/about-us/notices/public-notices

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

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

## 7. Contact Person(s)

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

**Last Name:** Sly

**First Name:** ShaRhonda

**Title:** HCBS Policy Section Chief

**Agency:** Ohio Department of Medicaid

**Address:** 50 West Town Street, Fifth Floor

**Address 2:** P.O. Box 182709

**City:** Columbus

**State:** **Ohio**

**Zip:** 43215

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

**Fax:** (614) 466-6945

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

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

**Last Name:** Dedino

**First Name:** Kim

**Title:** Chief, Division for Community Living

**Agency:** Ohio Department of Aging

**Address:** 246 North High Street

**Address 2:** 1st Floor

**City:** Columbus

**State:** **Ohio**

**Zip:**

43215

**Phone:**

(614) 531-9740 **Ext:** ☐ **TTY**

**Fax:**

(614) 466-9812

**E-mail:**

kdedino@age.ohio.gov

## 8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

**Signature:**

State Medicaid Director or Designee

**Submission Date:**

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

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:** **Ohio**

**Zip:**

**Phone:**

**Ext:** **TTY**

**Fax:**

**E-mail:**

## Attachments

**Attachment #1: Transition Plan**

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

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

Specify the transition plan for the waiver:

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

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

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

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

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

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

## Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

## Appendix A: Waiver Administration and Operation

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

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

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

○ **The Medical Assistance Unit.**

Specify the unit name:

*(Do not complete item A-2)*

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

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

*(Complete item A-2-a).*

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

Specify the division/unit name:

Ohio Department of Aging

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

## Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding

(MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

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

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

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

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

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

2) Conducting the Continuous Review of ODA Performance Data (described below and in Appendix H);
ODM will also examine performance data and other information gathered both by ODM and ODA to measure compliance and performance with respect to the federal waiver assurances including service planning, care management, free choice of provider, level of care, health and welfare, hearing rights, participant satisfaction, and validation of service delivery.

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

3) Assuring the resolution of case-specific problems.

4) Generating and compiling quarterly performance data.

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

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

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

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

ODM convenes the interagency HCBS waiver quality steering committee (QSC), comprised of mid-level management staff to monitor waiver operations. The QSC provides administrative oversight for Ohio' Medicaid HCBS Waiver Quality Strategy.

Using a collaborative process, the QSC reviews and analyzes data across waivers to identify promising practices

and opportunities for quality improvement. Reports for programs may include monthly enrollment, disenrollment & census reports; data gathered through the waiver's approved performance measures; financial reports, and annual provider certification & activity reports.

The QSC uses these discussions to assess and compare performance and innovative data analytics across Ohio's HCBS waivers to support collaborative efforts, improve waiver systems, and help move Ohio toward more unified quality management.

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

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

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

## Appendix A: Waiver Administration and Operation

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

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

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

## Appendix A: Waiver Administration and Operation

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

○ **Not applicable**

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

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

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

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

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

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

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

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

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

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

Same as description above.

## Appendix A: Waiver Administration and Operation

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

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

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

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

## Appendix A: Waiver Administration and Operation

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

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

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

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

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

## Appendix A: Waiver Administration and Operation

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

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

# Appendix A: Waiver Administration and Operation

## Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

**a. Methods for Discovery: Administrative Authority**

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

**i. Performance Measures**

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

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

***Where possible, include numerator/denominator.***

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

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

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

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

| | | |
|---|---|---|
| | | |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☒ **Other**<br>Specify:<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☒ **Other**<br>Specify:<br>Semi-Annually |

**Performance Measure:**
**A-2: Number and percent of quarterly performance measure reports that were submitted to Ohio Department of Medicaid (ODM) by Ohio Department of Aging on time and in the correct format. Numerator: Number of quarterly performance measure reports submitted on time and in the correct format. Denominator: Total number of quarterly performance measure reports required by ODM.**

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**
If 'Other' is selected, specify:

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

**Performance Measure:**
**A-7: Number and percent of Passport Administrative Agency (PAA) activity reports submitted to Ohio Department of Medicaid (ODM) by Ohio Department of Aging on time and in the approved format. Numerator: Number of reports submitted on time and in the approved format. Denominator: Total number of PAA activity reports required by ODM.**

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

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

| | | |
|---|---|---|
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

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

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

| | | |
|---|---|---|
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☒ **Other**<br>Specify:<br>As required by ODM | |

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**A-6: Number and percent of Passport Administrative Agency (PAA) monitoring reports submitted to Ohio Department of Medicaid (ODM) by Ohio Department of Aging on time and in the approved format. Numerator: Number of reports submitted on time and in the approved format. Denominator: Total number of PAA monitoring reports required by ODM.**

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

| **Responsible Party for data collection/generation***(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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**A-4: Number and percent of structural compliance reviews completed timely by Ohio Department of Aging or its designee. Numerator: Number of structural compliance reviews completed timely. Denominator: Total number of structural compliance reviews due.**

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

| **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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and** | ☐ **Other** |

| | | |
|---|---|---|
| | **Ongoing** | Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**A-5: Number and percent of annual quality monitoring and improvement reports submitted to Ohio Department of Medicaid (ODM) by Ohio Department of Aging on time and in the approved format. Numerator: Number of reports submitted on time and in the approved format. Denominator: Total number of annual quality monitoring and improvement reports required by ODM.**

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

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid** | ☐ **Weekly** | ☒ **100% Review** |

| Agency | | |
|---|---|---|
| ☒ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

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

**b. Methods for Remediation/Fixing Individual Problems**

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

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

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

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

**ii. Remediation Data Aggregation**

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

| **Responsible Party***(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**<br>Specify: | ☒ **Annually** |
| | ☒ **Continuously and Ongoing** |

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| | ☒ **Other**<br>Specify:<br>once per waiver cycle |

**c. Timelines**

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

◉ **No**

○ **Yes**

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

## Appendix B: Participant Access and Eligibility

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

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

| Target Group | Included | Target SubGroup | Minimum Age | Maximum Age | |
|---|---|---|---|---|---|
| | | | | Maximum Age Limit | No Maximum Age Limit |
| ☒ **Aged or Disabled, or Both - General** | | | | | |
| | ☒ | **Aged** | 65 | | ☒ |
| | ☒ | **Disabled (Physical)** | 21 | 64 | |
| | ☐ | **Disabled (Other)** | | | |
| ☐ **Aged or Disabled, or Both - Specific Recognized Subgroups** | | | | | |
| | ☐ | **Brain Injury** | | | ☐ |
| | ☐ | **HIV/AIDS** | | | ☐ |
| | ☐ | **Medically Fragile** | | | ☐ |
| | ☐ | **Technology Dependent** | | | ☐ |
| ☐ **Intellectual Disability or Developmental Disability, or Both** | | | | | |
| | ☐ | **Autism** | | | ☐ |
| | ☐ | **Developmental Disability** | | | ☐ |
| | ☐ | **Intellectual Disability** | | | ☐ |
| ☐ **Mental Illness** | | | | | |
| | ☐ | **Mental Illness** | | | ☐ |
| | ☐ | **Serious Emotional Disturbance** | | | |

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

Individuals enrolled in the Assisted Living waiver who are potentially subject to mandatory enrollment in the ICDS 1915(b)(c) waiver shall be eligible for participation in Assisted Living only until the date on which enrollment in the ICDS waiver commences. Transition into the ICDS waiver shall occur as described in the waiver's Transition Plan, which includes a requirement for the continuation of Assisted Living waiver services.

ODA will be permitted to enroll individuals disenrolling from another NF-LOC waiver, who meet the eligibility criteria for the Assisted Living waiver. These individuals will retain their LOC determination for the period it would have been effective in the waiver from which they disenrolled, absent a change of condition. The Assisted Living waiver case manager at the PAA will assist the individual enrolling from another NF-LOC waiver to facilitate their transition.

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

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

*Specify:*

Once a disabled (physical) participant reaches the maximum age limit, they become part of the Aged category and waiver enrollment continues. As indicated in (B)(1)(a), there is no maximum age limit under the aged category.

## Appendix B: Participant Access and Eligibility

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

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

- ○ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

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

    Specify the percentage:

  - ○ **Other**

    *Specify:*

- ○ **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.*

This waiver consists of two services: assisted living services (base, memory care and critical access) and community transition service. The community transition service can cost no more than $2,000.00 and the assisted living service is paid on a daily rate, based on the tier assignment. The highest cost assisted living service is $155 per day. Therefore, the highest cost for an individual is $58,575.00 ($155 per day X 365 days and a one-time Community Transition Service of up to $2,000.00) which is lower than the average institutional cost in Ohio.

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

◉ **The following dollar amount:**

Specify dollar amount: 58575

**The dollar amount** *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

◉ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

*Specify:*

## Appendix B: Participant Access and Eligibility

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

**b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

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

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

**c. Participant Safeguards.** When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☒ **Other safeguard(s)**

Specify:

In the event additional waiver services are not authorized in excess of the annual cost limit described in B-2-a, referrals to other community services, including institutional services, are provided to the individual. The individual retains hearing rights in the event ODA does not approve the additional services in excess of the individual cost limit.

## Appendix B: Participant Access and Eligibility

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

**a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

**Table: B-3-a**

| Waiver Year | Unduplicated Number of Participants |
|---|---|
| **Year 1** | 5967 |
| **Year 2** | 6063 |
| **Year 3** | 6831 |
| **Year 4** | 7599 |
| **Year 5** | 8367 |

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

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

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

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

**Table: B-3-b**

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

Purpose(s) the state reserves capacity for:

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

## Appendix B: Participant Access and Eligibility

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

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

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

**Purpose** *(describe):*

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

**Describe how the amount of reserved capacity was determined:**

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

**e. Allocation of Waiver Capacity.**

*Select one*:

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

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

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

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

Specifically, these rules are in Ohio Administrative Code in the ODM section:
5160-33-03 (Eligibility)
5160-33-04 (Enrollment)

In addition, eligibility and enrollment rules are in ODA's section of the Ohio Administrative Code:
173-38-02 (Eligibility)
173-38-03 (Enrollment)

# Appendix B: Participant Access and Eligibility

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

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

# Appendix B: Participant Access and Eligibility

## B-4: Eligibility Groups Served in the Waiver

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

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

**2. Miller Trust State.**

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

- ( ) **No**
- (●) **Yes**

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

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

- [ ] **Low income families with children as provided in §1931 of the Act**
- [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: [ ]

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

*Specify:*

42 CFR 435.110: Parents and other Caretaker Relatives

Section 1925: Transitional Medical Assistance

42 CFR 435.115: Extended Medicaid due to Spousal Support Collections

42 CFR 435.116: Pregnant Women

42 CFR 435.130: Individuals Receiving Mandatory State Supplements

42 CFR 435.131: Individuals Who Are Essential Spouses

42 CFR 435.132: Institutionalized Individuals Continuously Eligible Since 1973

42 CFR 435.133: Blind or Disabled Individuals Eligible in 1973

42 CFR 435.134: Individuals Who Lost Eligibility for SSI/SSP Due to an Increase in OASDI Benefits in 1972

42 CFR 435.135: Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA increases since April 1977

42 CFR 435.137: Disabled Widows and Widowers Ineligible for SSI due to Increase in OASDI

42 CFR 435.138: Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security Section 1619(b): Working Disabled under 1619(b)

1634(c): Disabled Adult Children

42 CFR 435.213: Certain Individuals Needing Treatment for Breast or Cervical Cancer

42 CFR 435.210: Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash Assistance

42 CFR 435.119: Adult Group - Individuals at or below 133% FPL Age 19 through 64 - newly eligible for all states

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

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

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

*Select one and complete Appendix B-5.*

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

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

*Check each that applies*:

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

*Select one*:

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

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

Specify percentage:

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

Specify dollar amount:

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

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

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

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

*Select one*:

○ **100% of FPL**

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

Specify percentage amount:

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

*Specify:*

## Appendix B: Participant Access and Eligibility

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

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

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

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

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
*Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).*

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

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

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

◉ **The following standard included under the state plan**

*Select one*:

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

(*select one*):

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

Specify the percentage:

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

Specify dollar amount:

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

Specify percentage:

○ **Other standard included under the state Plan**

*Specify:*

○ **The following dollar amount**

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

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

*Specify:*

○ **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:*

AFDC need standard using the following formula: The Family Maintenance Needs Allowance (FMNA) standard is the AFDC payment standard for the same number of applicable dependent family members minus the combined monthly income of the dependent family members, then the result is rounded down to the nearest dollar.

○ **Other**

*Specify:*

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

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

Select one:

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

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

○ **The state establishes the following reasonable limits**

*Specify:*

## Appendix B: Participant Access and Eligibility

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

**i. Allowance for the personal needs of the waiver participant**

(*select one*):

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

  Specify percentage:
- ( ) **The following dollar amount:**

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

  *Specify formula:*
- ( ) **Other**

  *Specify:*

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

*Specify the entity:*

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

- ○ **Other**

*Specify:*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

An RN, LPN, LSW or LISW completes the assessment and determines whether the applicant meets the SLOC or ILOC criteria set forth in OAC rule 5160-3-08. The individual is also assessed for Assisted Living waiver eligibility pursuant to OAC rule 5160- 33-03.

The assessment is documented in the ODM approved assessment and case management system, and the individual is informed of fair hearing/appeal rights in accordance with OAC Division 5101:6.

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

The process for re-evaluation of the level of care is the same.

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

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

  *Specify the other schedule:*

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

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

  *Specify the qualifications:*

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

Timely re-evaluations are assured through the PAA's use of an ODM-approved assessment and case management system that generates a report identifying waiver participants who are due for a re-evaluation. On a monthly basis, ODA runs this report retrospectively to ensure the timely completion of the re-evaluations.
In addition, ODA generates reports monthly that include timely reevaluations. By monitoring these reports, ODA identifies participants who do not receive their re-evaluations timely. In the event that ODA finds this type of discrepancy, ODA would provide remediation (technical assistance in the form of calls, emails, and if needed, on-site visits) to the PAA(s). If a statewide pattern or trend is noted, ODA will develop and implement strategies to educate the PAAs about program expectations and monitor compliance.

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

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

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

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

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

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

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

**Data Source** (Select one):
**Analyzed collected data (including surveys, focus group, interviews, etc)**
If 'Other' is selected, specify:

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

| | | |
|---|---|---|
| | | |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

**Performance Measures**

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

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

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

**Data Source** (Select one):
**Analyzed collected data (including surveys, focus group, interviews, etc)**
If 'Other' is selected, specify:

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

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

**Performance Measures**

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

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

**Performance Measure:**
**B-3: Number and percent of participants with LOC determinations/redeterminations reviewed that were completed using the processes and instruments described by the waiver in B-6. N: Number of participants that LOC determinations/redeterminations reviewed that were completed using the process required by the approved waiver. D: Total number of participants with LOC determinations completed.**

**Data Source** (Select one):

**Record reviews, off-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(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**<br>Confidence Interval =<br>95% CI with a MOE +/- 5% |
| ☒ **Other**<br>Specify:<br>ODA's designees | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>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**<br>Specify: |

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

**b. Methods for Remediation/Fixing Individual Problems**

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

Activities by ODM for addressing individual problems include:

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

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

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

**ii. Remediation Data Aggregation**

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

| **Responsible Party***(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**<br>Specify:<br>ODA's designees | ☒ **Annually** |
| | ☒ **Continuously and Ongoing** |
| | ☒ **Other**<br>Specify:<br>Once per waiver cycle |

**c. Timelines**

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

◉ **No**

○ **Yes**

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

## Appendix B: Participant Access and Eligibility

### B-7: Freedom of Choice

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

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

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

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

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

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

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

Written copies of the Agency-Client Agreement are maintained by the PAAs in accordance with state and federal regulations.

## Appendix B: Participant Access and Eligibility

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

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

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

ODA and PAA

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

ODM

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

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

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

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

## Appendix C: Participant Services

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

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

| Service Type | Service | | |
|---|---|---|---|
| **Other Service** | **Assisted Living Service** | | |
| **Other Service** | **Community Transition Service** | | |

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Assisted Living Service

**HCBS Taxonomy:**

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

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Assisted living service a service provided in a licensed residential care setting, which promotes aging in place by supporting the individual's independence, choice, and privacy and includes all of the following activities:

•Hands-on assistance, supervision, and/or cuing of ADLs, IADLs, and other supportive activities.

•Nursing activities, including the initial and subsequent health assessments under rule 3701-16-08 of the Administrative Code, monitoring the individual according to the standards of practice for the individual's condition, education management according to rule 3701-16-09 of the Administrative Code, part-time intermittent skilled nursing care described in rule 3701-16-09.1 of the Administrative Code when not available to the individual through a third-party payer.

•Coordinating three meals per day and snacks according to rule 3701-16-10 of the Administrative Code with access to food according to rule 5160-44-01 of the Administrative Code.

•Coordinating the social, recreational, and leisure activities under rule 3701-16-11 of the Administrative Code to promote community participation and integration, including non-medical transportation to services and resources in the community.

Waiver participants reside in an HCBS settings compliant licensed residential care setting.

Service is authorized at the following levels:
-Base assisted living service: This service category is the minimum threshold of service need for all individuals enrolled in the assisted living waiver program.
-Memory care assisted living service: This service category is inclusive of the base assisted living service, plus additional costs associated with care needs of individuals with a diagnosis of dementia.
-Critical access assisting living service: This service category, newly effective 7/1/24, is inclusive of the base assisted living service, plus additional costs attributed to service providers with a census consisting of 50% or more Medicaid waiver enrollees.

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

The service is limited to one unit per calendar day.

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

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

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Residential Care Facility |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Assisted Living Service**

**Provider Category:**

Agency

**Provider Type:**

Residential Care Facility

**Provider Qualifications**

**License** *(specify):*

Only a provider who maintains a current, valid RCF license from ODH and maintains compliance with Chapter 3721. of the Revised Code and Chapters 3701-13 and 3701-16 of the Administrative Code qualifies to provide this service.

**Certificate** *(specify):*

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

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

OAC 173-39-02.16 Assisted Living Service Specification

This rule establishes the guidelines for the resident unit requirements to ensure a homelike, non-institutional setting, service scope, and staff orientation, training and supervision.

**Other Standard** *(specify):*

Ohio Department of Medicaid (ODM)
Active Medicaid Provider Agreement (OAC 5160-1-17.2)

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

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

**Frequency of Verification:**

Ohio Department of Health in accordance with chapter 3701-16 of the Ohio Administrative Code. Verification of provider qualifications occurs in accordance with rule 173-39-04 of the Ohio Administrative Code.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Community Transition Service

**HCBS Taxonomy:**

| **Category 1:** | **Sub-Category 1:** |
|---|---|
| 16 Community Transition Services | 16010 community transition services |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

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

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

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

The service may be authorized up to 180 consecutive days before an individual’s transition from an institutional setting to an HCBS setting. In such cases, the service may not be billed for until, the date the individual leaves the institution and enters the waiver.

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

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Social Workers, Healthcare Professionals, Community-based social service provider |
| Agency | Human Service Agencies, Social Service Agencies, Licensed Residential Care Facility, Senior Centers, Community Action Organizations, Home Health Agencies, ODM contracted Transition Coordinators |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Community Transition Service**

**Provider Category:**

Individual

**Provider Type:**

Social Workers, Healthcare Professionals, Community-based social service provider

**Provider Qualifications**

**License** *(specify):*

License as required by profession

**Certificate** *(specify):*

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

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

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

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

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

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Community Transition Service**

**Provider Category:**

Agency

**Provider Type:**

Human Service Agencies, Social Service Agencies, Licensed Residential Care Facility, Senior Centers, Community Action Organizations, Home Health Agencies, ODM contracted Transition Coordinators

**Provider Qualifications**

**License** *(specify):*

License as required by profession.

**Certificate** *(specify):*

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

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

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

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

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

**Frequency of Verification:**

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

# Appendix C: Participant Services

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

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

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

*Check each that applies:*

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☒ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

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

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

# Appendix C: Participant Services

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

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

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

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

-Types of positions: Any paid direct-care position, unless exempted under OAC 173-9-02.
-Entity responsible: ODA, ODAs designee, waiver service provider
-Scope of investigation: State and national criminal records checks (R.C. §§ 109.572, 173.38, 173.381)
-Process for ensuring compliance: ODA does not certify, and will terminate certification of, disqualified providers and conducts annual monitoring of assisted living service providers and a minimum of every three years for community transition service providers.

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

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

**registry.**

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

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

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

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

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

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

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

## Appendix C: Participant Services

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

**Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.**

## Appendix C: Participant Services

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

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

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

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

☐ **Self-directed**

☐ **Agency-operated**

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

◉ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

○ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

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

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

○ **Other policy.**

Specify:

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

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

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

Prospective providers have ready access to information regarding requirements and procedures to qualify, and timeframes are established for qualifying and enrolling in the program through:
-ODAs website (https://aging.ohio.gov/wps/portal/gov/aging/agencies-and-service-providers/certification)
-Ohio Administrative Code https://codes.ohio.gov/ohio-administrative-code/chapter-173-39
-Contacting ODA or their local PASSPORT Administrative Agency to obtain assistance and information about the application process.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

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

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

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**
**C-1: Number and percent of new providers that meet initial certification requirements prior to providing waiver services. Numerator: Number of new providers that meet initial certification requirements prior to providing waiver services. Denominator: Total number of new providers enrolled.**

**Data Source** (Select one):
**Program logs**
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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>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**<br>Specify: |

**Performance Measure:**
**C-2: Number and percent of enrolled providers for which appropriate background checks were conducted timely at the time of their structural compliance review. Numerator: Number of enrolled providers for which appropriate background checks were conducted timely at the time of the structural compliance review. Denominator: Total number of structural compliance reviews conducted.**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(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**<br>Confidence Interval = |
| ☒ **Other**<br>Specify:<br>PASSPORT Administrative Agency | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**C-3: Number and percent of providers that continue to meet certification requirements at time of Structural Compliance Review. Numerator: Number of providers that continue to meet certification requirements at the time of a structural compliance review. Denominator: Total number of structural compliance reviews conducted.**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(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**<br>Confidence Interval = |
| ☒ **Other**<br>Specify:<br>PASSPORT Administrative Agency | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

**Performance Measure:**
**C-4:Number & percent of provider owned & controlled settings reviewed that meet OAC 5160-44-01 home and community-based settings requirements. N:Number of HCBS provider owned and controlled settings reviewed that meet all requirements of OAC 5160-44-01 home and community-based services programs: home and community-based settings. D:Number of HCBS provider owned and controlled settings reviewed**

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

| **Responsible Party for data collection/generation** *(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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

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

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

**Performance Measure:**
**N/A**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**N/A**

| **Responsible Party for data** | **Frequency of data collection/generation** | **Sampling Approach** *(check each that applies):* |
|---|---|---|

| **collection/generation** *(check each that applies):* | *(check each that applies):* | |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☒ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☒ **Other**<br>Specify:<br>N/A | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☒ **Other**<br>Specify:<br>N/A |
| | ☒ **Other**<br>Specify:<br>N/A | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☒ **Other**<br>Specify:<br>N/A | ☐ **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**<br>Specify:<br>N/A |

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

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

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

**Performance Measure:**
**C-5: Number and percent of providers who have been verified at the time of their structural compliance review to have met training requirements. Numerator: Number of providers who have been verified at the time of their structural compliance review to have met training requirements. Denominator: Total number of provider structural compliance reviews conducted.**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

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

| | | |
|---|---|---|
| ☒ **Other**<br>Specify:<br>PASSPORT Administrative Agency | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

**b. Methods for Remediation/Fixing Individual Problems**

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

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

ODA monitors both activities performed by the PAAs to assure that all provider enrollment and oversight requirements and protocols are followed. ODA's assessment methods and their frequency include, at minimum, quarterly review of established performance indicators, and analysis of the results from the PAA quarterly retrospective record reviews. ODA analyzes the data, upon discovery of non-compliance develops remediation plans (as needed), oversees the implementation of the remediation plan and evaluates the subsequent results.

When non-compliance or opportunities for improvement are discovered, the individual PAA is notified and technical assistance is provided using on-site technical assistance, e-mail, phone contact, letters to PAA Director. When assessed as needed, ODM will provide individual PAA or state-wide training.

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

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

ODM and ODA collaborate to identify and communicate observed trends, propose changes to rules and protocols, and support ongoing improvement in systems intended to assure compliance with waiver assurances.

**ii. Remediation Data Aggregation**

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

| **Responsible Party***(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**<br>Specify:<br>ODAs designees | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☒ **Other**<br>Specify:<br>once per waiver cycle |

**c. Timelines**

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

◉ **No**

○ **Yes**

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

## Appendix C: Participant Services

### C-3: Waiver Services Specifications

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

## Appendix C: Participant Services

### C-4: Additional Limits on Amount of Waiver Services

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

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

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

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

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

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

☐ **Other Type of Limit.** The state employs another type of limit.
*Describe the limit and furnish the information specified above.*

# Appendix C: Participant Services

## C-5: Home and Community-Based Settings

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

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

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

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

Beginning in 2015, Ohio completed an initial assessment of the HCBS "settings" rule regulations to determine systemic and program specific regulations and processes requiring modification to achieve compliance with the HCBS settings rule requirements. This assessment process resulted in proposed changes to Ohio regulations, development of provider assessment and provider training tools.

Statute and Administrative Code Updates
Ohio identified and updated Ohio Administrative Code (OAC) regulations needed to assure incorporation of HCBS settings requirements for HCBS programs. Ohio added regulations to the OAC to require individuals enrolled in programs reside in settings that meet HCBS settings rule requirements, provider compliance with the regulations, and person-centered service planning activities to be completed in accordance with the federal regulations. Below is a listing of state statute and administrative code that have been updated or created in response to meet the HCBS settings rule requirements.
-Rule 5160-44-01 | Nursing facility-based level of care home and community-based services programs: home and community-based settings
-Rule 5160-44-02 | Nursing facility-based level of care home and community-based services programs: person-centered planning
-Rule 5160-33-03 | Eligibility for the Medicaid funded component of the assisted living program
-Rule 173-38-01 | Assisted living program (Medicaid-funded component): introduction and definitions
-Rule 5160-33-04 | Enrollment process for Medicaid-funded component of the assisted living waiver program
-Rule 173-38-03 | Assisted living program (Medicaid-funded component): enrollment and reassessment of individuals

Applicable Services
All assisted living waiver services are provided in a provider owned and controlled residential setting.

Person Centered Planning and Monitoring
To ensure proper training for PCSP development, the State has published three training modules, geared toward care coordination responsibilities within the nursing facility-based waiver programs. These include HCBS Settings Overview, HCBS Settings Criteria and Modifications and Care Coordination Role in HCBS Settings. The training modules are located here: https://medicaid.ohio.gov/families-and-individuals/citizen-programs-and-initiatives/hcbs/hcbs-transition.

The state reviews a sampling of person-centered service plans to ensure ongoing compliance.
Description of how the state assesses providers for initial compliance and conducts ongoing monitoring for continued compliance
Initial Compliance

Beginning in 2016, 100% of existing HCBS settings were evaluated to determine compliance with settings criteria. Provider owned and controlled settings (Assisted Living and Adult Day Service providers) were reviewed and determined either have met compliance with HCBS settings or submitted to CMS for heightened scrutiny approval.

Ohio continues to complete re-reviews and remediation of provider owned and controlled settings, as described and approved by CMS in the corrective action plan.

Ongoing HCBS Setting Compliance Monitoring
Residential and non-residential settings serving individuals in Ohio's HCBS delivery systems to be monitored beyond the transition period through scheduled provider compliance reviews and ongoing reviews completed by entities responsible for program care coordination and service authorization activities. Event-based reviews continue to be conducted upon receipt of complaints from individuals/guardians, community members, or others.
In the event a setting that previously demonstrated evidence of compliance cannot (or does not) subsequently produce acceptable evidence of compliance, the State's established relocation team, led by the State Long-Term Care Ombudsman and/or entities responsible for program care coordination, will work with individuals to transition them to a setting of their choice that meets the HCBS characteristics.

New Residential and non-residential HCBS service setting applicants:
An initial on-site assessment is conducted for all new settings that provide residential and non-residential HCBS.
- For all settings applying to serve individuals in an Ohio HCBS program, the assessment is conducted prior to the entity being issued a Medicaid provider agreement to furnish HCBS waiver services.
- For individuals enrolled on an Ohio HCBS program, the entity responsible for care coordination and/or service authorization will ensure that new settings comply with the HCBS settings standards prior to adding the service to the individual's service plan. If a setting's non-compliance prevents a service from being added to an individual's plan, the individual will be afforded due process in accordance with Ohio Revised Code 5101:6-1 through 5101:6-9.

All HCBS service providers newly applying to become a service provider are assessed and verified to meet HCBS settings requirements prior to approval to become a Medicaid waiver service provider. Sites unable to meet HCBS settings requirements are prohibited from becoming new service providers. Providers meeting criteria for Heightened Scrutiny may not receive approval until the outcome of the CMS HS review has been determined and approval is received.

Description of a beneficiary's recourse to notify the state of provider non-compliance (grievance process, notification of case manager, etc.) and how the state will address beneficiary feedback.

Ombudsman
In conjunction with the State Long Term Care Ombudsman Office, the State employed a public education and outreach campaign on the HCBS settings characteristics, including communicating the process for individuals to raise concerns regarding the community nature, or lack thereof, of a specific setting. There also was guidance developed for ombudsman representatives, case managers, and waiver Service coordinators when educating individuals about HCBS settings and person-centered planning. Additional guidance was developed to provide guidance to individuals receiving Assisted Living or Adult Day Services in the Assisted Living, PASSPORT, Ohio Home Care and MyCare Ohio Waivers.

The State recognizes protection and advocacy entities are key partners in ongoing compliance by informing individuals of their right to file a complaint regarding a specific setting and/or to report directly to the State any concerns with a setting's ability to comply. Upon receiving a report by an individual or another entity, the State will initiate a formal review, as appropriate.
Using the existing complaint processes, individuals have the right to file a complaint regarding a specific setting Individuals may report complaints through their care coordination entity, long term state ombudsman and/or to report directly to the State any concerns with a setting's ability to comply. Upon receiving a report by an individual or another entity, the State will initiate a formal review, as appropriate.

Case Manager
The case manager or waiver service coordinator also is an independent resource that the consumer can notify of any ongoing issue whether it is related to the HCBS settings rule or not. The waiver service coordinator serves as an invaluable resource for the HCBS participant to help with authorizing paid supports, locating and informing the HCBS participant about community related resources, acting as support when there are provider related concerns including the HCBS settings rule, and just and a trusted confident to the HCBS participant. The waiver service coordinator is expected to make referrals to the appropriate entity depending on the instance, whether that is the Ombudsman, licensing agency, provider compliance, or protective services. The waiver service coordinator frequently reaches out the HCBS participant for regular assessments and check-ins and is also available by phone, in-person, or electronically as the HCBS participant needs or concerns arise.

# Appendix D: Participant-Centered Planning and Service Delivery

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

**State Participant-Centered Service Plan Title:**

Service Plan

**a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☒ **Registered nurse, licensed to practice in the state**
- ☒ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  *Specify qualifications:*
- ☒ **Social Worker**
  *Specify qualifications:*

Ohio licensure as a state-tested and Board certified independent social worker or a state-tested and Board-certified social worker.

☒ **Other**

*Specify the individuals and their qualifications:*

Licensure described above and at least one year prior experience in healthcare, medical social worker, or geriatrics.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

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

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (3 of 8)

**c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Ohio’s nursing facility based waiver programs implement person-centered planning requirements contained in CFR 441.540 Person-centered service plan requirements through adoption of Ohio Administrative Code (OAC) 5160-44-02 Nursing facility based level of care home and community-based services programs. The service planning process and documentation requirements describe how individuals are afforded the opportunity to lead service planning development processes, are offered informed choice of program participation, receipt of services, etc.

The Assisted Living service plan development process provides the individual with the opportunity to actively lead and engage in the development of the plan, including identifying individuals who will be involved in the process. Chapter 173-32 of the Ohio Administrative Code describes this process for the Assisted Living waiver.

Through written and verbal descriptions of services and supports available through the waiver, the case manager provides individuals with education needed to facilitate informed choice of waiver participation, provider selection options and opportunities to engage in their community in a meaningful way.

Supports and information made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process include

-Assistance with development of an individualized person-centered service plan.
-Participant education in order to promote informed choice, understanding of risk and benefits of care options/decisions, and confidentiality standards including the following topics: related to how to contact the PAA and the assigned case manager, services provided by the long-term care ombudsman program and the medicaid hotline.

Additional details describing the person-centered services process are described in section D-1-d of this waiver application.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (4 of 8)

**d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Ohio’s nursing facility based waiver programs, including Assisted Living) implement person-centered planning requirements contained in CFR 441.540 Person-centered service plan requirements through adoption of Ohio Administrative Code (OAC) 5160-44-02 Nursing facility-based level of care home and community-based services programs.

The case manager is responsible for facilitating the person-centered planning process described below and described in OAC 5160-44-02.

The person-centered planning process is required to:
-Include a team of people chosen by the individual.
-Provide necessary information and support to ensure that the individual directs the process to the maximum extent possible
and is enabled to make informed choices and decisions.
-Be timely and occur at times and locations of convenience to the individual.
-Reflect cultural considerations of the individual. The process shall be conducted by providing information in plain language
and in a manner that is accessible to persons with disabilities and persons who are
limited English proficient, consistent with 42 CFR 435.905(b).
-Include strategies for solving conflict or disagreement within the process.
-Ensure that providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for
the individual must not provide case management, provider oversight, or develop the
person-centered services plan.
-Offer informed choices to the individual regarding the services and supports he or she receives and from whom.
-Include a method for the individual to request updates to the plan as needed. The individual may request a person-centered
services plan review at any time.

The person-centered services plan describes the person-centered goals, objectives and interventions selected by the individual and team to support him or her in his or her community of choice. The plan addresses the assessed needs of the individual by identifying medically necessary services and supports provided by natural supports, medical and professional staff and community resources.

The plan must:
-Identify the setting in which the individual resides is chosen by the individual and record the alternative home and community-based settings that were considered by the individual.
-Reflect the individual's strengths.
-Reflect the individual's preferences.
-Reflect clinical and support needs as identified through the assessment process.
-Include the individual's identified goals and desired outcomes.
-Identify the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports and those services the individual elects to self-direct.
-Address any risk factors and measures in place to minimize them, when needed.
-Include back-up plans that meet the needs of the individual.
-Reflect that the setting chosen by the individual is integrated and supports the full access of individuals receiving medicaid
HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in
community life, control personal resources and receive services in the community to the same degree of access as people not
receiving medicaid HCBS.

The person-centered services plan contains documentation that any modification of the additional conditions for provider-owned or controlled residential settings set forth in rule 5160-44-01 of the Administrative Code must be supported by a specific assessed need and justified in the person-centered services plan. The following requirements must be documented in the person-centered services plan:

-Identify a specific and individualized assessed need;
-Document the positive interventions and supports used prior to any modifications to the person-centered services plan;
-Document less intrusive methods of meeting the need that have been tried but did not work;
-Include a clear description of the condition that is directly proportionate to the specific assessed need;
-Include a regular collection and review of data to measure the ongoing effectiveness of the modification;
-Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
-Include informed consent of the individual; and
-Include an assurance that interventions and supports will not cause any harm to the individual.

The person-centered services plan must:
-Be understandable to the individual receiving services and supports, and the people important in supporting him or her.
At a minimum, it must be written in plain language and in a manner that is accessible to persons with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b) (as in effect on October 1, 2021).
-Identify the person and/or entity responsible for monitoring the plan.
-Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all people and providers
responsible for its implementation. Acceptable signatures include, but are not limited to a handwritten signature, initials,
a stamp or mark, or an electronic signature. Any accommodations to the individual's or authorized representative's signature
shall be documented on the plan.
-Be distributed to the individual and other people involved in the plan.
-Prevent the provision of unnecessary or inappropriate services and supports.
-Be reviewed, and revised upon reassessment of functional need as required by 42 CFR 441.365(e) (as in effect on October 1, 2021),
at least every twelve months, when the individual experiences a significant change, or at the request of the individual.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

Participant risk and safety considerations are identified and with the informed involvement of the individual, potential interventions that promote independence and safety are considered. During assessments, reassessments, and anytime thereafter, any known or perceived risk and/or safety considerations are identified and noted on the person-centered service plan and in clinical documentation. Where necessary, the PAAs may initiate risk and safety planning via the implementation of a Health and Safety Action Plan developed by the PAA that identifies situations, circumstances and/or behaviors that without intervention may jeopardize the individual’s health and welfare and potentially risk his or her enrollment on the waiver or explore development of a behavior support plan by appropriate personnel.

Regarding back-up planning, individuals are encouraged to be prepared with service alternatives so as not to jeopardize their health and welfare if providers do not arrive when expected. Individuals are instructed to immediately call the provider and/or go to their back-up plan. If the provider is employed by an agency, the agency must either have back-up available or assist the individual in making other arrangements. If the individual receives services from a non-agency or participant-directed provider, then the individual must be willing to develop a back-up plan for individual provider absences and emergencies and submit it to the case manager. Back-up plans are documented on the person-centered service plan.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (6 of 8)

**f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The PAA assessor/case manager will make available to the participant, prior to enrollment, at annual re-assessment, and at any time upon request, a summary of each ODA certified long-term care agency and non-agency provider serving participants in that PAA's region. This list of providers includes information about the location, size, and general demographics of the provider in addition to current certification reports. The provider list includes current ODA certified long-term care individual providers who have expressed an interest in being employed by additional participants.

Participants review the provider list with their assessor/case manager, who will explain the information presented to assist the participant in making the best decisions for their care needs. If the participant has any questions, the PAA staff either responds to or researches the question and provides information back to the participant so they may make an informed choice of service provider. The PAA will be responsible for ensuring the provider information is current by updating the summary document on an ongoing basis

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (7 of 8)

**g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

ODA monitors person-centered planning compliance through ongoing oversight activities, providing policy and operational guidance and reviewing service authorizations and documentation of individual records.

ODM conducts targeted reviews focusing on both performance measures and participation satisfaction. Reviews are completed with a sample size adequate to report results with 95% confidence of being within a +/- 5% margin of error. Topics can include service planning, care management satisfaction, free choice of provider, level of care, health and welfare, hearing rights, and validation of service delivery. ODM reviewers compare assessments to person-centered service plans to determine if an individual's person-centered service plan includes services and supports consistent with the individual's assessed needs. ODM retains the right to review and modify person-centered services plans at any time.

Additional descriptions of ODM service planning oversight are described throughout this waiver application.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

*Specify the other schedule:*

**i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a

minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

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

  *Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-2: Service Plan Implementation and Monitoring

**a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The PAAs are primarily responsible for implementing the person-centered service plans.

Face to face monitoring visits occur at least quarterly (no more than 90 calendar days between face to face visits) to determine if the service plan has been appropriately implemented, meets the needs of the participant, ensures participant health and welfare, and to verify that the participant has ongoing access to non-waiver services. Additional contacts may occur either by face to face visit or telephone, based on the individual's assessed need and/or per individual request.

Monitoring activities include reviewing and assuring the following:
-Services are furnished in accordance with the service plan
-Participant has access to waiver services identified in service plan
-Participants exercise free choice of provider
-Services meet participants' needs
-Effectiveness of back-up plans
-Participant health and welfare needs are met

Modifications to the service plan and service delivery schedule are initiated upon discovery. The individual chooses from a variety of methods to resolve the identified issue(s) including: the selection of alternate providers or direct service workers, negotiation with current providers for service modifications, adding (waiver and non-waiver) services, and changes in the level of involvement of the participant's informal support systems.

The written service plan is updated to describe the intervention developed to address the issue(s), time frames for implementation, entities responsible for implementation and times frames to evaluate the effectiveness of the intervention in resolving the identified need or problem. The case manager is responsible for ongoing monitoring and evaluation of the effectiveness and participant satisfaction of the intervention.

The PAAs are required by ODA policy to have established internal quality assurance practices for assessment and case management activities. These internal practices identify trends and patterns related to clinical practice issues that impact participant outcomes. The PAAs use this data to identify training needs in the clinical and provider network and to develop best practices and protocols to enhance participant outcomes.

ODA will continue a quarterly record review system for PAAs. The record reviews ensure that services are furnished in accordance with the participant's service plan; participants have access to waiver services identified in their service plan which includes: participants are provided with information about service providers in their geographic area and given their free choice of providers; and participants are asked questions about their back-up plans, if they have had to use their back-up plans and how the back-up plan worked when used. ODA may provide remediation needs identified through one-on-one technical assistance or practice directives issued to the PAAs.

At least annually, ODA compiles aggregate findings of trends and patterns related to service plan implementation and monitoring. ODA recommends concerns/issues for further remediation and/or quality initiatives in accordance with the Quality Management Strategy.

**b. Monitoring Safeguards.** *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### Quality Improvement: Service Plan

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

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

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**
**D-1: Number and percent of participants whose service plans are comprehensive and interventions are sufficient to meet the individual's assessed needs. Numerator: Number of participants whose service plans are comprehensive and interventions are sufficient to meet the individual's assessed needs. Denominator: Total number of participants' service plans reviewed.**

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

| **Responsible Party for data collection/generation** *(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**<br>Confidence Interval =<br>95% CI with +/-5% MOE |
| ☒ **Other**<br>Specify:<br>ODA's designee | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| | | |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**D-2: Number and percent of participants whose service plans have identified potential health & safety risks and include interventions to mitigate/eliminate these risks. N: Number of participants whose service plans have identified potential health & safety risks and include interventions to mitigate/eliminate these risks. D: Total number of participants' service plans reviewed.**

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

| **Responsible Party for data collection/generation** *(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**<br>Confidence Interval =<br>95% CI with +/-5% MOE |
| ☒ **Other**<br>Specify:<br>ODA's designee | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>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**<br>Specify: |

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

**Performance Measures**

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

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

**Performance Measure:**
**D-3: Number & percent of service plans developed according to the policies & procedures in the approved waiver. N: Number of service plans developed according to the policies & procedures in the approved waiver. D: Total number of service plans 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**<br>Confidence Interval = |

| | | |
|---|---|---|
| | | 95% CI with =/-5% |
| ☒ **Other**<br>Specify:<br>PASSPORT Administrative Agencies | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c.** ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the***

***waiver participants needs.***

**Performance Measures**

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

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

**Performance Measure:**
**D-4: Number and percent of service plans reviewed that were updated when the participant's needs changed. Numerator: Number of service plans reviewed that were updated when the participant's needs changed. Denominator: Total number of service plan reviewed for whom participants experienced a change in need.**

**Data Source** (Select one):
**Record reviews, 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**<br>Confidence Interval =<br>95% CI with +/-5% MOE |
| ☒ **Other**<br>Specify:<br>ODAs designees | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**D-5: Number and percent of service plans reviewed that were updated at least annually. Numerator: Number of service plans reviewed that were updated at least annually. Denominator: Total number of service plan reviewed.**

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

| **Responsible Party for data collection/generation** *(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 =<br>95% CI with +/-5% MOE |
| ☒ **Other**<br>Specify:<br>ODAs designees | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**d.** ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

**Performance Measures**

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

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

**Performance Measure:**
**D-6: Number and percent of participants reviewed who received services in the type, scope, amount and frequency specified in the service plan. Numerator: Number of participants reviewed who received services in the type, scope, amount, duration and frequency specified in the service plan. Denominator: Total number of participants' service plan reviewed.**

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

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☒ **Operating Agency** | ☐ **Monthly** | ☒ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** | ☒ **Representative Sample**<br>Confidence Interval =<br>95% CI with +/-5% MOE |
| ☒ **Other**<br>Specify:<br>ODAs designees | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**e.** ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

**Performance Measures**

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

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

**Performance Measure:**
**D-7: Number and percent of participants notified of their rights to choose among waiver services and/or providers. Numerator: Number of participants notified of their rights to choose among waiver services and/or providers. Denominator: Total number of participants' records reviewed.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(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**<br>Confidence Interval =<br>95% CI with +/-5% MOE |
| ☒ **Other**<br>Specify:<br>ODAs designees | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>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**<br>Specify: |

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

**b. Methods for Remediation/Fixing Individual Problems**

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

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

ODA monitors both activities performed by the PAAs to assure that all provider enrollment and oversight requirements and protocols are followed. ODA's assessment methods and their frequency include, at minimum, quarterly review of established performance indicators, and analysis of the results from the PAA quarterly retrospective record reviews. ODA analyzes the data, upon discovery of non-compliance develops remediation plans (as needed), oversees the implementation of the remediation plan and evaluates the subsequent results. When non-compliance or opportunities for improvement are discovered, the individual PAA is notified and technical assistance is provided using on-site technical assistance, e-mail, phone contact, letters to PAA Director. When assessed as needed, ODM will provide individual PAA or state-wide training.

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

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

ODM and ODA collaborate to identify and communicate observed trends, propose changes to rules and protocols, and support ongoing improvement in systems intended to assure compliance with waiver assurances.

**ii. Remediation Data Aggregation**

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

| **Responsible Party***(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**<br>Specify:<br>PASSPORT Administrative Agencies | ☐ **Annually** |
| | ☒ **Continuously and Ongoing** |
| | ☒ **Other**<br>Specify:<br>once per waiver cycle. |

**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 enrollment in the waiver, the PAA assessor/case manager provides the individual with information in both written and verbal formats including: the right to choose HCBS as an alternative to institutional care, and the right to appeal any decision regarding benefits (e.g., failure to be given a choice of HCBS as an alternative to institutional care, denial of choice of services and/or providers, and/or denial, suspension, reduction or termination of benefits, etc.).

Individuals receive notice regarding proposed adverse benefit determination on the ODJFS 04065 "Prior Notice of Right to a State Hearing," and an explanation of state hearing procedures on the ODJFS 04059 "Explanation of State Hearing Procedures." If they do not agree with the proposed benefit determination outlined in the notice, they have a right to a state hearing within 90 days of the mailing date of the prior notice. If someone other than an individual submits a written hearing request, it must include a written statement signed by the individual authorizing the person to act on the individual's behalf. While the individual has 90 days from the date the notice was mailed to request a hearing, in accordance with OAC Chapter 5101:6, the individual must request a hearing within 15 days of the date the notice was mailed in order to continue benefits during the appeal process.

The waiver participant receives written information regarding instructions on how to locate free legal services; the date, time and location of their hearing at least ten days in advance; the right to have representation during the hearing, access to the case file, and any rules being applied to the case; hearing decisions are rendered no later than 90 days from the date of the hearing request; ODM must take the action ordered by the decision within 15 days of the date of the decision; and instructions on how to ask for an administrative appeal in the event the individual loses the hearing.

Computer-generated adverse action notices and formal notices of approval are stored in ODM’s eligibility system. When an enrolled participant requests an appeal in a timely manner, the PAA will continue waiver services as outlined in the service plan pending resolution of the appeal.

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

**a. Availability of Additional Dispute Resolution Process.** Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

**b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

**a. Operation of Grievance/Complaint System.** *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

**b. Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

The ODA is responsible for the operation of the complaint process that may be utilized by waiver participants, caregivers, family members, government entities, and the general public regarding the waiver program. The operating agency's complaint process does not replace the waiver participant's ability to request a fair hearing to address problems that fall under the scope of the this process.

In addition to the operating agency's complaint system, the following complaint systems are available to the waiver participant:

The ODM maintains a Medicaid Hot Line available to waiver participants, family members, caregivers, and the general public to file a complaint regarding a Medicaid-funded program or provider.

The Ohio Department of Health (ODH) is responsible for the operation of a complaint system when the issue is pertaining to the residential care facility licensure rules Ohio Administrative Code (OAC) 3701-16-04. ODH maintains a centralized contact point and a coordinated information source regarding allegations submitted through the complaint hotline https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/complaints-nursing-home-and-healthcare-facilities. Any residential care facility resident, or their representative, may file a complaint with the ODH using a toll-free number. The caller may choose to remain anonymous. Complaints are investigated within thirty days by ODH facility surveyors as outlined in Ohio Revised Code (ORC) 3721.031 regarding the investigation of complaints; ORC 3721.16 pertaining to discharge and transfer, and ORC 3721.17 which focuses on grievances.

The Office of the State Long-Term Care Ombudsman program (SLTCOP) is responsible for addressing complaints regarding the health, safety, welfare, and civil rights of waiver participants, as well as violations of rights of residents of nursing homes and residential care facilities found in Ohio Revised Code (ORC) 3721.10 - 3721.17. Further, the SLTCOP investigates allegations of the action or inaction of a provider of long term care or a representative of a provider of long term care, government entities, or private social service agencies whose actions may adversely affect the health, safety, welfare or rights of a participant.

None of these complaint processes replace the waiver participant's ability to request a fair hearing to address problems that fall under the scope of this process.

**c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Types of Complaints: Individuals are informed by the CMAs of their right to voice dissatisfaction and/or register a complaint any time they feel a Medicaid service provider, PAA or any of its employees have been unresponsive to their requests or have been inconsistent in efforts to help the individual reach their home care goals, objectives or desired outcomes.

Process and Timelines for Addressing Complaints: Complaints can be directed to staff of the PAA, ODA or ODM. They can originate from a face-to-face conversation, phone call, email, ODA or ODM inquiry, or regular mail.

Details of the complaint are assessed by the receiver to determine level of priority (health and safety related complaints require initiation of care coordination activities upon discovery) and triaging of complaint resolution to the PAA, ODA or ODM staff most appropriate to address the complaint. If ODM receives a complaint about the Assisted Living program, the complaint is referred to ODA for follow -up and resolution (as is possible) and provides a deadline for response to the complaint. The length of time given to provide a response/resolution depends on the type and seriousness of the complaint registered, but the length of time for a response rarely exceeds 30 days.

When referred to the PAA for response/resolution: Within seven days of receipt of the complaint by the case manager and/or supervisor, the problem-solving process will be initiated. However, issues with immediate health or safety implications are addressed upon receipt. Documentation of the outcome must occur no later than 30 days from receipt of the complaint.

Mechanisms in place used to resolve grievances/complaints include tracking of complaints received through resolution, PAA documentation of activities completed in the individual's case record as applicable and routine ODA and ODM quality oversight activities described throughout this waiver application.

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

**a. Critical Event or Incident Reporting and Management Process.** Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

**b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The State has an established system for reporting, responding to, investigation and remediation of incidents through Ohio Administrative Code (OAC) 5160-44-05.
Ohio's aligned Nursing Facility Based waiver programs incident management requirements are contained in OAC 5160-44-05.
Incidents that are required to be reported by Ohio's aligned Nursing Facility Based waiver programs are classified into two categories: critical and reportable. The full list and definitions of these incident categories can be found in OAC 5160-44-05, including but not limited to:
Critical Incidents

1) Abuse
2) Neglect
3) Exploitation
4) Misappropriation
5) Unnatural or accidental death
6) Self-harm or suicide attempt resulting in emergency room treatment, in-patient observation, or hospital admission
7) The health and welfare of the individual is at risk due to the individual being lost or missing
8) Any of the following prescribed medication issues:
   a. Provider error
   b. Prescribed medication issue resulting in emergency medical services (EMS) response, emergency room visit, or hospitalization

Reportable Incidents

1) Natural deaths that are not due to events such as accidents, injuries, homicide, suicide, and overdoses
2) Individual or family member behavior, action, or inaction resulting in the creation of or adjustment to a health and safety action plan
3) The health and welfare of the individual is at risk due to any of the following:
   a. Loss of the individual's paid or unpaid caregiver
   b. Prescribed medication issue not resulting in EMS response, emergency room visit, or hospitalization
4) Suicide attempt that does not result in emergency room treatment, in-patient observation, or hospital admission

OAC 5160-44-05 outlines the entities required to report incidents that impact individuals enrolled in Ohio's Nursing Facility Based waiver programs. These parties include:

1) ODM and its designees
2) ODA and its designees
3) Managed care organizations (MCOs)
4) Providers of waiver services
5) Providers of services under the specialized recovery services (SRS) program
6) OhioRISE care management entities
7) Providers serving individuals in the OhioRISE program
8) Providers that furnish services under contract with an MCO

Upon discovering an incident, the reporting entities must do the following, as outlined in OAC 5160-44-05:

1) Take immediate action to ensure the health and welfare of the individual.
2) Report the incident to the waiver case management agency immediately upon discovery but no later than twenty-four hours after discovering the incident. Reports may be made via phone, in-person, or in written form.

**c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Information regarding how to prevent, identify, and report abuse, neglect and exploitation is provided to individuals and/or their informal caregivers.

Entities Responsible for providing the training/information
The PAA (ODA's designee) is primarily responsible for providing the training/information regarding how to prevent, identify, and report abuse, neglect and exploitation.

Frequency the Training/Information is Provided
At a minimum, the training/information is required to be provided at initial enrollment and at the annual re-assessment. Information will also be provided during the course of the wavier enrollment in response to participant specific circumstances. Training is provided to the individual by the Case Manager in all three formats: Written, Verbal and In-Person. Documentation of this training is noted in the individual's Case Notes in ODA's PASSPORT Information Management System (PIMS). ODA evaluates compliance with this requirement on a quarterly basis as part of the Quarterly Record Review process.

**d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

All incidents impacting individuals enrolled in Nursing Facility Based waiver programs are reported to the waiver case management agency. The waiver case management agency completes the initial evaluation of a critical incident report. The evaluation includes: ensuring immediate action is taken, as applicable to the nature of the incident, to protect the health and welfare of the individual and any other individuals who may be at risk; issuing notification to any appropriate investigative, protective authority or regulatory, oversight or advocacy entities; and submitting the required reports to ODM.

The waiver case management agency must follow the documentation process described in OAC 5160-44-05. This includes entering incidents into the incident management system as follows:

1) Critical incidents must be entered within one business day of receiving the incident report.
2) Reportable incidents must be entered within three business days of receiving the incident report.

Once an incident has been documented in the incident management system, the investigation may be carried out by either the waiver case management agency or a designated third-party, as described in OAC 5160-44-05. The investigation process includes conducting a review of relevant documents, conducting and documenting interviews, identifying causes and contributing factors, determining whether the incident is substantiated, and documenting all investigative activities in the incident management system.
The steps of the investigation include:

1) The investigation must be initiated within two business days of receiving the incident report.
2) Unless a longer timeframe has been prior approved, the investigation must be concluded no later than forty-five days after receipt of the incident report.

Once the investigation is complete, the waiver case management agency must carry out the closure process described in 5160-44-05. The steps of the closure process include:

1) A summary of the investigative findings and whether the incident was substantiated must be communicated with the individual and
their authorized representative or legal guardian unless such action could jeopardize the health and welfare of the individual.
2) For a substantiated critical incident, a prevention plan must be entered into the incident management system and the incident
must be closed within seven days after being notified of the substantiation.
3) For a reportable incident, the incident must be addressed and remediated as determined appropriate, and the incident must be
closed within thirty business days after its submission into the incident management system.

**e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is

conducted, and how frequently.

State Entity Responsible for overseeing the operation of the incident management system
ODA is responsible for overseeing the operation of the incident management system.

Methods for overseeing the operation of the incident management system

Oversight of the incident management system includes regular monitoring of reports generated by the system as well as any ad hoc pulling or review of data to review and trend incidents and reportable events to predict and prevent future re-occurrences.

Frequency of Oversight Activities
At least quarterly or more often as necessary.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

**a. Use of Restraints.** *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

Individual waiver participant service delivery oversight occurs at the ODA's designee's level in accordance with ODAs established service plan monitoring process outlined in Appendix D. Service delivery records will be reviewed quarterly by the ODA designee for evidence of compliance with the care plan and to confirm the waiver participant is not subjected to the use of restraints or seclusion.

Potential residential care facility licensure issues, identified by the REs or ODA, referred to ODH for investigation and follow-up.

ODH monitors for unauthorized use of restraints or seclusion in the RCFs through standard survey activities conducted at least every fifteen months and complaint surveys which may take place more frequently than the standard survey. The identification by ODH of the use of restraints or seclusion requires the development and approval of a plan of correction. ODH will provides a report to the State Long Term Care Ombudsman Office regarding the outcome of survey activity and plans of corrections to ODA. These reports are maintained on the Long Term Care Consumer Guide website (www.ltcohio.org) and are available for public review.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

**i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is

conducted and its frequency:

# Appendix G: Participant Safeguards

## Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

**b. Use of Restrictive Interventions.** *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **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 use of restrictive interventions is authorized in the individual's person centered service plan in accordance with OAC 5160-44-02, paragraph B(2). One type of restrictive intervention permitted in a licensed residential care facility is the use of a specialized care unit that restricts the individual's freedom of movement throughout the facility. The specialized care unit provides single occupancy living accommodations in a setting that enhances safety and promotes decisional autonomy for waiver participants at all levels of cognitive and physical functioning.

The use of physical and chemical restraints, including emergency use of restraints, is specifically prohibited in a licensed residential care facility. (OAC 3701-16-07).

The methods used to detect the unauthorized use of restraints include: ODH on-site surveys, referrals to the ODH complaint hot-line, referrals to the LTCOP, critical incident reports submitted by the RE to the ODA and ongoing contact of the RE case manager.

The Long Term Care Consumer Guide (www.ltcohio.org) is an additional tracking mechanism available to ODJFS and ODA to identify the unauthorized use and/or misuse of restrictive interventions.

The waiver participant may choose a single occupancy living unit on a specialized care unit under these conditions:

-Prior to the move, a physician determination must been made that the environment and services provided on the special care unit is needed (OAC 3701-16-08;

-The care and services provided are in accordance with the participants needs and preferences, not for staff convenience (OAC 3701-16-09);

-The continued need for a single occupancy living unit on a specialized care unit is established during periodic assessments completed by the case manager, facility staff, and the physician. (OAC 3701-16-08); and

-Waiver participants who are not cognitively impaired, and choose to reside in a single occupancy living unit on a specialized care unit, are able to enter and exit the unit without assistance.

Compliance with this process is measures through the appendix D performance measure: the percentage of care plans which address all assesss needs, including health and safety risks, and document the interventions planned to meet the assessed needs.

The methods used by the ODA designee to detect unauthorized use of restrictive interventions include:

Regular contacts with the participant and/or the participants designee;
Quarterly on-site visits with the participant and facility staff;
Ongoing review documentation completed by the facility staff;
Review of medications orders;
Ongoing contact with the facility staff; and
Review of ODH survey findings.

The initial and subsequent ongoing care planning process assesses participant needs and identifies the intervention planned to meet the needs. The non-aversive interventions employed to promote independence and choice while ensuring safety of a cognitively impaired individual include, but are not limited to: environmental engineering, predictable daily schedules, prompting, and modeling.

The ODA designee case manager authorizes the use of a single occupancy unit on a specialty care unit. The tier assignment and authorization of a specialty care unit is documented on the participants care plan.

The RCF obtains the Physician's determination that a single occupancy living unit on a specialty care unit is required. This documentation is kept in the participants medical record maintained by the RCF.

The ODA designees are required to maintain initial and annual assessments, which include a functional assessment of ADL/IADLS, and care plans which document the selection of a single occupancy living unit on a specialized care unit.

The facility that operates a specialized care unit is required by state law to disclose to the participant and/or authorized representative the following information about the specialized care unit: scope of services provided, staff training, and a description of the physical environment and design features (OAC 3701-16-07))

The facility is also required to maintain:

An initial and annual health assessment for the participant, including a functional assessment of ADL/IADLs.

A physician's determination the services of a specialty care unit are required.

The ODA designee case manager responsible for conducting assessments and developing the care plans are registered nurses, licensed practical nurses and licensed social workers.

The RCF licensure rules (OAC 3701-16-07) require initial training and continuing education requirements of direct care staff of specialty care units to include training in Alzheimers and/or dementia care.

**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:

Individual waiver participant service delivery oversight occurs at ODA designee level in accordance with ODAs established service plan monitoring process outlined in Appendix D. Service delivery records will be reviewed quarterly by the ODA designee for evidence of compliance with the care plan, including the appropriate use of restrictive interventions.

ODA will conduct annual assessment and service plan data reviews via its information management system to ensure restrictive interventions are used as appropriate and is documented.

Issues identified by ODA and/or the ODA designee that are within the jurisdiction of ODH by statute, and rule will be referred to ODH for investigation and follow-up.

ODH monitors the use of restrictive interventions in the RCFs through standard survey activities conducted at least every fifteen months and complaint surveys which may take place more frequently than the standard survey. The identification of mis-use of restrictive interventions by ODH requires the development and approval of a plan of correction. ODH will provide a report regarding the outcome of survey activity and plans of corrections to ODA.

ODA reviews the reports to determine potential impact of the findings on individuals enrolled in the waiver. As applicable, case management follow up or intervention may include in-person or phone contact with the individuals potentially impacted. Provider oversight staff also review these reports and responds accordingly to ensure compliance with Ohio’s Administrative Code.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

**c. Use of Seclusion.** *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

ODA does not permit the use of restraints or seclusion during the delivery of waiver services.

ODA will instruct PAA case management staff and/or their supervisors that if during an in-person visit or a telephone conversation with the waiver participant, staff learns of the use of restraints or seclusion, staff is to alert PAA management of any situation where restraints or seclusion are used in the participant's home. In cases where the PAA staff has witnessed the use of restraints or seclusion on an Assisted Living waiver participant, ODA will instruct the PAA staff to alert any involved family/caregiver, agency providing services, PAA management and the local APS agency and file an incident report with ODA.

ODA will notify ODM of the event via our established incident reporting system. ODA's oversight would be conducted on an individual basis and as frequently as necessary until the issue is resolved.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

**i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

**a. Applicability.** Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*

◉ **Yes. This Appendix applies** *(complete the remaining items)*

**b. Medication Management and Follow-Up**

**i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The waiver participants physician and waiver provider nursing staff have first line responsibility for assuring that waiver participants medication regimens are prescribed appropriately and managed effectively. This responsibility includes:

-ensuring medication regimens (including self-administration, medication supervision, and medication administration) are delivered as ordered by the prescribing medical professionals:
-documenting oversight and implementation of the medication regimen outlined in the care plan;
-identifying risk factors to management of the medication regimen (ex: cognitive limitations, multiple medications and/or prescribing medical professionals;
-reporting to the prescribing medical professionals any issues related to the medication regimen, including but not limited to participant compliance and reported and/or observed changes in the participants response to the medications;

The ODA desginee (Case manager) is responsible for conducting an initial comprehensive assessment to determine medication management needs. A reassessment of medication management needs is conducted at least annually and as needed. At each quarterly contact, and as needed, the ODA designee case manager confirms the level of medication management ordered in the participants care plan is being delivered and reviews the facility record to determine if there have been changes in the medication regimen.

ODH is responsible for on-site monitoring of medication management processes through annual survey activities and through the investigation of complaints related to medication management issues.

**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.

ODH monitors medication management through regular survey activities and complaints. The ODH survey activities are conducted at least once every fifteen months per facility or more often if number and type of complaints warrant more immediate review. The identification of harmful practices cited by ODH requires the development and approval of a plan of correction. The ODA designee and ODA collaborate with the ODH to advise the regulatory agency of any concerns or adverse experiences regarding medication errors.

ODH provides a report to the entity which filed the complaint regarding the outcome of any complaints investigation, as well as the outcomes of annual surveys. The findings were maintained on ODA's Long Term Care Consumer Guide website (www.ltc.ohio.org).

ODA is responsible for conducting annual monitoring of the ODA's designees and a review and remediation of medication management issues identified through the critical incident reporting process outlined in Appendix G-1-a.

## 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).

The Ohio Department of Health's residential care facility rule OAC 3701-16-09 limits the administration of medication to a physician, a registered nurse, and a licensed practical nurse holding proof of successful completion of a course in medication administration under the direction or a registered nurse or physician, or a person authorized by law to administer medication (ie: certified medication aide).

A medication record for each participant is maintained which identifies each medication administered and any medication refused by the participant. Observations of negative reactions are recorded in the record and the participant's physician is contacted.

**iii. Medication Error Reporting.** *Select one of the following:*

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
*Complete the following three items:*

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

◉ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

The Ohio Department of Health (ODH) licensed residential care facility rules (Ohio Administrative Code OAC 3701-16-12) outlines the action a facility must take when an accident or episode occurs that presents a risk to the health, safety or well-being of a waiver participant.

The Conditions of Participation (OAC 173-39-02) for require the waiver provider to report, within 2 business days to the ODA's designee, medication errors with health and welfare implications. The ODA designee and the ODA follow the critical incident reporting process outlined in Appendix G-1.

**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.

Waiver providers that employ medical professionals with responsibility for the administration of medication to participants are monitored by the ODA designees on a quarterly basis as a part of the ODA designee's ongoing case management. At each quarterly contact, and as needed, the ODA designee case manager confirms the level of medication management ordered in the participants care plan is being delivered, confirms any changes in the medication regiment, reports to ODA any medication management errors, and assists the waiver provider and participant with the development of interventions to ensure medication management is delivered as ordered by the prescribing physician.

ODA monitors the waiver provider's management of the participants' medication management on at least an annual basis or as needed. Daily incident report oversight occurs at the ODA designee level in accordance with ODAs established incident reporting process. ODA and the ODA designee's will incorporate survey reports and information into its monitoring process.

ODH monitors medication management in the RCFs through standard survey activities conducted at least every fifteen months and complaint surveys which may take place more frequently than the standard survey. The identification of harmful practices cited by ODH requires the development and approval of a plan of correction. ODH will provide a report regarding the outcome of survey activity and plans of corrections to ODA.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

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

**a. Methods for Discovery: Health and Welfare**

***The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.*** *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

**i. Sub-Assurances:**

**a.** ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

**Performance Measures**

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

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

**Performance Measure:**
**G-2: Number and percent of unexplained deaths with a required need for investigation for which an investigation was completed according to rule requirements. N= Total number of unexplained death investigations completed according to rule requirements. D= Total number of unexplained death investigations.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**ODA WIRED data system**

| **Responsible Party for data collection/generation** *(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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>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**<br>Specify: |

**Performance Measure:**
**G-1: Number and percent of Abuse (physical, verbal, emotional, sexual), Neglect, Exploitation and Misappropriation incidents (over $500) reported into the ODA-approved incident management system within the required timeframe. N= Total number of ANEM incidents reported into the ODA-approved incident management system within the required timeframe. D= Total number of ANEM incidents.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**ODA WIRED data system**

| **Responsible Party for data 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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | | |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**b.** ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

**Performance Measures**

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

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

**Performance Measure:**

**G-3: Number and percent of Abuse (physical, verbal, emotional, sexual), Neglect, Exploitation, and Misappropriation Incident (over $500) investigations that were completed according to the rule requirements. N= Total number of ANEM investigations completed according to the rule requirements. D= Total number of ANEM investigations.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**ODA - WIRED data system**

| **Responsible Party for data collection/generation** *(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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**G-4: Number and percent of substantiated Abuse (physical, verbal, emotional, sexual), Neglect, Exploitation, and Misappropriation incidents (over $500) with a prevention plan developed as a result of the incident. N= Total number of ANEM prevention plans completed. D= Total number of ANEM incidents needing a prevention plan.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**ODA - WIRED data system**

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

| | | |
|---|---|---|
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c.** ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or*

*sub-assurance), complete the following. Where possible, include numerator/denominator.*

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

**Performance Measure:**
**G-5: Number and percent of substantiated unapproved restraint, seclusion or other restrictive intervention incidents with a prevention plan developed as a result of the incident. N= Total number of unapproved restraint prevention plans completed. D= Total number of unapproved restrain incidents needing a prevention plan.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**ODA- WIRED data system**

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

**d.** ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

**Performance Measures**

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

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

**Performance Measure:**
**G-6: Number and percent of incidents investigated for Abuse (physical, verbal, emotional, sexual), Neglect, Exploitation, and all Misappropriation (over $500) incidents investigated that involved paid caregivers. N= total number of ANEM incidents investigated that involved a paid caregiver. D= Total number of ANEM incidents that involved a paid caregiver.**

**Data Source** (Select one):
**Other**

If 'Other' is selected, specify:
**ODA - WIRED data system**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **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** | ☒ **Annually** |

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

**Performance Measure:**
**G-7: Number and percent of substantiated Provider Medication Error incidents with a prevention plan developed as a result of the incident. N= Total number of Provider Medication Error incidents with prevention plans completed. D= Total number of Provider Medication Error incidents needing a prevention plan.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Wired-ODA Data System**

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

| | | |
|---|---|---|
| | **Ongoing** | Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

**b. Methods for Remediation/Fixing Individual Problems**

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

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

ODA monitors both activities performed by the PAAs to assure that all provider enrollment and oversight requirements and protocols are followed. ODA's assessment methods and their frequency include, at minimum, quarterly review of established performance indicators, and analysis of the results from the PAA quarterly retrospective record reviews. ODA analyzes the data, upon discovery of non-compliance develops remediation plans (as needed), oversees the implementation of the remediation plan and evaluates the subsequent results. When non-compliance or opportunities for improvement are discovered, the individual PAA is notified and technical assistance is provided using on-site technical assistance, e-mail, phone contact, letters to PAA Director. When assessed as needed, ODM will provide individual PAA or state-wide training.

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

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

ODM and ODA collaborate to identify and communicate observed trends, propose changes to rules and protocols, and support ongoing improvement in systems intended to assure compliance with waiver assurances.

**ii. Remediation Data Aggregation**

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

| **Responsible Party***(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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

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

◉ **No**

○ **Yes**

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

## Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

**Quality Improvement Strategy: Minimum Components**

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## Appendix H: Quality Improvement Strategy (2 of 3)

## H-1: Systems Improvement

**a. System Improvements**

**i.** Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

ODM system improvement activities as described in Appendix A of this waiver application.

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

ODA monitors both activities performed by the PAAs to assure that all provider enrollment and oversight requirements and protocols are followed. ODA's assessment methods and their frequency include, at minimum, quarterly review of established performance indicators, and analysis of the results from the PAA quarterly retrospective record reviews. ODA analyzes the data, upon discovery of non-compliance develops remediation plans (as needed), oversees the implementation of the remediation plan and evaluates the subsequent results. When non-compliance or opportunities for improvement are discovered, the individual PAA is notified and technical assistance is provided using on-site technical assistance, e-mail, phone contact, letters to PAA Director. When assessed as needed, ODM will provide individual PAA or state-wide training.

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

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

ODM and ODA collaborate through mechanisms described throughout this waiver application to identify and communicate observed trends, propose changes to rules and protocols, and support ongoing improvement in systems intended to assure compliance with waiver assurances.

**ii. System Improvement Activities**

| **Responsible Party***(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**<br>Specify:<br>ODA's designees | ☒ **Other**<br>Specify:<br>Continuous and ongoing |

**b. System Design Changes**

**i.** Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system

design changes. If applicable, include the state's targeted standards for systems improvement.

ODM monitoring and oversight responsibilities include ensuring that ODA is exercising its authority for the day-to-day operation of the waiver in accordance with federal Medicaid requirements. ODM supports and facilitates ongoing qualitative improvements in the systems, procedures, and protocols ODA employs to ensure conformity of providers, recipients, and other entities with federal Medicaid requirements. When a program component is determined to be out of compliance with federal Medicaid requirements, ODM will work with ODA to assess the root cause and develop and implement an appropriate course of action to remedy the program.

ODA monitoring and oversight and responsibilities include ensuring that the regional entities are establishing and implementing systems, procedures and protocols to ensure conformity of providers, recipients, staff, or other entities with federal Medicaid requirements. The ODA will support and facilitate ongoing qualitative improvements in the systems, procedures, and protocols at the PAA level. When a program component is determined to be out of compliance with federal Medicaid requirements, ODM will work with ODA to assess the root cause and develop and implement an appropriate course of action to remedy the problem.

ODM is responsible for ensuring ODA and PAA compliance with federal regulations, including the amount, duration and scope of services, free choice of providers, timeliness of delivery of services to waiver eligible participant and the availability of services statewide and conducts A-133 audits of the regional entities at least once every three years based on risk.

ODA is responsible for ensuring the PAAs performance is in accordance with the following, in order of precedence: Code of Federal Regulations, Ohio’s HCBS waivers, Ohio Revised Code, Ohio Administrative Code, and operational policies.

The assessment Methods and Frequency include: on-site operational reviews conducted every year; on-site technical assistance visits performed as needed; review of performance data related to screening, assessment, enrollments, disenrollments, and ongoing census on a monthly basis.

**ii.** Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

ODM in conjunction with ODA will, at least annually, review the effectiveness of the systems improvement strategy including plans of correction, quality improvement projections completed, technical assistance provided, and training offered to improve program operations.

## Appendix H: Quality Improvement Strategy (3 of 3)

### H-2: Use of a Patient Experience of Care/Quality of Life Survey

**a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):***

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

**b. Specify the type of survey tool the state uses:**

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ◉ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

# Appendix I: Financial Accountability

## I-1: Financial Integrity and Accountability

***Financial Integrity.*** *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

*Each of the PASSPORT Administrative Agencies (PAA) that the Department of Medicaid (ODM) passes funds on to receive and expend sufficient funding require an annual Single Audit as required by OMB Circular A-133. The Single Audits are performed by independent public accounting firms. The results of these audits are forwarded to ODA along with a corrective action plan to address any audit findings. ODA reviews the results of the audits and follows up with the PAA regarding their corrective action plans. ODA has achieved the goal of reviewing the Single Audit results within 45 days of receiving them.*

*In addition to the Single Audits, OMB Circular A-133 requires that ODA engage in a sub- recipient monitoring process. Each PAA is fiscally and programmatically monitored by ODA every year. ODA requires the PAAs to submit corrective action plans when the results of the monitoring visit identify noncompliance with laws, rules, regulations and/or ODA policy or weaknesses in internal accounting controls.*

*Each PAA also receives a financial and compliance audit performed by ODM, the Single State Medicaid Agency in Ohio.*

*ODM audits cost reports from ODA and the regional PAAs to establish that ODA and the PAA operations are compliant with applicable federal and state requirements, and with the terms and conditions established in three-party agreements between ODM, ODA, and each PAA. The state is currently utilizing a risk-based auditing approach. Under this approach, individual PAAs are audited at least once every three years and ODM determines which PAAs to audit by assessing various risk factors, including: percentage of program dollars, significant changes in expense levels, operational concerns, and the significance of prior audit findings. ODM will continue the practice of performing monthly desk reviews of PAA cost reports.*

*Additionally, as part of the subrecipient monitoring audit, the ODM assesses the fiscal and programmatic monitoring efforts of ODA to assure they satisfy the requirements of OMB Circular A-133. Incorporated within ODM's testing is an assessment as to whether ODA monitors the PAA's activities related to services rendered to beneficiaries and that ODA personnel verifies, on a sample basis, the accuracy and allowability of paid service units. ODM also examines and analyzes data from ODA's claims authorization system as a means to evaluate statewide compliance of paid claims. These sub-recipient audits are conducted annually and may be for a period of six months to one year based on risk.*

*ODM performs ongoing audits and reviews to verify the medical necessity and legitimacy of Medicaid paid claims, including whether claims are allowable, reasonable, and compliant with applicable requirements. On an annual basis ODM staff conduct a risk-assessment to determine which types of Medicaid providers and services represent higher risk for potential fraud, waste, abuse, or noncompliance with other requirements. To determine risk, ODM considers the amount of funds dispersed (materiality), reimbursement changes, fraud risk factors (opportunity, attitude, incentive, and pervasiveness), the strength of Ohio Administrative Code rules, recent rule changes, recent industry changes, control factors, and the program's age. All Risk Factors are rated on a scale of 1 to 10 and then weighted to generate a total risk assessment by category of service.*

*ODM relies on the outcomes of this risk assessment to guide its strategy for data mining (to identify abnormalities and/or outliers in relation to Medicaid paid claims) and to inform the design of direct audit and review activities. All Medicaid services provided under any Medicaid waiver are subject to the risk-based assessment and review.*

*ODM communicates the amount of monetary findings to ODA for tracking as an accounts receivable and for collection. ODM staff refer any provider suspected of engaging in fraudulent activities to the Attorney General's Medicaid Fraud Control Unit. Final resolution of these recovery efforts is managed by ODM and/or the office of the Attorney General as appropriate.*
*ODA also receives an annual Single Audit as performed by the Ohio Auditor of State and is audited under the same guidelines as the PAAs by ODM.*

*Independent audit requirements: The State requires the PASSPORT Administrative Agencies (PAA) to secure an independent audit of their financial statements on an annual basis. Assisted Living waiver providers are viewed as contractors and as such are not required to secure an independent audit.*

*On-site reviews: The Ohio Department of Aging (ODA) conducts on-site reviews of the PAAs on an annual basis. These reviews include both fiscal and program components to ensure the PAA adheres to state and federal law and program/operational guidance.*

*As outlined in the approved waiver, the Ohio Department of Medicaid (ODM) performs desk reviews of the PAAs. If a desk review performed by ODM reveals an issue, ODA may conduct an on-site review of the PAA at the direction of ODM.*

*Assignment of Risk Factors: A risk factor rating of low, medium or high is determined by the aggregate score of all components. The score assigned to each component is determined by the pre-audit environmental scan. Examples of when the assessment may lead to further action includes the following: an aggregate high-risk rating, a significant change in the rating compared to previous ratings, or an indication that previous actions to resolve findings were not effective or sustained.*

*All PAAs are reviewed annually.*

*Assisted Living service providers are subject to an in-person review by ODA or their designee within 365 days from the date of the provider's initial certification date. Thereafter in-person annual reviews are conducted. This schedule may not be modified.*

*Community transition service providers are subject to an in-person review by ODA or their designee within 365 days from date of the provider's initial certification date. Thereafter in-person annual reviews are conducted. At the discretion of ODA, ODM or their designee, structural reviews may be conducted, no more than every 3 years, when a) there are no findings against the provider during the provider's most recent review; b) the provider has not been determined as substantiated to be the violator of an incident described in OAC rule 5160- 45-05; c) the provider has not been the subject of more than one complaint investigation during the previous twelve months;*
*Scope of Claims Review: The on-site reviews conducted by the PAA of all waiver service providers in accordance with OAC 173-39-04 includes a claims review. The sample size of claims reviewed must be 10% of the provider's services furnished, at minimum, during the on-site visit. The frequency of the review is established above.*

## *Appendix I: Financial Accountability*

### *Quality Improvement: Financial Accountability*

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

***a. Methods for Discovery: Financial Accountability Assurance:***
***The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.*** *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

***i. Sub-Assurances:***

***a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.***
*(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

***Performance Measures***

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

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

***Performance Measure:***
***I-1: Number and percent of waiver claims paid using the correct input rate. Numerator: Number of waiver claims paid using the correct input rate. Denominator: Total number of submitted waiver claims.***

***Data Source*** *(Select one):*
***Analyzed collected data (including surveys, focus group, interviews, etc)***
*If 'Other' is selected, specify:*

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

***Performance Measure:***
***I-2: Number and percent of waiver claims submitted supported by required documentation at time of review. Numerator: Number of waiver claims submitted supported by required documentation at the time of review. Denominator: Total number of waiver claims submitted.***

***Data Source*** *(Select one):*
***Analyzed collected data (including surveys, focus group, interviews, etc)***
*If 'Other' is selected, specify:*

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

| | | |
|---|---|---|
| | | |
| | ☐ ***Other***<br>*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***<br>*Specify:* | ☒ ***Annually*** |
| | ☐ ***Continuously and Ongoing*** |
| | ☐ ***Other***<br>*Specify:* |

***Performance Measure:***
***I-3: Number and percent of claims paid for individuals who were enrolled on the waiver on the date of services. Numerator: Number of waiver claims paid for individuals who were enrolled on the waiver on the date of services. Denominator: Total number of submitted waiver claims.***

***Data Source*** *(Select one):*
***Analyzed collected data (including surveys, focus group, interviews, etc)***
*If 'Other' is selected, specify:*

| ***Responsible Party for data collection/generation*** *(check each that applies):* | ***Frequency of data collection/generation*** *(check each that applies):* | ***Sampling Approach****(check each that applies):* |
|---|---|---|
| ☐ ***State Medicaid Agency*** | ☐ ***Weekly*** | ☒ ***100% Review*** |

| | | |
|---|---|---|
| ☒ ***Operating Agency*** | ☐ ***Monthly*** | ☐ ***Less than 100% Review*** |
| ☐ ***Sub-State Entity*** | ☐ ***Quarterly*** | ☐ ***Representative Sample***<br>*Confidence Interval =* |
| ☐ ***Other***<br>*Specify:* | ☒ ***Annually*** | ☐ ***Stratified***<br>*Describe Group:* |
| | ☐ ***Continuously and Ongoing*** | ☐ ***Other***<br>*Specify:* |
| | ☐ ***Other***<br>*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***<br>*Specify:* | ☒ ***Annually*** |
| | ☐ ***Continuously and Ongoing*** |
| | ☐ ***Other***<br>*Specify:* |

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

***b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

***Performance Measures***

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

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

***Performance Measure:***
***I-4: Number and percent of waiver claims that were paid using the rate authorized for the service set in accordance with rule 5160-33-07 of the Administrative Code and not to exceed maximum rates set in rule 5160-1-06.5 of the Administrative Code. Numerator: Total number of claims paid using the authorized rate. Denominator: Total number of paid claims.***

***Data Source*** *(Select one):*
***Other***
*If 'Other' is selected, specify:*
***PASSPORT Information Management System (PIMS) MITS***

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

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

***Data Source*** *(Select one):*
***Other***
*If 'Other' is selected, specify:*
***PASSPORT Information Management System (PIMS) MITS***

| ***Responsible Party for data collection/generation*** *(check each that applies):* | ***Frequency of data collection/generation*** *(check each that applies):* | ***Sampling Approach****(check each that applies):* |
|---|---|---|
| ☒ ***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***<br>*Specify:* | ☒ ***Annually*** |
| | ☐ ***Continuously and Ongoing*** |
| | ☐ ***Other***<br>*Specify:* |

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

***b. Methods for Remediation/Fixing Individual Problems***

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

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

*ODA monitors both activities performed by the PAAs to assure that all provider enrollment and oversight requirements and protocols are followed. ODA's assessment methods and their frequency include, at minimum, quarterly review of established performance indicators, and analysis of the results from the PAA quarterly retrospective record reviews. ODA analyzes the data, upon discovery of non-compliance develops remediation plans (as needed), oversees the implementation of the remediation plan and evaluates the subsequent results. When non-compliance or opportunities for improvement are discovered, the individual PAA is notified and technical assistance is provided using on-site technical assistance, e-mail, phone contact, letters to PAA Director. When assessed as needed, ODM will provide individual PAA or state-wide training.*

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

***ii. Remediation Data Aggregation***

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

| ***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***<br>*Specify:* | ☐ ***Annually*** |
| | ☒ ***Continuously and Ongoing*** |
| | ☐ ***Other***<br>*Specify:* |

***c. Timelines***

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

◉ ***No***

○ ***Yes***

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

## *Appendix I: Financial Accountability*

***a. Rate Determination Methods.*** *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

*The Ohio Department of Medicaid and the Ohio Department of Aging are responsible for the development of the provider rates. ODM provides oversight in developing the methodology used to establish the rate and reviewing the data and analysis used compiled by ODA to determine the rates. The provider payment rates are set in Ohio Administrative Code (OAC) 5160-33-07 and, as part of the process of adopting Administrative Code.*

*Assisted Living Service:*
*A statewide rate setting methodology is used for the Assisted Living Service. One unit of assisted living service equals one calendar day. The payment rate is based on three service categories.*

*•Base assisted living service: This service category is the minimum threshold of service need for all individuals enrolled in the assisted living waiver program. The current rate per diem rate is set at a maximum of $130 per day. The current rate was established through a legislative budget increase, approved in the waiver application and effective 1/1/2024.*

*•Memory care assisted living service: This service category is inclusive of the base assisted living service, plus additional costs associated with care needs of individuals with a diagnosis of dementia. The current per diem rate is set at a maximum of $155 per day. The current rate was established through a legislative budget allocation, approved in the waiver application and effective 1/1/2024.*

*•Critical access assisting living service: This service category, newly effective 7/1/24, is inclusive of the base assisted living service, plus additional costs attributed to service providers with a census consisting of 50% or more Medicaid waiver enrollees. The rate is set at a maximum of $145 per day. This rate was established through legislative budget allocation and is newly proposed with the renewal of this waiver application.*

*As a result of Ohio's House Bill 33, the Ohio Department of Medicaid (ODM) biennial budget incorporated a new "critical access" reimbursement rate of $145/day for any assisted living waiver provider whose census is comprised predominantly of low-income residents who meet eligibility requirements for the Ohio Assisted Living Waiver. An Assisted Living Waiver provider is considered to "predominately serve low-income residents who meet eligibility requirements for the Ohio Assisted Living Waiver" if its census of Medicaid Assisted Living Waiver residents represents 50% or more of its entire resident census. The critical access reimbursement rate of $145/day is exclusive of any costs associated with room and board. The incremental rate of $15/day corresponds to roughly 30-60 minutes of additional staff time per day to meet each Medicaid resident's service needs. The incremental rate increase is supported by an analysis of data from the National Health and Aging Trends Study that shows that Medicaid residents in assisting living have 82% more self-care needs than non-Medicaid residents in assisted living. These self-care needs like bathing, dressing and toileting require more staff time, thus elevating the cost of care for Medicaid residents. Because of their higher self-care needs, Medicaid residents cost more, and as they increase as a percentage of the population in an assisted living community, they impose substantial additional costs on the provider while lowering private pay revenues which can offset those costs.*

*Community Transition Service*
*The State uses the negotiated market rate model of rate setting for this service. The service is reimbursed on a per job basis. The selected provider submits a bid for the provision of the service; the bid represents all the items/supports identified in the person-centered services plan. The accepted bid is authorized in the services plan. The maximum ceiling for the service is based on historical utilization of the service in the Money Follows the Person (MFP) grant and the PASSPORT, Assisted Living, and My Care waivers.*

***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:*

*Assisted Living waiver provider billings are submitted for review through ODA's ODM approved case management and billing system. Providers can either use a direct data entry module into the database or use a HIPAA compliant electronic data interchange. Paper invoices can also be submitted to the PAA for data entry into the system by PAA staff. The regional entities (as described in A-4) process the billings to determine the extent of payment to the providers. Prior to payment, service claims are verified against program ad provider service eligibility requirements, and in accordance with person-centered service plan authorizations.*

*Payment to providers comes from advances provided to the regional entities from state GRF dollars. Payment to providers comes from advances provided to the regional entities by ODA from state GRF dollars. After the payments are documented, ODA will compile a claim from the payment records and submit it through Ohio's MITS to in order for the state to obtain the federal share.*

*Providers have the option to bill and be directly reimbursed by ODM. They may choose to exercise this right during their provider certification process.*

## *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:*

*Provider claims are initially reviewed using ODA's claims processing system. This system contains edits to assure that the participant is enrolled, that the service is prior authorized, and it is delivered according to the participant's service plan using certified providers who have a Medicaid provider agreement. The system identifies an approved payment amount for each service.*

*ODA compiles claims from these approved payment records and submits an electronic file to ODM's claims processing system. The ODM claims processing system has controls in place to ensure that participants are Medicaid eligible and entitled to receive certain waiver services at a certain maximum cost for a given period of time; that providers are eligible to receive payment for those waiver services; and that providers are eligible to provide the certain waiver services.*

*Process for Removing Inappropriate billings: The State's claims validation and payment process is designed to reduce the likelihood of inappropriate billings being included in the State's FFP calculation.*
*Waiver providers submit claims into ODAs claims processing system. Prior to issuing payment, the provider claims are pre-adjudicated to determine the following conditions are met for service dates: participant eligibility, provider eligibility, service authorization, billing units are consistent with the authorization, and correct reimbursement rate.*

*Claims that are not validated by ODAs claims processing system are not paid, are not submitted to ODMs federally approved claims processing system for adjudication and subsequently are not included in the State's FFP calculation.*

*Claims that are validated by ODAs claims processing system are paid and ODA submits the claims to ODMs federally approved claims processing system. ODM adjudicates the claims in MITS to determine the following conditions are met for service dates: validity, eligibility, general policy restrictions, waiver policy restrictions and utilization auditing.*

*Claims that are not adjudicated in MITS are not included in the State's FFP calculation.*

*In addition, ODM compiles a report on a quarterly basis of all claims adjustments, including waiver claims. The report findings are categorized by federal fiscal year and inappropriate billings are removed from the State's FFP calculation.*

*Recouping payment for inappropriate billings: The State recoups payment for inappropriate billing in accordance with ORC 5164.57 and OAC 5160-1-27.*
*In accordance with OAC 173-39-04, providers are to refund overpayments, resulting from inappropriate billings to ODA using acceptable state auditing procedures including adjusting against a future payment or repayment of the overpaid claims.*

*In accordance with OAC 5160-1-19, providers are to refund overpayments to ODM within sixty days of discovery. Providers can offset overpaid claims against a future payment.*

***e. Billing and Claims Record Maintenance Requirement.*** *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

## *Appendix I: Financial Accountability*

### *I-3: Payment (1 of 7)*

***a. Method of payments -- MMIS*** *(select one):*

- (●) ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ( ) ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  *Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures*

*on the CMS-64:*

○ ***Payments for waiver services are not made through an approved MMIS.***

*Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:*

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

*Describe how payments are made to the managed care entity or entities:*

## *Appendix I: Financial Accountability*

### *I-3: Payment (2 of 7)*

***b. Direct payment.*** *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☒ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

*Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:*

*ODM uses the ODA and its regional entities as a limited fiscal agent to pay for all waiver services. As stated previously, waiver providers use the option of submitting their claims to the regional entities for payment. The regional entity adjudicates the claims using the ODA payment system edits to assure appropriateness and accuracy of payment. Subsequently, ODA compiles the claims for submission to ODM's claims system in order for the state to obtain FFP. ODM through its claims system will adjudicate the ODA claim.*

*Provider claims are initially adjudicated through ODAs electronic claims system. This system adjudicates claims to assure several factors are met for the service dates including:*
*-Participant is enrolled in the Assisted Living waiver program.*
*-Service is authorized by the case manager as shown through the service plan*
*-Number and types of units of services billed are included within the service plan.*
*-The provider is certified by ODA and has a Medicaid provider number.*
*-Payments to the provider are limited to the rates identified for each service*
*-ODA then compiles its claim for FFP from these approved payment records and submits an electronic file to ODM's claims system which is housed and maintained by ODM.*
*-The ODM system has controls in place to ensure that participants are Medicaid eligible and entitled to receive certain waiver services at a certain maximum cost for a given period of time; that providers are eligible to receive payment for those waiver services; and that providers are eligible to provide the certain waiver services.*

*After the PAA adjudicates the claim, the PAA sends the payment (check) to the provider. ODM's role is to adjudicate the ODA claim for federal reimbursement.*

*The regional entities are paid for administrative costs by ODM pursuant to the provisions in the Three-Party Agreements and pursuant to the standards of OMB Circular A-133. ODM performs audits of those costs as indicated in the three-party agreements at least once every 3 years. ODA performs fiscal audits every year to ensure the provider meets program and fiscal standards.*

*ODM may use the targeted review process, described in Appendix A, to determine whether ODA complies with financial accountability requirements for waiver enrollees. ODM selects a sample of enrollees and associated claims and verifies whether services were delivered within service limits as recorded in the ODA claims system. For enrollees with a recorded patient liability, claims data is reviewed to determine whether patient liability amounts were appropriately accounted for before claims were submitted to ODM for payment. Once patient liability is met, services are eligible for payment through Medicaid. To test the delivery of services in compliance with patient liability and assessed needs, PIMS service authorization and claims data is used for a sample of waiver enrollees. This data is used to review all authorized services for the selected enrollees to assure only those services were delivered. The data was tested to verify that patient liability was appropriately tracked and applied to claims and only authorized services were delivered within authorized limits and denied otherwise.*

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

*Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.*

## *Appendix I: Financial Accountability*

### *I-3: Payment (3 of 7)*

***c. Supplemental or Enhanced Payments.*** *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

*Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.*

## *Appendix I: Financial Accountability*

### *I-3: Payment (4 of 7)*

***d. Payments to state or Local Government Providers.*** *Specify whether state or local government providers receive payment for the provision of waiver services.*

○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*

◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

*Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:*

*Local Senior centers, human and social service agencies that provide the community transition services. State or local government providers do not receive payments that in the aggregate exceed the cost of the waiver services.*

## *Appendix I: Financial Accountability*

### *I-3: Payment (5 of 7)*

***e. Amount of Payment to State or Local Government Providers.***

*Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:*

◉ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

*Describe the recoupment process:*

## Appendix I: Financial Accountability

### I-3: Payment (6 of 7)

***f. Provider Retention of Payments.*** *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

*Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.*

## Appendix I: Financial Accountability

### I-3: Payment (7 of 7)

***g. Additional Payment Arrangements***

***i. Voluntary Reassignment of Payments to a Governmental Agency.*** *Select one:*

- ○ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ◉ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

*Specify the governmental agency (or agencies) to which reassignment may be made.*

*Ohio Department of Aging*

***ii. Organized Health Care Delivery System.*** *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

*Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:*

***iii. Contracts with MCOs, PIHPs or PAHPs.***

- (●) ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ( ) ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  *Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.*

- ( ) ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  *In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.*

## *Appendix I: Financial Accountability*

### *I-4: Non-Federal Matching Funds (1 of 3)*

***a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.*** *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

- [x] ***Appropriation of State Tax Revenues to the State Medicaid agency***
- [ ] ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

  *If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:*

☒ ***Other State Level Source(s) of Funds.***

*Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:*

*To the extent these funds are used for waiver services, the source of funds is a horse racing excise tax (ORC 3769) and some moneys from a nursing facility franchise fee (ORC- 5168) These funds are allocated directly to ODM through the state's biennial budget process.*

## *Appendix I: Financial Accountability*

### *I-4: Non-Federal Matching Funds (2 of 3)*

***b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.*** *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

*Check each that applies:*

☐ ***Appropriation of Local Government Revenues.***

*Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:*

☐ ***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:*

*The Ohio Department of Medicaid collects an annual franchise permit fee from each Ohio nursing home based on the number of licensed and certified beds in each facility.*

## *Appendix I: Financial Accountability*

### *I-5: Exclusion of Medicaid Payment for Room and Board*

***a. Services Furnished in Residential Settings.*** *Select one:*

○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

***b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.*** *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

*The waiver provider receives two separate payments: the monthly room and board payment and the service payment. These payments come from two different sources. The authorized service payments are paid to the provider by the ODA designee, adjudicated through ODAs electronic billing system and then through ODMs electronic billing system. The room and board payment is made by the waiver participant directly to the waiver provider. The state does not play any role in collecting or paying the room and board payment.*

*The state's role in the cost of room and board furnished in a residential setting to a waiver participant is limited to establishing the maximum monthly rate paid by a waiver participant. The provider may not charge the waiver participant a security deposit or an additional fee above the maximum monthly room and board rate to hold the living unit during a temporary absence (ie: hospital or short term nursing facility stay).*

*The room and board rate is the current Supplemental Security Income (SSI) federal benefit minus a $50.00 personal needs allowance. The room and board rate increases annually when the SSI benefit cost of living adjustment is applied. The state set the rate to coincide with the Supplemental Security Income to allow for participation in the assisted living waiver of the lowest income individuals. The room and board rate may not exceed the rate established by the state.*

## *Appendix I: Financial Accountability*

### *I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver*

***Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.*** *Select one:*

◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***

○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of***

***Medicaid services.***

*The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:*

## *Appendix I: Financial Accountability*

### *I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)*

***a. Co-Payment Requirements.*** *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- (●) ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ( ) ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

***i. Co-Pay Arrangement.***

*Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):*

***Charges Associated with the Provision of Waiver Services*** *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] ***Nominal deductible***
- [ ] ***Coinsurance***
- [ ] ***Co-Payment***
- [ ] ***Other charge***

*Specify:*

## *Appendix I: Financial Accountability*

### *I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)*

***a. Co-Payment Requirements.***

***ii. Participants Subject to Co-pay Charges for Waiver Services.***

***Answers provided in Appendix I-7-a indicate that you do not need to complete this section.***

## *Appendix I: Financial Accountability*

### *I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)*

***a. Co-Payment Requirements.***

***iii. Amount of Co-Pay Charges for Waiver Services.***

***Answers provided in Appendix I-7-a indicate that you do not need to complete this section.***

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

***a. Co-Payment Requirements.***

***iv. Cumulative Maximum Charges.***

***Answers provided in Appendix I-7-a indicate that you do not need to complete this section.***

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

***b. Other State Requirement for Cost Sharing.*** *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

*Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:*

## Appendix J: Cost Neutrality Demonstration

### J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

***Composite Overview.*** *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

***Level(s) of Care: Nursing Facility***

| Col. 1 | Col. 2 | Col. 3 | Col. 4 | Col. 5 | Col. 6 | Col. 7 | Col. 8 |
|---|---|---|---|---|---|---|---|
| Year | Factor D | Factor D' | Total: D+D' | Factor G | Factor G' | Total: G+G' | Difference (Col 7 less Column4) |
| 1 | 21579.00 | 6409.94 | 27988.94 | 48583.14 | 13033.56 | 61616.70 | 33627.76 |
| 2 | 21719.00 | 6602.23 | 28321.23 | 48583.14 | 13424.56 | 62007.70 | 33686.47 |
| 3 | 21788.00 | 6800.30 | 28588.30 | 48583.14 | 13827.30 | 62410.44 | 33822.14 |
| 4 | 23295.00 | 7004.31 | 30299.31 | 48583.14 | 14242.12 | 62825.26 | 32525.95 |
| 5 | 24401.00 | 7214.44 | 31615.44 | 48583.14 | 14669.38 | 63252.52 | 31637.08 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (1 of 9)

***a. Number Of Unduplicated Participants Served.*** *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

*Table: J-2-a: Unduplicated Participants*

| Waiver Year | Total Unduplicated Number of Participants (from Item B-3-a) | Distribution of Unduplicated Participants by Level of Care (if applicable) |
|---|---|---|
| | | Level of Care: |
| | | Nursing Facility |
| Year 1 | 5967 | 5967 |
| Year 2 | 6063 | 6063 |
| Year 3 | 6831 | 6831 |
| Year 4 | 7599 | 7599 |
| Year 5 | 8367 | 8367 |

## 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.*

*For each year the state calculates average length of stay as all client days in a given program year divided by the total unduplicated clients. The average length of stay is calculated based on actual experience through September 2018 and estimated phase-in and phase-out assumptions for future time periods. Changes in average length of stay over the course of the five-year renewal period are based on projected changes in enrollees over the waiver period and reflecting slightly shorter stays with more people phasing into the waiver than phasing out in a given year.*

*Average Length of Stay = [client days]/(total unduplicated clients).*

*Year 1 Average Length of Stay in client months per unduplicated participant= 233 days [1,390,947/5,967)] = 233*

*Year 2 Average Length of Stay in client months per unduplicated participant= 235 days [1,425,987/6,063)] = 235*

*Year 3 Average Length of Stay in client months per unduplicated participant= 233 days [1,593,411/6,831)] = 233*

*Year 4 Average Length of Stay in client months per unduplicated participant= 247 days [1,878,962/7,599)] = 247*

*Year 5 Average Length of Stay in client months per unduplicated participant= 257 days [2,154,051/8,367)] = 257*

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (3 of 9)

**c. Derivation of Estimates for Each Factor.** *Provide a narrative description for the derivation of the estimates of the following factors.*

**i. Factor D Derivation.** *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

*Development of the Factor D costs for the Assisted Living waiver program is based on historically filed experience for the covered services and adjusted for projected future enrollment. We reviewed historical experience for the covered services from the Assisted Living WY 3 372 report to ensure that historical experience aligned with projected future experience. Factor D for the new 5-year waiver period for the renewal (July 1, 2024 through June 30, 2029) was developed in the following manner:*

*Base number of users was estimated by determining the allocated number of users from the historically filed experience along with assumptions about future expectations, which is reflective of anticipated growth in the program due to the new Critical Access Assisted Living Service reimbursement level.*

*For the Community Transition Service, the percentage of members identified as using a service from the historical unduplicated participant count was applied to future projected unduplicated participant for Waiver Year 1.*

*For the Assisted Living Services, the percentage of total users was identified using the historical encounter data and the distribution between the three service levels was developed through data summaries and future expectations.*

- *Historical experience shows that approximately 50% of the population using Assisted Living services will utilize the Memory Care Assisted Living Service.*
- *We anticipate 20% of the Non-Memory Care beds will get paid the Critical Access rate with all remaining users in the base assisted living service level.*
- *The projected number of users for WY 1 represents the expected percentage of utilization multiplied by the projected unduplicated participant count for WY 1. Projected number of user growth from WY 1 to WY 5 of the renewal period reflects an increase of approximately 1.6% annually from WY 1 to WY 5 of the renewal period for the Community Transition Service, Base Assisted Living Service and Memory Care Assisted Living Service levels. The Critical Access Assisted Living Service is assumed to increase by approximately 1.6% from WY1 to WY2. Additional annual increases are projected for WY 3 to WY 5 based on an assumed 638 additional beds.*

*Baseline average units per user was calculated by adjusting the historically filed experience of average units per user by projected growth in the Average Length of Stay (ALOS). Therefore, a projected average units per user was developed based on WY 5 experience multiplied by the change in ALOS from WY 5 to WY 1. Change from WY 1 to WY 5 of the renewal period applied the same methodology. The change reflected in WY 1 of the renewal period for average units per user was calculated from the projected WY 5 average units per user multiplied by the estimated change in ALOS from WY5 of the currently approved waiver to WY1 of the renewal period.*

*The average cost per unit for the Base Assisted Living Service and Memory Care Assisted Living Service levels were updated to reflect budgetary changes effective January 1, 2024. The Base Assisted Living Service level average cost per unit was set to $130 per diem consistent with proposed legislative changes for provider reimbursement. This change was proposed under Ohio House Bill 33 targeting the nursing services crisis and the ability to provide quality home and community based services which reflected a rate increase from historical time periods of over 80%. The Critical Access Assisted Living Service level is equivalent to the base service with a $15 add-on for providers whose Medicaid population comprises greater than 50% of the individuals served. A 20% increase from the Base Assisted Living Service level was proposed to cover patients with dementia under the Memory Care Assisted Living Service level at an average cost per unit of $155 per diem. The average cost per unit for all services is held constant over the 5 waiver years.*

***ii. Factor D' Derivation.*** *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

*Base Year data reflects Waiver Year 3 of the current filing: July 1, 2021 through June 30, 2022 as reported in the waiver year 3 372 report.*

*Factor D’ was trended at a rate of 3.0% per year based on historical experience and budget forecast trends.*

***iii. Factor G Derivation.*** *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

*Base Year data reflects actual nursing facility experience for the MyCare Ohio institutional population during SFY 2022 (July 1, 2021 through June 30, 2022). This population serves as the proxy population for the Nursing Facility costs represented by Factor G in this waiver.*

*Factor G costs were trended at a rate of 0.0% per year based on historical experience and budget forecast trends.*

***iv. Factor G' Derivation.*** *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

*Base Year data reflects actual state plan service costs for the MyCare Ohio institutional population during SFY 2022 (July 1, 2021 through June 30, 2022). This population serves as the proxy population for the Nursing Facility level of care costs represented by Factor G' in this waiver.*

*Factor G' costs were trended at a rate of 3.0% per year based on historical experience and budget forecast trends.*

## *Appendix J: Cost Neutrality Demonstration*

### *J-2: Derivation of Estimates (4 of 9)*

***Component management for waiver services.*** *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

| *Waiver Services* | |
|---|---|
| *Assisted Living Service* | |
| *Community Transition Service* | |

## *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* |
|---|---|---|---|---|---|---|
| ***Assisted Living Service Total:*** | | | | | | ***128525250.00*** |
| *Base* | *day* | *2267* | *172.00* | *130.00* | ***50690120.00*** | |
| *Critical Access* | *day* | *567* | *172.00* | *145.00* | ***14140980.00*** | |
| *Memory Care* | *day* | *2834* | *145.00* | *155.00* | ***63694150.00*** | |
| ***Community Transition Service*** | | | | | | ***238000.00*** |
| | | | | ***GRAND TOTAL:*** | | ***128763250.00*** |
| | | | | ***Total Estimated Unduplicated Participants:*** | | ***5967*** |
| | | | | ***Factor D (Divide total by number of participants):*** | | ***21579.00*** |
| | | | | ***Average Length of Stay on the Waiver:*** | | *233* |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Total:** | | | | | | |
| Community Transition Service | per job | 119 | 1.00 | 2000.00 | **238000.00** | |
| | | | | **GRAND TOTAL:** | | **128763250.00** |
| | | | | **Total Estimated Unduplicated Participants:** | | **5967** |
| | | | | **Factor D (Divide total by number of participants):** | | **21579.00** |
| | | | | **Average Length of Stay on the Waiver:** | | 233 |

## *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 |
|---|---|---|---|---|---|---|
| **Assisted Living Service Total:** | | | | | | **131440320.00** |
| Base | day | 2304 | 173.00 | 130.00 | **51816960.00** | |
| Critical Access | day | 576 | 173.00 | 145.00 | **14448960.00** | |
| Memory Care | day | 2880 | 146.00 | 155.00 | **65174400.00** | |
| **Community Transition Service Total:** | | | | | | **242000.00** |
| Community Transition Service | per job | 121 | 1.00 | 2000.00 | **242000.00** | |
| | | | | **GRAND TOTAL:** | | **131682320.00** |
| | | | | **Total Estimated Unduplicated Participants:** | | **6063** |
| | | | | **Factor D (Divide total by number of participants):** | | **21719.00** |
| | | | | **Average Length of Stay on the Waiver:** | | 235 |

## *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 |
|---|---|---|---|---|---|---|
| **Assisted Living Service Total:** | | | | | | **148585870.00** |
| Base | day | 2340 | 172.00 | 130.00 | **52322400.00** | |
| Critical Access | day | 1223 | 172.00 | 145.00 | **30501620.00** | |
| Memory Care | day | 2926 | 145.00 | 155.00 | **65761850.00** | |
| **Community Transition Service Total:** | | | | | | **246000.00** |
| Community Transition Service | per job | 123 | 1.00 | 2000.00 | **246000.00** | |

| | |
|---|---|
| **GRAND TOTAL:** | **148831870.00** |
| **Total Estimated Unduplicated Participants:** | **6831** |
| **Factor D (Divide total by number of participants):** | **21788.00** |
| **Average Length of Stay on the Waiver:** | 233 |

## 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 |
|---|---|---|---|---|---|---|
| **Assisted Living Service Total:** | | | | | | **176771000.00** |
| Base | day | 2376 | 182.00 | 130.00 | **56216160.00** | |
| Critical Access | day | 1880 | 182.00 | 145.00 | **49613200.00** | |
| Memory Care | day | 2972 | 154.00 | 155.00 | **70941640.00** | |
| **Community Transition Service Total:** | | | | | | **250000.00** |
| Community Transition Service | per job | 125 | 1.00 | 2000.00 | **250000.00** | |

| | |
|---|---|
| **GRAND TOTAL:** | **177021000.00** |
| **Total Estimated Unduplicated Participants:** | **7599** |
| **Factor D (Divide total by number of participants):** | **23295.00** |
| **Average Length of Stay on the Waiver:** | 247 |

## 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* |
|---|---|---|---|---|---|---|
| ***Assisted Living Service Total:*** | | | | | | ***203909775.00*** |
| *Base* | *day* | *2412* | *189.00* | *130.00* | ***59262840.00*** | |
| *Critical Access* | *day* | *2547* | *189.00* | *145.00* | ***69800535.00*** | |
| *Memory Care* | *day* | *3018* | *160.00* | *155.00* | ***74846400.00*** | |
| ***Community Transition Service Total:*** | | | | | | ***254000.00*** |
| *Community Transition Service* | *per job* | *127* | *1.00* | *2000.00* | ***254000.00*** | |

| | |
|---|---|
| ***GRAND TOTAL:*** | ***204163775.00*** |
| ***Total Estimated Unduplicated Participants:*** | ***8367*** |
| ***Factor D (Divide total by number of participants):*** | ***24401.00*** |
| ***Average Length of Stay on the Waiver:*** | *257* |