

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 15-014	2. STATE OHIO
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2016	
5. TYPE OF PLAN MATERIAL (<i>Check One</i>):		
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT		
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate Transmittal for each amendment</i>)		
6. FEDERAL STATUTE/REGULATION CITATION: Section 1915(i) of the Social Security Act 42 CFR 431 Subpart E 42 CFR 441.710 42 CFR 447.200, 447.204	7. FEDERAL BUDGET IMPACT: a. FFY 2016 \$5,485.92 thousands b. FFY 2017 \$21,841.81 thousands	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 2.2-A, pages 23g and 23h Attachment 3.1-G, pages 1 through 62 Attachment 4.19-B, pages 2 and 3	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>):	
10. SUBJECT OF AMENDMENT: Eligibility, Coverage and Limitations, and Payment for Services: 1915(i) Home and Community-Based Services option		
11. GOVERNOR'S REVIEW (<i>Check One</i>):		
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED: The State Medicaid Director is the Governor's designee
12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO:	
13. TYPED NAME: JOHN B. McCARTHY	Carolyn Brewer Ohio Department of Medicaid P.O. BOX 182709 Columbus, Ohio 43218	
14. TITLE: STATE MEDICAID DIRECTOR		
15. DATE SUBMITTED:		
FOR REGIONAL OFFICE USE ONLY		
17. DATE RECEIVED:	18. DATE APPROVED:	
PLAN APPROVED – ONE COPY ATTACHED		
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME:	22. TITLE:	
23. REMARKS:		

Instructions on Back

Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the State is **also** covering the optional categorically needy eligibility group of individuals under 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the State under section 1915(c), (d) or (e) or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income benefit rate. (select at least one):

The State covers all of the individuals described in item 1(a) and (b) as described below. Complete 1(a) and 1(b):

Or

The State covers only the individuals described in either item 1(a) or (b) as described below. Complete 1(a) OR 1(b):

1(a). Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services.

Income Standard 150% FPL

Methodology used (Select one)

SSI

OTHER (describe):

For states that have elected the SSI methodology, the State uses the following less restrictive 1902(r)(2) income disregards for this group. There is no resource test for this group. (specify):

After SSI countable income, the State disregards income in the amount of the difference between 150% of the Federal Poverty Level (FPL) and 300% of the FBR plus a \$20 disregard for personal needs.

1(b). Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income benefit rate. For individuals eligible for 1915(c), (d) or (e) waiver services, this amount must be the same amount as the income standard specified under your state plan for the special income level group. For individuals eligible for 1915(c) like services under an approved 1115, this amount must be the same as the amount of the income standard used for individuals using institutional rules. (Select one):

- 300% of the SSI/FBR
- (Specify) _____ % Less than 300% of the SSI/FBR

The State uses the same eligibility criteria that it uses for the special income level group.

The State covers only the following group individuals described below. Complete 1(a) or 1(b):

1(a). Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services.

Income Standard 150% FPL

Methodology used (Select one) SSI
 OTHER (describe):

**1915(i) State plan Home and Community-Based Services
Administration and Operation**

The State implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below.

1. Services. *(Specify the State’s service title(s) for the HCBS defined under ‘Services’ and listed in Attachment 4.19-B):*

Recovery Management (RM), Peer Recovery Support (PRS) and Individualized Placement and Support- Supported Employment (IPS-SE).

2. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one):*

<input checked="" type="radio"/>	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program <i>(select one)</i> :		
<input checked="" type="radio"/>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;">The Medical Assistance Unit <i>(name of unit)</i>:</td> <td style="width: 50%; padding: 5px;">Ohio Department of Medicaid</td> </tr> </table>	The Medical Assistance Unit <i>(name of unit)</i> :	Ohio Department of Medicaid
The Medical Assistance Unit <i>(name of unit)</i> :	Ohio Department of Medicaid		
<input type="radio"/>	Another division/unit within the SMA that is separate from the Medical Assistance Unit <i>(name of division/unit)</i> This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.		
<input type="radio"/>	The State plan HCBS benefit is operated by <i>(name of agency)</i> : A separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

3. Distribution of State plan HCBS Operational and Administrative Functions.

(By checking this box the State assures that): When the Medicaid agency does not directly conduct an administrative 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. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (check each that applies):

(Check all agencies and/or entities that perform each function):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2 Eligibility evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3 Review of participant Person-Centered Plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4 Prior authorization of State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5 Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6 Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Execution of Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Establishment of a consistent rate methodology for each State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

1. Information for potential enrollees will be disseminated by the Medicaid Agency (the Ohio Department of Medicaid [ODM]), the Ohio Department of Mental Health and Addiction Services (OhioMHAS) (collectively referred to as the state), the independent entities contracted to perform enrollments/re-enrollments and to provide the recovery management service, Single Entry Points (SEPs) under Ohio's balancing incentive program (BIP), and enrolled provider agencies.
2. ODM makes the final 1915(i) enrollment eligibility decision. Program eligibility determinations and re-determinations, except for financial, will be performed by the independent entities. The Medicaid financial eligibility reviews and the final 1915(i) enrollment will be performed by ODM. Targeting, risk, and needs-based criteria assessments and person-centered planning will be performed by Recovery Managers employed by statewide independent entities, pursuant to state issued policies and procedures. Utilization management staff who report through different lines of authority within the independent entities will serve as the evaluator for verifying program eligibility and for approving the Person-Centered Plan.
3. Review of participant Person-Centered Plans will be conducted by the independent entity contracted with the state, pursuant to state-approved policies and procedures. When 1915(i) services are the responsibility of a managed care plan, the plan will review Person-Centered Plans as part of the managed care plans' utilization management activities. If an individual in the 1915(i) is assigned to/enrolled in a comprehensive care management program operated by an accountable entity (e.g., patient centered medical home, or managed care plan) the individual and the Recovery Manager will participate in the care planning process as a member of the trans-disciplinary team which is directed by the accountable entity's care manager. The Person-Centered Plan developed by the individual and the Recovery Manager will be incorporated into the individualized care plan developed and maintained by the entity accountable for the comprehensive care management. The entity accountable for comprehensive care management will work with the Recovery Manager to coordinate the individual's full set of Medicaid (and Medicare) benefits and community resources across the continuum of care, including behavioral, medical, LTSS, and social services.
4. Prior Authorization of Person-Centered Plans will be conducted by the independent entity contracted with the state, pursuant to state-approved policies and procedures, or by a managed care plan when the 1915(i) services are the responsibility of the managed care plan.
5. Utilization management will be conducted by the independent entity contracted with the state pursuant to state-approved policies and procedures, and by a managed care plan when the 1915(i) services are the responsibility of the plan.
6. Qualified provider enrollment will be conducted by the state.
7. Execution of Medicaid provider agreements with 1915(i) providers will be conducted by ODM.
8. Establishment of a consistent rate methodology for each State plan HCBS is completed by the Medicaid agency. Managed care plans will establish contracted rates when the 1915(i) services are the responsibility of the plan.
9. State rules governing the State plan HCBS benefit are promulgated by ODM. Policies, procedures and information will be jointly developed by ODM and OhioMHAS.

10. Quality assurance and quality improvement activities will be conducted by ODM and/or its designee pursuant to the quality improvement strategy (QIS) and state-approved policies and procedures.

(By checking the following boxes the State assures that):

4. **Conflict of Interest Standards.** The State assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
- related by blood or marriage to the individual, or any paid caregiver of the individual
 - financially responsible for the individual
 - empowered to make financial or health-related decisions on behalf of the individual
 - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the State, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement):*

ODM makes the final 1915(i) enrollment eligibility decisions. Program Eligibility determinations, except for financial, will be performed by the independent entity. The financial eligibility reviews for Medicaid will be performed by county departments of job and family services, on behalf of ODM, and the final 1915(i) enrollment will be performed by ODM. Targeting, risk, and clinical needs-based criteria assessments and person-centered planning will be performed by Recovery Managers employed by statewide independent entities, pursuant to state issued policies and procedures. Person-centered planning will be performed by the managed care plans when 1915(i) services are the responsibility of the managed care plan. The needs based assessments and Person-Centered Plans will be reviewed and approved by the independent entities contracted with the state pursuant to the quality improvement strategy (QIS).

Utilization management staff and Recovery Managers employed by the independent entities and staff at the individual's managed care plan are prohibited from being related by blood or marriage to the individual or their family members or having any financial relationships with the individual requesting services, their families or the entity selected to provide the state plan 1915(i) services. The independent entity, Recovery Managers, managed care plans, and their employees who are performing the verification of the assessments and/or and developing and approving the Person-Centered Plan are not and will not be providers of PRS or IPS-SE. The independent entities have no financial relationship with any care providers in the state.

Eligibility assessments and proposed Person-Centered Plans are completed and submitted by the Recovery Managers to the utilization review staff at the independent entity for needs-based eligibility determination. Person-Centered Plan approval is performed for eligibility determination and utilization review purposes. The independent entity reviews the documentation to determine if the needs-based criteria are met and to ensure the independence of the person performing the assessment and person-centered planning process.

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Responsibility for 1915(i) needs-based eligibility determination and approval of the initial Person-Centered Plan proposed services, in all cases, is retained by the independent entity in order to ensure no conflict of interest in the final determinations. The Recovery Manager submits the results from the face-to-face assessment, required supporting documentation, and a proposed Person-Centered Plan to the independent entity for an independent review. The independent entity approves needs-based clinical eligibility for 1915(i) services based upon its review of the clinical documentation of applicant's identified needs and alignment of needs with goals and recommended services. The state also requires documentation, signed by the applicant/individual, that attests to the following:

- 1) The individual is an active participant in the planning and development of the 1915(i) Person-Centered Plan.
- 2) The individual is the person requesting 1915(i) services on the Person-Centered Plan.
- 3) The individual received a list of eligible 1915(i) service provider agencies in his or her community and has selected the provider(s) of his or her choice to deliver the 1915(i) service or services on the Person-Centered Plan.

In addition, the independent entities and managed care plans are required to have written policies and procedures available for review by the state which clearly define and describe how conflict of interest requirements are implemented and monitored. The state ensures compliance through policies designed to be consistent with CMS conflict of interest assurances and through quality assurance activities.

The following conflict mitigation strategies are utilized by ODM and its designees:

- Assuring that individuals can advocate for themselves or have an advocate present in care planning meetings;
- Documenting that the individual has been offered choice among all qualified and/or managed care plan-contracted providers of direct services;
- Making continuing efforts to recruit and retain a choice of HCBS provider agencies;
- Having clear, well-known, and easily accessible means for individuals to make grievances and/or appeals to the State, or its designee, for assistance regarding concerns about choice, quality, and outcomes.
- OhioMHAS, ODM and the assigned managed care ombudsman office are also available via toll-free lines to assist individuals in resolving issues with Medicaid providers, Medicaid managed care plans or services. Information on these rights and grievance/appeal processes will be provided in writing to each enrolled individual.
- Documenting the number and types of appeals and the decisions regarding grievances and/or appeals, analyzing trends and patterns in case systems and performing remediation as needed.
- Having the independent entities, managed care plans and State staff oversee 1915(i) providers to assure individual choice and control are not compromised.
- Conducting periodic on-site reviews, desk reviews and analysis of aggregate and individual data.
- Documenting individual experiences with measures that capture the quality of Individual Person-Centered Plan (IRP) development.

External Quality Review Organization (EQRO) review of managed care plan care management processes for individuals who assess their 1915(i) services through their managed care plan is the responsibility of the plan.

5. **Fair Hearings and Appeals.** The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.
6. **No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.
7. **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually.

(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	07/01/2016	12/31/2016	5,500
Year 2	01/01/2017	12/31/2017	5,650
Year 3	01/01/2018	12/31/2018	5,800
Year 4	01/01/2019	12/31/2019	5,950
Year 5	01/01/2020	12/31/2020	6,100

2. **Annual Reporting.** *(By checking this box the State agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. **Medicaid Eligible.** *(By checking this box the State assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State’s Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act.)

2. **Income Limits.**

In addition to providing State plan HCBS to individuals described in item 1 above the State is **also** covering the optional categorically needy eligibility group of individuals under 1902(a)(10)(A)(ii)(XXII) who are eligible for home and community-based services under the needs-based criteria established under 1915(i)(1)(A) or who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d), (e), or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income federal benefit rate. *(Select one):*

The State covers all of the individuals described in item 2(a) and (b) as described below. *(Complete 2(a) and 2(b))*

The State covers only the following group of individuals described below. *(Complete 2(a) or 2(b))*

2. (a) Individuals not otherwise eligible for Medicaid who meet the needs-based criteria for the 1915(i) benefit, have income that does not exceed 150% of the federal poverty line, and will receive 1915(i) State plan HCBS.

Methodology used (*Select one*): AFDC
 SSI
 OTHER (*Describe*):

For States that have elected the AFDC or the SSI methodology, the State uses the following less restrictive 1902(r)(2) income disregards for this group. There is no resource test for this group. (*Specify*):

After SSI countable income, the State disregards income in the amount of the difference between 150% of the Federal Poverty Level (FPL) and 300% of the Federal Benefit Rate (FBR) plus a \$20 disregard for personal needs.

2.(b) Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d), (e), or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income federal benefit rate. For individuals eligible for 1915(c), (d), or (e) waiver services, this amount must be the same amount as the income standard specified under your State plan for the special income level group. For individuals eligible for 1915(c)-like services under an approved 1115, this amount must be the same as the amount of the income standard used for individuals found eligible using institutional eligibility rules. (*Select one*):

- 300% of the SSI/FBR
- (*Specify*) _____% Less than 300% of the SSI/FBR

(*Select one*):

Specify the 1915(c) waiver/waivers CMS base control number/numbers for which the individual would be eligible: _____

Specify the name(s) or number(s) of the 1115 waiver(s) for which the individual would be eligible:

3. Medically Needy. (*Select one*):

<input checked="" type="radio"/>	The State does not provide State plan HCBS to the medically needy.
<input type="radio"/>	The State provides State plan HCBS to the medically needy (<i>select one</i>):
<input type="radio"/>	The State elects to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a State makes this election, medically needy individuals only receive 1915(i) services.
<input type="radio"/>	The State does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

4. Presumptive Eligibility. The State, at its option, elects to provide for a period of presumptive eligibility (not to exceed a period of 60 days) only for those individuals that the State has reason

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to believe may be eligible for home and community-based services. Such presumptive eligibility shall be limited to medical assistance for carrying out the independent evaluation and assessment to determine an individual’s eligibility for such services and if the individual is so eligible, the specific home and community-based services that the individual will receive.

Evaluation/Reevaluation of Eligibility

1. Responsibility for Performing Evaluations / Reevaluations. Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

<input type="radio"/>	Directly by the Medicaid agency
<input checked="" type="radio"/>	By Other (<i>specify State agency or entity under contract with the State Medicaid agency</i>): ODM will make the final 1915(i) State plan enrollment determination based on information collected from the Recovery Managers, which has been independently validated by the independent entity contracted with the state. The professional performing the initial evaluation of financial eligibility (a financial eligibility worker), the service assessment and developing the Person-Centered Plan (Recovery Managers) cannot also be a provider on the Person-Centered Plan for PRS and IPS-SE services. Appeal rights are granted as a result of a 1915(i) eligibility determination.

2. Qualifications of Individuals Performing Evaluation/Reevaluation. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. (*Specify qualifications*):

Recovery Managers and reviewers at the independent entities conducting the state evaluation for eligibility determination and recommendation of the Person-Centered Plans hold a least a bachelor’s degree in social work, counseling, psychology, or similar field and have a minimum of 3 years post degree experience working with individuals with severe and persistent mental illness (SPMI). Recovery Managers must be trained in the following: person-centered planning, how to administer the Adult Needs and Strengths Assessment (ANSA) tool, HCBS compliant settings, HIPAA privacy requirements, 42 CFR part 2 confidentiality of alcohol and drug abuse patient records, and incident management (including incident reporting, prevention planning, and risk mitigation).

Supervision of staff at the independent entities who are performing eligibility determinations/redeterminations and authorizing Person-Centered Plans is provided by clinically licensed staff from the fields of nursing, social work, psychology, or psychiatry. All individuals must be trained on the eligibility evaluation and assessment tools and criteria used the State.

3. Process for Performing Evaluation/Reevaluation. Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used

to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

Information about 1915(i) services is posted on the ODM and OhioMHAS public websites. It will also be posted on benefits.ohio.gov/longtermcare. This website will summarize the eligibility criteria, the available services, how to access the independent entities and Recovery Managers, locations where potential enrollees may go to apply, and how to access assessments and services. There is no wrong door for an individual to enter the 1915(i) program:

- The Single Entry Points (SEP) in Ohio may refer an individual.
- Any provider or Medicaid managed care plan may refer potential enrollees who are believed to meet the 1915(i) eligibility criteria to the program.
- Any individuals may request screening in the 1915(i) program and contact the state for information about 1915(i) eligibility and the process to apply.

Depending on the entry point, if the individual is new to the system, the SEP or independent entity will perform a brief screen with the individual to determine if an individual will potentially meet eligibility criteria (targeting, risk, and financial criteria). If the individual is already receiving mental health services, the individual's referring provider can perform this brief screen. All individuals meeting targeting, risk, and financial criteria contained within the brief screen are referred to the independent entities. Once referred individuals choose a Recovery Manager, the Recovery Manager completes the face-to-face assessment, determines if the individual meets the needs-based criteria, and completes the initial person-centered planning process and 1915(i) referral form developed by the state.

The Recovery Manager will collect supporting documentation that provides specific information about the person's health status, current living situation, family functioning, vocational/employment status, social functioning, living skills, self-care skills, capacity for decision making, potential for self-injury or harm to others, substance use/abuse, need for assistance managing a medical condition, and medication adherence.

The Recovery Managers and the applicant jointly develop a Person-Centered Plan that includes all federally required elements including desired goals and services requested and deemed necessary to address these goals. Please see the section 'Supporting the Participant in Person-Centered Plan Development' for further details regarding person-centered care planning. Upon completion of the referral packet (including but not limited to the ANSA, verification of HCBS compliant living arrangement, eligibility checklist, documentation supporting the SPMI diagnosis, and initial Person-Centered Plan), the Recovery Manager submits the documents to the utilization management staff at the independent entity through a secure, HIPAA compliant process.

Upon receipt of the referral packet, the independent entity reviews all submitted documentation and determines whether or not the applicant meets the targeting, risk, and needs-based criteria for 1915(i) and approves, requests changes or denies the Person-Centered Plan. The independent entity sends eligibility information to ODM. All official eligibility determinations and denials are made by ODM or its designee.

Time spent by the independent entity and Recovery Manager for the referral, eligibility evaluation, person-centered planning, and approval of Person-Centered Plans cannot be billed or reimbursed under the 1915(i) benefit before eligibility for this benefit has been determined. Presumptive eligibility under the 1915(i) is requested for these administrative activities. The Recovery Manager’s eligibility evaluation and assessment for individuals not already eligible for Medicaid as well as the eligibility determination process completed by the independent entity are billed as an administrative activity.

Enrollment into the 1915(i) occurs on the date when all programmatic and financial criteria are met. Once the eligibility determination is completed a notice is sent by ODM to the applicant. Once enrolled in the 1915(i), services on the initial Person-Centered Plan may begin immediately following approval of that plan. When the 1915(i) services are the responsibility of a managed care plan, services may begin immediately upon authorization by the managed care plan. If the individual requires immediate 1915(i) services to remain in the community, and meets both financial and non-financial eligibility criteria, the Recovery Manager may develop an initial Person-Centered Plan and initiate services while the Person-Centered Plan is being reviewed by the independent entity.

Per the request on page 9 of this state plan amendment, the State is requesting presumptive eligibility under the 1915(i) in order to administratively claim for these activities in anticipation of the individuals being found eligible for the 1915(i) program.

If determined ineligible for the 1915(i) service due to not meeting the needs-based criteria or financial criteria, a denial notice is sent to the applicant by ODM informing them that their application for this program and service has been denied. The notice is generated by ODM and will include the reason for denial, and appeal rights and process. The Recovery Manager will communicate this denial to the individual and discuss alternative options and resources available to the individual.

Re-evaluations for continued 1915(i) services follow this same process.

The evaluation/reevaluation must use the targeting, risk, and needs-based assessment criteria using the ANSA as outlined in this 1915(i) State plan. The evaluation/reevaluation must be performed by a qualified independent individual listed in number 2 above.

4. **Reevaluation Schedule.** *(By checking this box the State assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. **Needs-based HCBS Eligibility Criteria.** *(By checking this box the State assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual’s support needs, and may include other risk factors: *(Specify the needs-based criteria):*

In order to be eligible for enrollment in the 1915(i) individuals must:

1. Have been assessed using the Adult Needs and Strengths Assessment (ANSA) and score a Level of 2 or higher on the 'mental health needs' or 'risk behaviors' domains or scored a Level of 3 on the 'life domain functioning' domain.
2. Demonstrate needs related to the management of his or her behavioral health as documented in the ANSA.
3. Demonstrate a need for home and community-based services outlined in the State Plan 1915(i) application and would not otherwise receive that service.
4. Have been determined to meet the Social Security Administration's definition of disability.
5. Have at least one of the following risk factors during the five years previous to enrollment in the 1915(i) program:
 - More than 30 days of psychiatric inpatient services at an inpatient psychiatric hospital
 - Three or more psychiatric inpatient admissions at an inpatient psychiatric hospital
 - Discharged from psychiatric inpatient services after an inpatient stay greater than 60 days at an inpatient psychiatric hospital
 - Discharged from correctional facilities with a history of inpatient or outpatient behavioral health treatment.
 - Two or more emergency department (ED) visits with primary psychiatric diagnosis.
 - A history of extended, repeated inpatient psychiatric stay(s) or extended tenure (three years or more of consecutive or cumulative hospitalization) in an inpatient psychiatric hospital

And either

6. Have one of the following needs based risk factors: requires the HCBS level of service to maintain stability, improve functioning, prevent relapse, maintain residence in the community, AND who is assessed and found that, but for the provision of HCBS for stabilization and maintenance purposes, would decline to prior levels of need (i.e., subsequent medically necessary services and coordination of care for stabilization and maintenance is needed to prevent decline to previous needs-based functioning).

Or

7. Previously have met the needs-based criteria above AND who is assessed and found that, but for the provision of HCBS for stabilization and maintenance purposes, would decline to prior levels of need (i.e., subsequent medically necessary services and coordination of care for stabilization and maintenance is needed to prevent decline to previous needs-based functioning).

Note: the individual must meet the needs-based criteria above (which are less than the inpatient level of care) and does not need to currently require an inpatient level of care for enrollment. This program does not exclude individuals needing institutional levels of care from enrolling. A history of hospitalization alone does not qualify someone for inpatient admission.

Qualifying Adult Needs and Strengths Assessment (ANSA) Criteria

Persons scoring a 2 or above on at least one of the items in the ‘mental health needs’ or ‘risk behaviors’ sections of the ANSA or persons scoring a 3 on at least one of the items in the ‘life domain functioning’ may be eligible for 1915(i) service(s).

The ANSA tool consists of items that are rated as:

‘0’ no evidence or no need for action

‘1’ need for watchful waiting to see whether action is needed

‘2’ need for action

‘3’ need for either immediate or intensive action due to a serious or disabling need

The items are grouped into categories or domains. Once the assessment has been completed, the agency staff receives a level of need recommendation based on the individual item ratings. The level of need recommendation from the ANSA is not intended to be a mandate for the level of services that an individual receives. There are many factors, including individual preferences and choice that influence the actual intensity of treatment services.

The mental health needs domains includes scoring on psychosis, impulse control, depression, anxiety, interpersonal problems, antisocial behavior, adjustment to trauma, anger control, substance use, and eating disturbance. The risk behaviors domain includes scoring on suicide risk, self-injurious behavior, other self-harm, gambling, exploitation, danger to others, sexual aggression, and criminal behavior.

Life functioning domain includes scoring on Physical/Medical; Family Functioning; Employment; Social Functioning; Recreational; Intellectual; Sexuality; Living Skills; Residential Stability; Legal; Sleep; Self Care; Decision Making; Involvement in Recovery; Transportation; and Medication Involvement.

The user’s manual for the ANSA may be found on-line at: [Adult Needs and Strengths Assessment \(ANSA\)](#)

6. **Needs-based Institutional and Waiver Criteria.** *(By checking this box the State assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the State has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

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Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/MR (& ICF/MR LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
<p>Persons scoring a 2 or above on at least one of the items in the ‘mental health needs’ or ‘risk behaviors’ sections of the ANSA and persons scoring a 3 on at least one of the items in the ‘life domain functioning’ section of the ANSA may be eligible for 1915(i) service(s).</p> <p>The ANSA tool consists of items that are rated as:</p> <p>‘0’ no evidence or no need for action ‘1’ need for watchful waiting to see whether action is needed ‘2’ need for action ‘3’ need for either immediate or intensive action due to a serious or disabling need</p> <p>The mental health needs domains</p>	<p>For 21 years and older</p> <p>Need for a minimum of one of the following:</p> <ul style="list-style-type: none"> ● Assistance with the completion of a minimum of 2 ADLs including: <ul style="list-style-type: none"> ○ Bathing (The adult needs assistance with applying cleansing agent and/or rinsing and/or drying.) ○ Dressing (The adult needs assistance with putting on and taking off an item of clothing/prosthesis and/or fastening and unfastening an item of clothing/prosthesis.) ○ Eating (The adult needs assistance with getting food into his or her mouth and/or chewing and/or swallowing.) ○ Grooming (The adult needs assistance with oral hygiene and hair care (either washing or brushing/coming hair) and nail care (either cutting fingernails or toenails.)) ○ Mobility (The adult needs assistance 	<p>For individuals age 10 and older, the criteria for a developmental disability level of care is met when:</p> <p>(a) The individual has been diagnosed with a severe, chronic disability that:</p> <ul style="list-style-type: none"> i. Is attributable to a mental or physical impairment or combination of mental and physical impairments, other than an impairment caused solely by mental illness; ii. Is manifested before the individual is age 22; and iii. Is likely to continue indefinitely. <p>(b) The condition is substantial functional limitations in at least three of the following major life activities, as determined through use of the developmental disabilities level of care assessment:</p> <ul style="list-style-type: none"> i. Self-care; ii. Receptive and expressive communication; iii. Learning; 	<p>The individual’s long term services and supports needs must exceed the criteria for the intermediate level of care or the developmental disabilities level of care.</p> <p>The individual requires a minimum of 1 of the following:</p> <ul style="list-style-type: none"> ● One skilled nursing service within the day on no less than 7 days per week. ● One skilled rehabilitation service within the day on no less than 5 days per week. <p>The individual must also have an unstable medical condition.</p>

<p>includes scoring on psychosis, impulse control, depression, anxiety, interpersonal problems, antisocial behavior, adjustment to trauma, anger control, substance use, and eating disturbance. The risk behaviors domain includes scoring on suicide risk, self-injurious behavior, other self-harm, gambling, exploitation, danger to others, sexual aggression, and criminal behavior. Life functioning domain includes scoring on Physical/Medical; Family Functioning; Employment; Social Functioning; Recreational; Intellectual; Sexuality; Living Skills; Residential Stability; Legal; Sleep; Self Care; Decision Making; Involvement in Recovery;</p>	<p>with bed mobility and/or locomotion and/or transfers inside the house.)</p> <ul style="list-style-type: none"> ○ Toileting (The adult needs assistance with using a toilet/urinal/bedpan and/or changing incontinence supplies/feminine hygiene products and/or cleansing him- or herself.) <p>OR</p> <ul style="list-style-type: none"> ● Assistance with the completion of 1 ADL as listed above and with medication self-administration. OR ● A minimum of 1 skilled nursing service or skilled rehabilitation service. OR ● 24 Hour support, in order to prevent harm, due to a cognitive impairment, as diagnosed by a physician or other licensed health professional and as determined by the BCAT. <p>*When an adult’s long term services and supports needs meet the criteria above, and the adult has a diagnosis of a developmental disability, but not an intellectual disability, and the adult is expected to require lifelong assistance with ADLs due to a physical limitation, the criteria for intermediate level of care is met.</p>	<ul style="list-style-type: none"> iv. Mobility; v. Self-direction; vi. Capacity for independent living; and vii. Economic self-sufficiency. <p>(c) The condition reflects the individual’s need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance of lifelong or extended duration that are individually planned and coordinated.</p>	
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Transportation; and Medication Involvement.			
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*Long Term Care/Chronic Care Hospital

7. **Target Group(s).** The State elects to target this 1915(i) State plan HCBS benefit to a specific population. With this election, the State will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the State may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C). *(Specify target group(s)):*

This 1915(i) State plan HCBS benefit is targeted to persons age 21 and over and who are diagnosed with one of the following behavioral health diagnoses. (Note: the X is used to indicate that all disorders within a category are included).			
Current SPMI Diagnosis Codes			
DSM IV Code	DSM 5 Code	Disorder	ICD-10
295.1X		Schizophrenia, Disorganized Type <i>(In DSM 5 Disorganized subtype no longer used)</i>	F20.1
295.2X	295.90	Schizophrenia, Catatonic Type <i>(In DSM 5 Catatonic subtype no longer used)</i>	F20.2
295.3X		Schizophrenia, Paranoid Type <i>(In DSM 5 Paranoid subtype no longer used)</i>	F20.0
295.4X	295.40	Schizophreniform Disorder	F20.81
295.6X	295.90	Schizophrenia, Residual Type <i>(In DSM 5 Residual subtype no longer used)</i>	F20.5
295.7X	295.70	Schizoaffective Disorder <ul style="list-style-type: none"> • Schizoaffective disorder, bipolar type • Schizoaffective disorder, depressive type • Other Schizoaffective disorders • Schizoaffective disorder, unspecified 	F25.0 F25.1 F25.8 F25.9
295.8X	295.90	Other types of Schizophrenia, unspecified	F.20.9
295.9X	295.90	Schizophrenia, Undifferentiated Type <i>(In DSM 5 Undifferentiated subtype no longer used)</i>	F20.3
296.0X		Bipolar I disorder, single episode <i>(In DSM 5 Bipolar single episode, manic no longer used)</i>	F30.10

296.4X	296.4X	Bipolar I disorder, most recent episode (or current) manic	
		<ul style="list-style-type: none"> Bipolar I disorder, most recent episode (or current) manic, unspecified 	F31.9 F31.11
		<ul style="list-style-type: none"> Bipolar I disorder, most recent episode (or current) manic, mild 	F31.12 F31.13
		<ul style="list-style-type: none"> Bipolar I disorder, most recent episode (or current) manic, moderate 	F31.2
		<ul style="list-style-type: none"> Bipolar I disorder, most recent episode (or current) manic, severe, without mention of psychotic behavior 	
		<ul style="list-style-type: none"> Bipolar I disorder, most recent episode (or current) manic, severe, specified as with psychotic behavior 	
296.5X	296.5X	Bipolar I disorder, most recent episode (or current) depressed	
		<ul style="list-style-type: none"> Bipolar I disorder, most recent episode (or current) depression, unspecified 	F31.9
		<ul style="list-style-type: none"> Bipolar I disorder, most recent episode (or current) depression, mild 	F31.31 F31.32
		<ul style="list-style-type: none"> Bipolar I disorder, most recent episode (or current) depression, moderate 	F31.4
		<ul style="list-style-type: none"> Bipolar I disorder, most recent episode (or current) depression, severe without mention of psychotic behavior 	F31.5
		<ul style="list-style-type: none"> Bipolar I disorder, most recent episode (or current) depression, severe specified as with psychotic behavior 	
296.6X		Bipolar I disorder, most recent episode (or current) mixed (<i>This Bipolar subtype was removed from DSM 5</i>)	F31.60
		<ul style="list-style-type: none"> Bipolar I disorder, most recent episode (or current), mixed, unspecified 	F31.61
		<ul style="list-style-type: none"> Bipolar I disorder, most recent episode (or current), mixed, mild 	F31.62
		<ul style="list-style-type: none"> Bipolar I disorder, most recent episode (or current), mixed, moderate 	F31.63
		<ul style="list-style-type: none"> Bipolar I disorder, most recent episode (or current), mixed, severe without mention of psychotic behavior 	F31.64
		<ul style="list-style-type: none"> Bipolar I disorder, most recent episode (or current), mixed, severe, specified as with psychotic behavior 	
296.7	296.7	Bipolar I disorder, most recent episode (or current) unspecified	F31.9
296.89	296.89	Bipolar II disorder	F31.81
298.9	298.9	Psychosis NOS (<i>in DSM 5 referred to as Unspecified</i>)	F29
296.23	296.23	Major Depressive Affective Disorder, single episode, severe, without mention of psychotic behavior	F32.2
296.24	296.24	Major Depressive Disorder, single episode, severe, with mention of psychotic behavior (<i>In DSM 5, "With Psychotic Features" is its own specifier, and, when present, is used instead of Mild, Moderate, or Severe, not in addition to Severe</i>)	F32.3
296.33	296.33	Major Depressive Disorder, Recurrent, Severe Without Psychotic Features (<i>In DSM 5, "Without Psychotic Features" is not a further specifier</i>)	F33.2

296.34	296.34	Major Depressive Disorder, Recurrent, Severe With Psychotic Features <i>(In DSM 5, "With Psychotic Features" is its own specifier, and, when present, is used instead of Mild, Moderate, or Severe, not in addition to Severe)</i>	F33.3
<p>Individuals in the 1915(i) cannot be concurrently enrolled in another HCBS authority (e.g., a 1915(c) waiver). The individual will be enrolled in the HCBS authority best meeting the totality of the individual’s needs regardless of the order in which the individual applied or became eligible for the HCBS authority subject to the choice of the individual (e.g., if the individual was on the 1915(i) but became eligible to be enrolled for a 1915(c) waiver that better met his or her needs, then the individual, at his or her option, could be enrolled in the 1915(c) waiver and disenrolled from the 1915(i) – conversely, an individual on a 1915(c) waiver whose needs are better met by the 1915(i) may choose to be enrolled in the 1915(i) and disenrolled from the 1915(c) waiver).</p>			

(By checking the following boxes the State assures that):

8. **Adjustment Authority.** The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. **"Home and Community-Based Settings":**

The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution (*Explain how residential and non-residential settings in this SPA comply with Federal HCB Settings requirements at 42 CFR 441.710(a)-(b) and associated CMS guidance. Include a description of the settings where individuals will reside in and where individuals will receive HCBS, and how these settings meet the Federal HCB Settings requirements, at the time of submission and in the future*):

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal HCB Setting requirements, at the time of this submission and ongoing.)"

All 1915(i) services are provided to individuals who reside in home and community based settings meeting HCBS characteristics (i.e., are not located within or on the grounds of an institutional setting, are integrated in and support 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 as individuals not receiving Medicaid HCBS). These individuals must also receive their 1915(i) services in their home or the community.

The Recovery Manager will review the HCBS living and provider settings of all individuals receiving State Plan 1915(i) services and ensure that all individuals live and receive services in settings that meet the standards at 42 CFR 441.710, annually, through random onsite reviews. The independent entity will review and validate compliance with setting requirements. ODM, or its designee, will oversee the independent entities and enforce compliance actions as necessary.

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The Recovery Manager's responsibility is to ensure the resident's involvement in decisions that affect his or her care, daily schedules, and lifestyle. The overall atmosphere of the setting is conducive to the achievement of optimal independence, safety, and development by the resident with his or her input. The location of the facility is made to provide residents reasonable access to the community at large, by public or agency-provided transportation, including but not limited to agency, medical, recreational, and shopping areas. Please note: the certified residential settings are intended to be homes where the individual lives. The majority of services and behavioral healthcare is provided in other locations outside of the residence, such as in the community at large or in a clinic setting. The 1915(i) services are designed to be delivered in community settings including, but not exclusively, in the individual's home.

Many persons eligible for the 1915(i) services live in their own home or with families or friends in the same manner as any adult who does not have a mental illness. Due to the eligibility criteria for the 1915(i) services, there are some persons seeking these services who do not have family or friends with whom they can live or are not functioning at a level where their health and safety can be supported in a totally independent setting. Depending upon the person's level of need and functioning, he or she may choose to live in full time supervised settings (settings that provide less than full time supervision or settings that provide no on-site supervision). The responses below relate only to living environments that are not fully independent.

In order to be considered community-based, settings must meet the following standards:

- a. The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
- b. The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the Person-Centered Plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
- c. Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- d. Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- e. Facilitates individual choice regarding services and supports, and who provides them.
- f. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.

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- g. Individuals are able to have visitors of their choosing at any time.
- h. The setting is physically accessible to the individual.
- i. Any modification of the additional conditions, under §441.301(c)(4)(vi) (A) through (D), must be supported by a specific assessed need and justified in the Person-Centered Plan. The following requirements must be documented in the Person-Centered Plan:
 - i. Identify a specific and individualized assessed need.
 - ii. Document the positive interventions and supports used prior to any modifications to the Person-Centered Plan.
 - iii. Document less intrusive methods of meeting the need that have been tried, but did not work.
 - iv. Include a clear description of the condition that is directly proportionate to the specific assessed need.
 - v. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
 - vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
 - vii. Include the informed consent of the individual.
 - viii. Include an assurance that interventions and supports will cause no harm to the individual.

Individuals will not reside or receive 1915(i) services in any of the following settings:

- Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,
- Any setting that is located in a building on the grounds of, or immediately adjacent to, a public institution, or
- Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS

Person-Centered Planning & Service Delivery

(By checking the following boxes the State assures that):

1. There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:
 - An objective face-to-face assessment with a person-centered process by an agent that is independent and qualified;
 - Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse/partner, family, guardian, and treating and consulting health and support professionals caring for the individual;
 - An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the Person-Centered Plan;

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- An examination of the individual’s physical and mental health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the Person-Centered Plan, a caregiver assessment;
- If the State offers individuals the option to self-direct State plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual’s representative, to exercise budget and/or employer authority; and
- A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.

2. Based on the independent assessment, the individualized Person-Centered Plan:

- Is developed with a person-centered process in consultation with the individual, and others at the option of the individual such as the individual’s spouse, family, guardian, and treating and consulting health care and support professionals. The person-centered planning process must identify the individual’s physical and mental health support needs, strengths and preferences, and desired outcomes;
- Takes into account the extent of, and need for, any family or other supports for the individual, and neither duplicates, nor compels, natural supports;
- Prevents the provision of unnecessary or inappropriate care;
- Identifies the State plan HCBS that the individual is assessed to need;
- Includes any State plan HCBS in which the individual has the option to self-direct the purchase or control ;
- Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
- Is reviewed at least every 12 months and as needed when there is significant change in the individual’s circumstances.

3. **Responsibility for Face-to-Face Assessment of an Individual’s Support Needs and Capabilities.**

There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. *(Specify qualifications):*

Recovery Managers conducting the face-to-face evaluation for eligibility determination/redetermination must have:

- Bachelor’s degree in social work, counseling, psychology, or similar field;
- Minimum of 3 years post degree experience working with individuals with severe and persistent mental illness (SPMI);
- Training in administering ANSA,
- Training in person-centered planning,
- Training in evaluating HCBS living arrangements,
- Training in HIPAA privacy requirements,
- Training in 42 CFR part 2 confidentiality of alcohol and drug abuse patient records,
- Training in incident reporting,
- Meet state conflict of interest standards.

- 4. Responsibility for Person-Centered Plan Development.** There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, Person-Centered Plan. *(Specify qualifications):*

Individualized, Person-Centered Plans are developed by individuals meeting the requirements in #3 above.

- 5. Supporting the Participant in Person-Centered Plan Development.** Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the Person-Centered Plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

All Person-Centered Plans are to be developed with the individual and consider his or her needs, goals, and preferences. The individual has authority to determine who is included in the person-centered care planning process. "Person-centered planning" is a process directed by the individual that identifies his or her strengths, values, capacities, preferences, needs, and desired outcomes. Person-Centered Plans require staff and individual signatures as well as documentation of individual participation. The independent entity reviews and approves or denies all Person-Centered Plans, including proposed 1915(i) services, to ensure the applicant/individual participated in the Person-Centered Plan development and to prevent a conflict of interest. When 1915(i) services are the responsibility of a managed care plan, the Recovery Manager and the individual will be participants on the trans-disciplinary care team. The following process and expectations are adhered to by Recovery Managers developing the Person-Centered Plan with the individuals:

The Person-Centered Plan is developed through a collaborative process that includes input from the applicant/individual, identified community supports (family/nonprofessional caregivers), the Recovery Manager, primary care/specialists, and managed care plan staff involved in assessing and/or providing care for the applicant/individual. The Person-Centered Plan is a comprehensive plan that integrates all components and aspects of care that are deemed medically necessary, needs based, are clinically indicated, and are provided in the most appropriate setting to achieve the individual's goals.

A Person-Centered Plan must be developed with each applicant/individual. The Person-Centered Plan must be comprehensive and include all indicated medical, behavioral health, and support service coordination needed by the applicant/individual in order to reside in the community, to function at the highest level of independence possible, and to achieve his or her goals.

The Person-Centered Plan is developed by:

- Review, discussion and documentation of the applicant/individual's desires, needs, and goals.
- Goals are recovery, habilitative or rehabilitative in nature with outcomes specific to the needs identified by the applicant/individual.

- Review of psychiatric symptoms and how they affect the applicant/individual's functioning, and ability to attain desires, needs and goals and to self-manage health services.
- Review of the applicant/individual's skills and the support needed for the applicant/individual to manage his or her health condition and services.
- Review of the applicant/individual's strengths and needs, including medical and behavioral.
- Including all people the individual has identified.

The individualized Person-Centered Plan is developed by the individual and the Recovery Manager and the trans-disciplinary care team, when the 1915(i) services are the responsibility of a managed care plan and includes:

- The short and long term goals as defined by the individual.
- The strengths, needs, and preferences as identified by the individual
- The identified Medicaid and non-Medicaid services
- The nature, amount and scope of the identified 1915(i) services.
- The nature of the non-Medicaid services and supports
- The Person-Centered Plan reflects that the setting in which the individual resides is chosen by the individual. The setting chosen by the individual is integrated in, and supports full access of, individuals receiving 1915(i) services to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving 1915(i) services.
- The Person-Centered Plan reflects the individual's strengths and weaknesses.
- The Person-Centered Plan reflects the clinical and support needs as identified through an assessment of functional need.
- The Person-Centered Plan includes individually identified goals and desired outcomes.
- The Person-Centered Plan reflects 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.
- The Person-Centered Plan reflects risk factors and measures to minimize them, including individualized back up plans and strategies when needed.
- The Person-Centered Plan is understandable to the individual and others. The Person-Centered Plan is written in plain language and in a manner that is accessible to individuals with disabilities and persons with limited English proficiency.
- The Person-Centered Plan identifies Care Manager responsible for monitoring the plan.
- The Person-Centered Plan was finalized and agreed to, with the individual's informed consent in writing, and signed by the individual and the 1915(i) service providers responsible for its implementation and explains how the final Person-Centered Plan will be distributed to the individual and providers.
- The Person-Centered Plan prevents the provision of unnecessary or inappropriate services and supports.
- If any restrictive interventions or supports to address a risk were identified then the PCP must include the following:

- Identify the specific and individualized assessed need.
- Document the positive interventions and supports used prior to any modifications to the person-centered service 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.
- Informed consent of the individual or legal representative or guardian.
- Assurance that interventions and supports will cause no harm to the individual.

The Recovery Manager who assists the individual in developing his or her Person-Centered Plan does so with the active involvement of the individual. The Recovery Manager will then:

- Provide the applicant/individual of 1915(i) services a list of eligible provider agencies and services offered in his or her geographic area, or which are under contract with the managed care plan.
- Support the individual in selecting providers of choice.
- Links the individual to his or her selected providers.

The Person-Centered Plan must reflect the individual's desires and choices. The individual's signature demonstrates his or her participation in the development and ongoing review of their Person-Centered Plan. Records must be maintained and are subject to State and/or Federal audit. The individual must attest to participation in the development of the Person-Centered Plan. On occasion, an individual may refuse to sign the Person-Centered Plan for reasons associated with the individual's behavioral health diagnosis. If an individual refuses to sign the Person-Centered Plan, the Recovery Manager is required to document on the Person-Centered Plan that the individual was present at the development of the plan and agreed to the plan but refused to sign. The Recovery Manager must also document in the Person-Centered Plan record that a planning meeting with the individual did occur and that the Person-Centered Plan reflects the individual's choice of services and agreement to participate in the services identified in the Person-Centered Plan. The Person-Centered Plan record must contain an explanation of why the individual refused to sign the plan and how this will be addressed in the future.

If an individual in the 1915(i) is assigned to/enrolled in a comprehensive care management program operated by an accountable entity (e.g., patient centered medical home, or managed care plan) the individual and the Recovery Manager will participate in the care planning process as a member of the trans-disciplinary team, which is directed by the accountable entity's care manager. The Person-Centered Plan developed by the individual and the Recovery Manager will be incorporated into the individualized care plan developed and maintained by the entity accountable for the comprehensive care management. The entity accountable for comprehensive care management will work with the Recovery

Manager to coordinate the individual's full set of Medicaid and Medicare benefits and community resources across the continuum of care, including behavioral, medical, LTSS, and social services.

Each eligible 1915(i) Recovery Manager and managed care plan is required to provide a written statement of rights to each individual. The statement shall include:

- (1) The toll-free consumer service line number and the telephone number for Ohio protection and advocacy, including any ombudsman assigned to the individual's managed care program.
- (2) Document that the Recovery Manager provides both a written and an oral explanation of these rights to each applicant/individual.

All complaints/grievances regarding 1915(i) provider agencies may be submitted to:

- The individual's managed care plan or
- The "Ohio Medicaid Consumer Hotline" (1-800-324-8680)

6. Informed Choice of Providers. *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the Person-Centered Plan):*

The Recovery Manager will inform the individual of qualified provider options as a part of the PCP creation and ongoing maintenance process. Documentation regarding provider choice will be included in the individual's Person-Centered Plan record.

The Recovery Manager explains the process for making an informed choice of provider(s) and answers questions. The applicant/individual is also advised that choice of providers and provider agencies is ongoing for the duration of the program. Therefore, providers within an agency and provider agencies themselves can be changed upon request from the individual. The State maintains a network of 1915(i) providers.

A list of qualified agency providers is presented to the individual by the independent entity, managed care plan or Recovery Manager. Individuals, and anyone of their choosing, may interview potential service providers and make their own choice. Managed care plans must maintain online and paper provider directories from which managed care enrollees may choose providers.

7. Process for Making Person-Centered Plan Subject to the Approval of the Medicaid Agency. *(Describe the process by which the Person-Centered Plan is made subject to the approval of the Medicaid agency):*

"Person-centered planning" is a process directed by the individual that identifies his or her strengths, values, capacities, preferences, needs, and desired outcomes. The process includes team members who assist and support the individual to identify and access medically necessary services and supports needed to achieve his or her defined outcomes in the most inclusive setting. The individual and team identify goals, objectives, and interventions to achieve these outcomes which are documented on the person-centered services plan by the Recovery Manager.

“Person-centered services plan” is the document that identifies 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.

ODM staff prior authorize Person-Centered Plans when projected costs for services detailed in the Person-Centered Plan exceed established thresholds. Managed care plans prior authorize 1915(i) services in accordance with 42 CFR 438.210. ODM monitors service planning through the ongoing review process and EQRO contract for managed care plan review. ODM also retains the right to review and modify Person-Centered Plans at any time.

8. Maintenance of Person-Centered Plan Forms. Written copies or electronic facsimiles of Person-Centered Plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Person-Centered Plans are maintained by the following (*check each that applies*):

<input checked="" type="checkbox"/>	Medicaid agency	<input type="checkbox"/>	Operating agency	<input checked="" type="checkbox"/>	Case manager
<input checked="" type="checkbox"/>	Other (<i>specify</i>):	Managed Care Plan			

Services

1. State plan HCBS. (*Complete the following table for each service. Copy table as needed*):

Service Specifications (<i>Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover</i>):	
Service Title:	Recovery Management
Service Definition (Scope):	
<p>Recovery Management includes coordinating all services received by an individual and assisting the individual in gaining access to needed Medicaid State Plan and 1915(i) services, as well as medical, social, educational, and other resources, regardless of funding source. Recovery Managers are responsible for monitoring the provision of services included in the Person-Centered Plan to ensure that the individual’s needs, preferences, health, and welfare are promoted. The Recovery Manager:</p> <ul style="list-style-type: none"> • Coordinates / leads development of the Person-Centered Plan using a person-centered planning approach which supports the individual in directing and making informed choices according to the individual’s assessed needs, preferences, and personal goals, and considers health and safety risk factors; • Coordinates all services received by the individual including logistical support, advocacy and education to assist individuals in navigating the healthcare system. 	

- Provides supporting documentation to be considered by the independent entity in the review and approval process;
- Identifies services / providers, brokers to obtain and integrate services, facilitates, and advocates to resolve issues that impede access to needed services;
- Develops / pursues resources to support the individual's recovery goals including non-HCBS Medicaid, Medicare, and/or private insurance or other community resources;
- Assists the individual in identifying and developing natural supports (family, friends, and other community members) and resources to promote the individual's recovery;
- Informs individuals of fair hearing rights;
- Assists the individual with fair hearing requests when needed and upon request;
- Assists the individual with retaining HCBS and Medicaid eligibility;
- Educates and informs individuals about services, the individual person-centered planning process, resources for recovery, rights, and responsibilities;
- Actively coordinates with other people and/or entities essential to physical and/or behavioral services for the individual (including the individual's managed care plan or patient-centered medical home) to ensure that other services are integrated and support the individual's recovery goals, health, welfare, and wellness. The goal of active coordination is to ensure that there are no gaps in or duplication of services. Coordination includes activities that help individuals gain access to needed health (physical and behavioral health) services, manage their health conditions such as adhering to health regimens, scheduling and keeping medical appointments, obtaining and maintaining a primary medical provider and facilitating communication across providers.
- Actively participates in the care planning process as a member of the trans-disciplinary team which is directed by the accountable entity's care manager when an individual in the 1915(i) program is assigned to/enrolled in a comprehensive care management program operated by an accountable entity (e.g. patient centered medical home or managed care plan). The Person-Centered-Plan developed by the individual and the Recovery Manager will be incorporated into the individualized care plan developed and maintained by the entity accountable for the comprehensive care management. The entity accountable for comprehensive care management will work with the Recovery Manager to coordinate the individual's full set of Medicaid and Medicare benefits and community resources across the continuum of care, including behavioral, medical, LTSS, and social services.
- Coordination of health services across systems, including but not limited to:
 - Physician consults
 - Serving as a communication conduit between the consumer and specialty medical and behavioral health providers

- Notification, with the individual's permission, of changes in medication regimens and health status
- Coaching to individuals to help them interact more effectively with providers
- Monitors health, welfare, wellness, and safety through regular monthly contacts (calls and visits with the individual, paid and unpaid supports, and natural supports) wherever the individual lives, works, or has activities;
- Responds to and assesses emergency situations and incidents and assures that appropriate actions are taken to protect the health, welfare, wellness, and safety of individuals;
- Monitors Plan of Care services, which includes but is not limited to review of providers' service documentation, the individual's participation and satisfaction with services and evaluating appropriate utilization, quality of services, gaps in care. Through the ongoing monitoring process, if there is discovery of a significant change event (e.g., inpatient hospital admission), the Recovery Manager will contact the individual by telephone by the end of the next calendar day. If there is confirmation of a significant change event, then a face to face visit must take place by the end of the third calendar day following the discovery.
- Updates the assessment, as applicable, and the Person-Centered Plan, based on information discovered during ongoing monitoring, which must occur as expeditiously as the individual's needs warrant but no later than fourteen (14) calendar days from the date the change in need/status is identified. Revisions to the Person-Centered Plan should occur no less frequently than annually
- Initiates Person-Centered Plan or trans-disciplinary team discussions and meetings when services are not achieving desired outcomes;
- Advocates for continuity of services, system flexibility and integration, proper utilization of facilities and resources, accessibility, and individual rights; and
- Participates in any activities related to quality oversight and provides reporting as required.

The contact schedule, including frequency and mode of contact (telephone or in-person), will be determined by the individual's assignment to a risk stratification level. Assignment to the appropriate risk stratification level will be completed by the independent entity or by the managed care plan. If the 1915(i) services are the responsibility of a managed care plan, the contract schedule will be established by the independent entity and the managed care plan, as applicable, as part of the authorization of recovery management services. Contacts and related activities are necessary to ensure the Person-Centered plan is effectively implemented and adequately addresses the needs of the individual. The activities and contacts may be with the individual, family members, non-professional care givers, providers, and other entities. Monitoring and follow-up is necessary to help determine if services are being furnished in accordance with a Person-Centered Plan, the adequacy of the services in the individualized

TN: 15-014

Supersedes:

TN: New

Approved: _____

Effective: 07/01/2016

integrated care plan, and changes in the needs or status of the individual. This function includes making necessary adjustments in the Person-Centered Plan and service arrangement with providers.

Recovery management includes functions necessary to facilitate community transition for individuals who receive Medicaid-funded institutional services. Recovery management activities for individuals leaving institutions must be coordinated with, and must not duplicate, institutional and managed care plan discharge planning and other community transition programs. This service may be provided up to 180 days in advance of anticipated movement to the community.

The maximum caseload for a Recovery Manager providing services through this program is set by the State, and includes individuals in other waiver or state plan programs and other funding sources, unless the requirement is waived by the State.

Services must be delivered in a manner that supports the consumer’s communication needs, including age-appropriate communication and translation services for individuals that are of limited-English proficiency or who have other communication needs requiring translation assistance.

Specify limits (if any) on the amount, duration, or scope of this service for (*chose each that applies*):

<input checked="" type="checkbox"/>	Categorically needy (<i>specify limits</i>):
	The following activities are excluded from recovery management as a billable 1915(i) service: <ul style="list-style-type: none"> • Travel time incurred by the Recovery Manager may not be billed as a discrete unit of service; • Services that constitute the administration of another program such as child welfare or child protective services, parole and probation functions, legal services, public guardianship, special education, and foster care; • Representative payee functions; and • Other activities identified by ODM
<input type="checkbox"/>	Medically needy (<i>specify limits</i>): NA

Provider Qualifications <i>(For each type of provider. Copy rows as needed):</i>			
Provider Type <i>(Specify):</i>	License <i>(Specify):</i>	Certification <i>(Specify):</i>	Other Standard <i>(Specify):</i>
Recovery Manager (RM) enrolled and contracted with ODM or its designee (a managed care plan) to provide recovery management services, or a recovery management entity which employs or contracts with individual recovery management providers (RMs).			<p>RMs must:</p> <ul style="list-style-type: none"> • Demonstrate knowledge of issues affecting people with severe and persistent mental illness and community-based interventions/resources for this population. • Complete ODM-required training in the 1915(i) program. • Hold a bachelor’s degree in social work, counseling, psychology, or similar field. • Have a minimum of 3 years post degree experience working with individuals with severe and persistent mental illness (SPMI). • Be trained in administering the ANSA, eligibility evaluation and assessment tools used by the State • Be trained in person-centered planning. • Be trained in incident management, including incident reporting, prevention planning, and risk mitigation. • Be trained in evaluating HCBS living arrangements. • Be trained in health insurance portability and accountability act (HIPAA) privacy requirements, 42 CFR part 2

			<p>confidentiality of alcohol and drug abuse patient records.</p> <p>Supervisor will have supervisory experience related to the scope of work and will have a Bachelor's degree plus 5 years of experience.</p>

Verification of Provider Qualifications *(For each provider type listed above. Copy rows as needed):*

Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>
HCBS provider agency	ODM or its designee	Annual

Service Delivery Method. *(Check each that applies):*

<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed
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Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title:	Individualized Placement and Support-Supported Employment (IPS-SE)
Service Definition (Scope):	
<p>Individualized Placement and Support-Supported Employment (IPS-SE) promotes recovery through the implementation of evidence based and best practices which allow individuals to obtain and maintain integrated competitive meaningful employment by providing training, ongoing individualized support, and skill development that honor client choice. The outcome of an employment service is that individuals will obtain and maintain a job of their choosing through rapid job placement which will increase their self-sufficiency and further their recovery. Employment services should be coordinated with mental health services and substance use treatment and services.</p> <p>Consistent with the purpose and intent of this service definition, IPS-SE shall include at least one of the following evidence based and best practice employment activities, as provided by the Qualified IPS-SE provider and as listed below:</p> <ol style="list-style-type: none"> 1. Vocational Assessment 	

2. Development of a Vocational Plan ;
3. On-the-job Training and skill development;
4. Job seeking skills training (JSST);
5. Job development and placement;
6. Job coaching;
7. Individualized job supports, which may include regular contact with the employers, family members, guardians, advocates, treatment providers, and other community supports;
8. Benefits planning;
9. General consultation, advocacy, building and maintaining relationships with employers;
10. Rehabilitation guidance and counseling; or,
11. Time unlimited vocational support.

Any of the following employment supports may be provided in conjunction with at least one (1) of the above eleven (11) employment activities or which has received prior approval from the Ohio Department of Mental Health and Addiction Services (OhioMHAS), including:

1. Facilitation of natural supports;
2. Transportation; or,
3. Peer services.

IPS-SE:

Individualized Placement and Support- Supported Employment (IPS-SE):

Providers who chose to offer IPS-SE employment service shall meet the following requirements to be OhioMHAS qualified providers:

1. IPS-SE is an evidence based practice which is integrated and coordinated with mental health treatment and rehabilitation designed to provide individualized placement and support to assist individuals with a severe and persistent mental illness obtain, maintain, and advance within competitive community integrated employment positions.
2. In order to be an IPS-SE qualified provider, the provider must:
 - (a) Provide the evidence-based practice of IPS-SE after completion of training/certification on the model;
 - (b) Have current fidelity reviews completed by an OhioMHAS approved fidelity reviewer as required by the developer of the practice; and,
 - (c) Achieve the minimum fidelity score necessary to maintain fidelity, as defined by the developer of the practice.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

N/A

Specify limits (if any) on the amount, duration, or scope of this service for (*chose each that applies*):

Categorically needy (*specify limits*):

	<p>Federal Financial Participation (FFP) is not claimed for incentive payments, subsidies, or unrelated vocational training expenses.</p> <ul style="list-style-type: none"> • Services do not include payment for the supervisory activities rendered as a normal part of the business setting. • Services do not include payment for supervision, training, support, and adaptations typically available to other non-disabled workers filling similar positions in the business. • Transportation to and from the work site will be a component of - and the cost of this transportation will be included in - the rate paid to providers, unless the individual can access public transportation or has other means of transportation available to them. If public transportation is available, then it should be utilized by the individual, if at all possible. • Employment Services may be used for an individual to gain work-related experience considered crucial for job placement (e.g., unpaid internship), only if such experience is vital to the person to achieve his or her vocational goal. • Documentation must be maintained for each individual receiving this service that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973, relating to vocational rehabilitation services, or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), relating to special education. • Services may not be for job placements paying below minimum wage. • Services must be delivered in a manner that supports and respects the individual’s communication needs including translation services, assistance with, and use of communication devices. • Services may not be provided on the same day and at the same time as services that contain elements integral to the delivery of Employment Services (e.g., rehabilitation). • Services must be provided in regular integrated settings and do not include sheltered work or other types of vocational services in specialized facilities, or incentive payments, subsidies, or unrelated vocational training expenses such as the following: <ul style="list-style-type: none"> • Incentive payments made to an employer to encourage hiring the individual; • Payments that are passed through to the individual; <ul style="list-style-type: none"> ○ Payments for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business; or ○ Payments used to defray the expenses associated with starting up or operating a business. <p>Services do not include adaptations, assistance, and training used to meet an employer’s responsibility to fulfill requirements for reasonable accommodations under the Americans with Disabilities Act.</p>
<input type="checkbox"/>	<p>Medically needy (<i>specify limits</i>):</p>

Provider Qualifications <i>(For each type of provider. Copy rows as needed):</i>			
Provider Type <i>(Specify):</i>	License <i>(Specify):</i>	Certification <i>(Specify):</i>	Other Standard <i>(Specify):</i>
Agency	N/A	CMHC certified by OhioMHAS per Section 5119.22 of the revised code	CMHC Licensed, certified or registered individuals in compliance with current, applicable scope of practice and supervisory requirements identified by appropriate licensing, certifying or registering bodies including meeting all requirements as an OhioMHAS Qualified IPS-SE Provider (listed in Service Definition)
			•
			•

Verification of Provider Qualifications *(For each provider type listed above. Copy rows as needed):*

Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>
Agency	ODM or its designee	Initially and annually or based on individual service monitoring concerns.

Service Delivery Method. *(Check each that applies):*

<input checked="" type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed
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Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title:	Peer Recovery Support (PRS)
Service Definition (Scope):	
<p>PRS service provides community-based supports to individuals with or in recovery from a mental illness with individualized and recovery focused activities that promote recovery, self-determination, self-advocacy, well-being and independence through a relationship that supports a person’s ability to promote his or her own recovery. Peer Recovery Supporters use their own experiences with mental illness, to help individuals reach their recovery goals. Activities included must be intended to achieve the identified goals or objectives as set forth in the individual’s individualized care plan, which delineates specific goals that are flexibly tailored to the individual and attempt to utilize community and natural supports. The structured, scheduled activities provided by this service emphasize the opportunity for</p>	

individuals to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery.

PRS services promote self-directed recovery by assisting an individual in:

- Ongoing exploration of recovery needs
- Achieving personal independence as identified by the individual
- Encouraging hope
- Facilitating further development of daily living skills
- Developing and working toward achievement of personal recovery goals
- Modeling personal responsibility for recovery
- Teaching skills to effectively navigate to the health care delivery system to effectively and efficiently utilize services
- Providing group facilitation that addresses symptoms, behaviors, thought processes, etc., that assist an individual in eliminating barriers to seeking or maintaining recovery, employment, education, or housing
- Assisting with accessing and developing natural support systems in the community
- Promoting coordination and linkage among similar providers
- Coordinating and/or assistance in crisis interventions and stabilization as needed
- Conducting outreach
- Attending and participating in treatment teams
- Assisting individuals in the development of empowerment skills through self- advocacy and stigma busting activities that encourage hope

Peer recovery support services will be provided in the natural environment of the person.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

N/A

Specify limits (if any) on the amount, duration, or scope of this service for (*chose each that applies*):

Categorically needy (*specify limits*):

Federal Financial Participation (FFP) is not claimed for incentive payments, subsidies or unrelated vocational training expenses.

Peers should not be involved in managing medications and should not generally be expected to perform tasks that other team members are trained to do.

Peer Recovery Supporters do not generally assist with activities of daily living (ADLs).

Peers should be supervised by other senior peers or non-peer staff that has been certified to supervise peers and receive regularly scheduled clinical supervision from a person meeting the qualifications of a mental health professional with experience regarding this specialized mental health service. Non-peer staff that wishes to supervise peers must complete the 16 hour OhioMHAS E-Based Academy Pre-Course Work for peer services. The Peer Support provider must receive regularly scheduled supervision from a competent behavioral health professional meeting the qualifications of either: a professional meeting the qualifications who meets the criteria for a "qualified behavioral health staff person" or a supervisor who is an individual working as a certified Peer Support provider for a minimum of five years, in which two years should have been as a credentialed peer advocate or its equivalent including specialized training and/or experience as a supervisor. The individual providing consultation, guidance, mentoring, and on-going training need not be employed by the same agency. Supervision of these activities may be delivered in person or by distance communication methods.

It is the expectation that 1 hour of supervision will be delivered for every 40 hours of Peer Support Services duties performed. There may be an administrative supervisor who signs the family peer specialist's timesheet and is the primary contact on other related human resource management issues. Supervisors must also be aware of and sensitive to the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues. The team must have training in the general training requirements required by ODM, including cultural competence and trauma informed care. Any practitioner providing behavioral health services must operate within an agency designated as a CMHC. The Caseload Size must be based on the needs of the clients/families with an emphasis on successful outcomes and individual satisfaction and must meet the needs identified in the individual treatment plan.

PRS is available daily, limited to no more than four hours per day for an individual client. Progress notes document the individual's progress relative to goals identified in the Person-Centered Plan PRS services are not a substitute for or adjunct to other HCBS or similar State Plan service.

The frequency and duration of PRS will be identified on the Person-Centered Plan and must be supported by an identified need and recovery goal. PRS will not substitute or supplant natural supports. Emerging evidence indicates peer recovery support can be instrumental in an individual achieving identified recovery goals, and it can be individualized to meet the changing needs of the individual. For instance, an individual who has transitioned to the community from extended tenure in the psychiatric hospital may benefit from multiple hours of daily peer support until they are acclimated to life outside an institution. The frequency and duration of peer recovery support encounters is anticipated to decline as the individual progresses in his or her recovery, builds natural

supports and strengths, and is better able to navigate recovery in his or her community of choice.			
<input type="checkbox"/> Medically needy (<i>specify limits</i>):			
Provider Qualifications (<i>For each type of provider. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Agency	N/A	Certified Ohio Peer Recovery Supporters with lived experience with mental illnesses	<p>HCBS provider agency enrolled and contracted with ODM to provide 1915(i) services, which employs or has agreements with registered Ohio Peer Recovery Supporters.</p> <p>Agencies may provide any component of the services listed and must employ/contract and utilize the qualified 1915(i) service providers necessary to maintain individuals in the community including Peer specialists.</p> <p>Peer Recovery Supporter</p> <ul style="list-style-type: none"> • Must be at least 18 years old, and have a high school diploma or equivalent • Must be certified in the State of Ohio to provide the service, which includes criminal, abuse/neglect registry and professional background checks, and completion of a state approved standardized basic training program. Individuals with histories of criminal justice involvement are not necessarily disqualified from being a peer, but must be reviewed on a case-by-case basis. • Must self-identify as having a lived experience of mental illness as a present or former recipient of mental health services. • Must have taken and passed the state-approved

			<p>standardized peer recovery supporter training that includes academic information as well as practical knowledge and creative activities focused on the principles and concepts of peer support and how it differs from clinical support. The training provides practical tools for promoting wellness and recovery, knowledge about individual rights advocacy, confidentiality, and boundaries as well as approaches to care that incorporate creativity.</p> <p>In addition to a personal lived experience of mental health and/or substance use disorder, peer recovery supporters must:</p> <ul style="list-style-type: none"> • Successfully complete 16 hour online OhioMHAS E-Based Academy courses • Successfully complete a minimum of 40 hours of peer service delivery training; or have completed 3 years of formal peer service delivery • Successfully passed the OhioMHAS Peer Recovery Supporter exam
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Verification of Provider Qualifications *(For each provider type listed above. Copy rows as needed):*

Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>
Agency	ODM or its designee	Initially and annually or based on individual service monitoring concerns.

Service Delivery Method. *(Check each that applies):*

<input checked="" type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed
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3. **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the State assures that):* There are policies pertaining to payment the State makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the State makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the State ensures that the provision of services by such persons is in the best interest of the individual; (d) the State's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

The State does not make or permit HCBS agencies to make payment to legally responsible family members for furnishing State Plan HCBS.

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. *(Select one):*

<input checked="" type="radio"/>	The State does not offer opportunity for participant-direction of State plan HCBS.
<input type="radio"/>	Every participant in State plan HCBS (or the participant’s representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input type="radio"/>	Participants in State plan HCBS (or the participant’s representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the State. <i>(Specify criteria):</i>

2. Description of Participant-Direction. *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

3. Limited Implementation of Participant-Direction. *(Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

<input type="radio"/>	Participant direction is available in all geographic areas in which State plan HCBS are available.
<input type="radio"/>	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the State. Individuals who reside in these areas may elect self-directed service delivery options offered by the State, or may choose instead to receive comparable services through the benefit’s standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. <i>(Specify the areas of the State affected by this option):</i>

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

5. Financial Management. *(Select one):*

<input type="radio"/>	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
<input type="radio"/>	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. **Participant-Directed Person-Centered Plan.** *(By checking this box the State assures that):* Based on the independent assessment, a person-centered process produces an individualized Person-Centered Plan for participant-directed services that:
- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual's ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
 - Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
 - For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
 - For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
 - Includes appropriate risk management techniques, including contingency plans that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

6. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the State facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

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7. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can hire and supervise staff). *(Select one):*

<input checked="" type="radio"/>	The State does not offer opportunity for participant-employer authority.
<input type="radio"/>	Participants may elect participant-employer Authority <i>(Check each that applies):</i>
<input type="checkbox"/>	Participant/Co-Employer. The participant (or the participant’s representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
<input type="checkbox"/>	Participant/Common Law Employer. The participant (or the participant’s representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant’s agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget). *(Select one):*

<input checked="" type="radio"/>	The State does not offer opportunity for participants to direct a budget.
<input type="radio"/>	Participants may elect Participant–Budget Authority.
<input type="radio"/>	Participant-Directed Budget. <i>(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and Person-Centered Plans. Information about these method(s) must be made publicly available and included in the Person-Centered Plan):</i>
<input type="radio"/>	Expenditure Safeguards. <i>(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards):</i>

Quality Improvement Strategy

(Describe the State’s quality improvement strategy in the tables below):

Discovery Activities					Remediation	
Requirement	Discovery Evidence (Performance Measures)	Discovery Activity (Source of Data & sample size)	Monitoring Responsibilities (agency or entity that conducts discovery activities)	Frequency	Remediation Responsibilities (Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	Frequency of Analysis and Aggregation
Person-Centered Plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.	<p>Sub-assurance: <i>Person-Centered Plans address all members’ assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.</i></p> <p>1. Number and percent of participants reviewed whose service plans adequately address their assessed needs.</p> <p>a. Numerator: Number of participants whose service plans adequately address their assessed needs, including health and safety risk factors, and personal goals.</p>	<p>1. Record review based on a representative sample with 95% confidence level and margin of error of +/- 5%.</p>	<p>1. The state or its designee conducts the review.</p>	<p>1. Quarterly</p>	<p>1. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered,</p>	<p>1. Annually</p>

	<p>b. Denominator: Total number of participants reviewed</p> <p>2. Number and percent of participants reviewed whose service plans have strategies to address and mitigate their health and welfare risk factors.</p> <p>a. Numerator: Number of participants whose service plans adequately address their health and welfare risk factors.</p> <p>b. Denominator: Total number of participants reviewed</p> <p>3. Number and percent of service plans reviewed that address individuals' personal goals.</p> <p>a. Numerator: The number of service plans reviewed that address individuals' personal goals.</p> <p>b. Denominator: Total number of service plans reviewed</p> <p>Sub-assurance: <i>Person-Centered Plans are</i></p>	<p>2. Record review based on a representative sample with 95% confidence level and margin of error of +/- 5%.</p> <p>3. Record review based on a representative sample with 95% confidence level and margin of error of +/- 5%.</p>	<p>2. The state or its designee conducts the review.</p> <p>3. The state or its designee conducts the review.</p>	<p>2. Quarterly</p> <p>3. Quarterly</p>	<p>but are no longer than 90 days.</p> <p>2. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p> <p>3. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than</p>	<p>2. Annually</p> <p>3. Annually</p>
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	<p><i>updated/revised at least annually or when warranted by changes in the 1915(i) participant's needs.</i></p> <p>4. Number and percent of participants whose service plans were updated at least once in the last twelve months</p> <p>a. Numerator: Number of service plans reviewed that were updated at least annually</p> <p>b. Denominator: Total number of participants reviewed</p> <p>5. Number and percent of sampled 1915(i) participants whose service plans were revised, as needed, to address changing needs.</p> <p>a. Numerator: Number of service plans reviewed that were updated when the participant's needs changed</p> <p>b. Denominator: Total number of participants</p>	<p>4. IT system(s) or database where service plan data is stored. 100% review.</p> <p>5. Record review based on a representative sample with 95% confidence level and margin of error of +/- 5%.</p>	<p>4. The state or its designee conducts the review.</p> <p>5. The state or its designee conducts the review.</p>	<p>4. Quarterly</p> <p>5. Quarterly</p>	<p>90 days.</p> <p>4. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p> <p>5. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered,</p>	<p>4. Annually</p> <p>5. Annually</p>
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	<p>reviewed whose needs changed.</p> <p>Sub-assurance: <i>Services are delivered in accordance with the Person-Centered Plan, including the type, scope, amount, duration, and frequency specified in the Person-Centered Plan.</i></p> <p>6. Number and percent of participants reviewed who received services in the type, scope, amount, duration and frequency specified in the service plan.</p> <p>a. Numerator: Number of participants reviewed who received 1915(i) services in the type, scope, amount, duration and frequency specified in the service plan</p> <p>b. Denominator: Total number of participants reviewed</p> <p>Sub-assurance: <i>Participants are afforded choice between/among waiver services and providers.</i></p>	<p>6. Record review based on a representative sample with 95% confidence level and margin of error of +/- 5%.</p>	<p>6. The state or its designee conducts the review.</p>	<p>6. Quarterly</p>	<p>but are no longer than 90 days.</p> <p>6. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p>	<p>6. Annually</p>
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	<p>7. Number and percent of participants notified of their rights to choose among 1915(i) services and/or providers.</p> <p>a. Numerator: Number of participants notified of their rights to choose among 1915(i) services and/or providers</p> <p>b. Denominator: Total number of participants reviewed</p>	<p>7. Record review based on a representative sample with 95% confidence level and margin of error of +/- 5%.</p>	<p>7. The state or its designee conducts the review.</p>	<p>7. Quarterly</p>	<p>7. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p>	<p>7. Annually</p>
<p>The processes and instruments described in the approved Ohio 1915(i) SPA are applied appropriately and according to the approved description to determine for the individual if the needs-</p>	<p><i>Sub-Assurance: An evaluation for needs-based criteria is provided to all applicants for whom there is reasonable indication that services may be needed in the future.</i></p> <p>8. Number and percent of new enrollees who had an evaluation indicating the individual met LON prior to receipt of services</p> <p>a. Numerator: Number of new enrollees who had an evaluation indicating the</p>	<p>8. Record review, at the independent entity; Record review, based on a representative sample of eligibility packets with 95% confidence level</p>	<p>8. The state or its designee conducts the review.</p>	<p>8. Quarterly</p>	<p>8. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary</p>	<p>8. Quarterly</p>

<p>based criteria were met.</p>	<p>individual met LON prior to receipt of services</p> <p>b. Denominator: Total number new enrollees</p> <p><i>Sub-Assurance: The processes and instruments described in the approved State Plan are applied appropriately and according to the approved description to determine initial participant LON.</i></p> <p>9. Number and percent of sampled initial LON determinations that were completed using the process required by the approved State Plan.</p> <p>a. Numerator: Number of sampled initial LON determinations reviewed that were completed using the process required by the approved State Plan</p> <p>b. Denominator: Total number of sampled initial LON determinations.</p> <p>10. Number and percent of sampled LON redeterminations for 1915(i) participants that</p>	<p>and +/- 5% margin of error.</p> <p>9. Record review, based on a representative sample of eligibility packets with 95% confidence level and +/- 5% margin of error.</p> <p>10. IT system(s) where redetermination records are</p>	<p>9. The state or its designee conducts the review.</p> <p>10. The state or its designee conducts the review.</p>	<p>9. Annually</p> <p>10. Monthly</p>	<p>based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p> <p>9. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p> <p>10. The state or its designee aggregates the data and produces reports. ODM, with</p>	<p>9. Annually</p> <p>10. Annually</p>
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	<p>were completed within 365 days of the previous LON determination.</p> <p>a. Numerator: Number of annual LON redeterminations that were completed within 365 days of the previous LON determination</p> <p>b. Denominator: Total number of reviewed LON re-determinations subject to a redetermination</p>	<p>maintained. Record review, based on a representative sample of eligibility packets with 95% confidence level and margin of error of +/- 5%.</p>			<p>other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p>	
<p>Providers meet required qualifications.</p>	<p><i>Sub-Assurance: The State verifies that providers initially and continually meet required participation standards and minimum qualifications and adhere to other standards prior to their furnishing 1915(i) services.</i></p> <p>Sub-assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.</p> <p>11. Number and percent of new RMs, that meet provider enrollment requirements prior to providing services.</p>	<p>11. 100% record review.</p>	<p>11. The state or its designee conducts the review.</p>	<p>11. Quarterly</p>	<p>11. The state or its designee aggregates the data and produces reports. ODM, with other state agencies,</p>	<p>11. Annually</p>

	<p>a. Numerator: Number of sampled providers that met enrollment requirements prior to providing services.</p> <p>b. Denominator: Total number of sampled providers who were enrolled during the review period.</p> <p>12. Number and percent of existing RM providers that continue to meet certification requirements at the time of structural compliance review.</p> <p>a. Numerator: Number of existing RM providers that continue to meet requirements at the time of structural compliance review.</p> <p>b. Denominator: Number of existing RM providers who had a structural compliance review.</p> <p>13. Number and percent of new peer recovery supporters that meet provider enrollment requirements prior to providing services</p>	<p>12. The state or its designee will review provider enrollment information. 100% review.</p> <p>13. 100% review.</p>	<p>12. The state or its designee conduct the reviews.</p> <p>13. The state or its designee conducts the review.</p>	<p>12. Quarterly</p> <p>13. Quarterly</p>	<p>reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p> <p>12. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p> <p>13. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance</p>	<p>12. Annually</p> <p>13. Annually</p>
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	<p>a. Numerator: Number of new providers that met enrollment requirements prior to providing services.</p> <p>b. Denominator: Total number of new providers who were enrolled during the review period.</p> <p>14. Number and percent of peer recovery supporters that continue to meet enrollment requirements at re-enrollment or review.</p> <p>a. Numerator: Number of providers that continue to meet enrollment requirements at re-enrollment or review.</p> <p>b. Denominator: Total number of providers due who received a structural review</p> <p>15. Number and percent of IPS-SE providers who meet provider enrollment requirements prior to providing services</p> <p>a. Numerator: Number of new providers that met provider enrollment</p>	<p>14. The state or its designee will review provider enrollment information. 100% review.</p> <p>15. The state or its designee will review provider enrollment information. 100% review.</p>	<p>14. The state or its designee conducts the review.</p> <p>15. The state or its designee conducts the review.</p>	<p>14. Quarterly</p> <p>15. Quarterly</p>	<p>and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p> <p>14. Ohio MHAS or designee aggregates and analyzes for ODM review.</p> <p>15. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is</p>	<p>14. Annually</p> <p>15. Annually.</p>
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	<p>requirements prior to providing services.</p> <p>b. Denominator: Total number of new providers who were enrolled during the review period</p> <p>16. Number and percent of IPS-SE providers that continue to meet enrollment requirements at the time of structural compliance review</p> <p>a. Numerator: Number of existing providers that continue to meet enrollment at the time of structural compliance review</p> <p>b. Denominator: Total number of providers who received a structural review</p>	<p>16. The state or its designee will review provider enrollment information. 100% review.</p>	<p>16. The state or its designee collects and generates.</p>	<p>16. Quarterly</p>	<p>necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p> <p>16. ODM or designee aggregates and analyzes for ODM review.</p>	<p>16. Annually.</p>
<p>The SMA retains authority and responsibility for program operations and oversight.</p>	<p><i>Sub-Assurance: The SMA assures compliance with authority for program operation and oversight.</i></p> <p>17. Number and percent of provider structural reviews required that were completed within the required timeframe.</p> <p>a. Numerator: Number of</p>	<p>17. The state or its designee will review; 100% review.</p>	<p>17. Independent entity under contract with the state or MCP collects and generates,</p>	<p>17. Annually</p>	<p>17. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance</p>	<p>17. Annually</p>

	<p>structural compliance reviews due that were completed within required timeframes.</p> <p>b. Denominator: Number of structural compliance reviews due</p> <p>18. Number and percent of level of need redeterminations for 1915(i) participants that were completed within 365 days of the previous level of need determination.</p> <p>a. Numerator: Number of participants with annual re-determined LON reviewed that were completed using the process required by the approved State Plan</p> <p>b. Denominator: Total number of enrollees subject to a redetermination</p> <p>19. The number and percent of qualified providers who continue to meet provider requirements at</p>	<p>18. Reports to ODM on performance measures; 100% review.</p> <p>19. IT system(s) or database. 100% review.</p>	<p>and sends reports to the state.</p> <p>18. Independent entity under contract with the state collects and generates and sends reports to the state.</p> <p>19. The state or its designee conducts the review.</p>	<p>8. Quarterly</p> <p>19. Quarterly</p>	<p>and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p> <p>18. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p> <p>19. The state or its designee aggregates the data and produces reports. ODM, with</p>	<p>18. Annually</p> <p>19. Annually</p>
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	<p>the time of their structural review.</p> <p>a. Numerator: Number of providers who continue to meet provider requirement at the time of their structural review.</p> <p>b. Denominator: Total number of providers who had a structural review.</p> <p>20. Number and percent of required reports submitted by the IVE in a complete and timely manner</p> <p>a. Numerator: Number of required reports submitted by the IVE in a complete and timely manner.</p> <p>b. Denominator: Total number of the required reports</p> <p>21. Number and percent of findings of IVE non-compliance that were remediated through an approved CAP or other method as required by the</p>	<p>20. Contracted Entity reports to ODM. 100% review.</p> <p>21. 100% review.</p>	<p>20. The state monitors the Contracted Entity.</p> <p>21. The state monitors the contractors' compliance.</p>	<p>20. Quarterly</p> <p>21. Continuous as non-compliance is identified.</p>	<p>other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p> <p>20. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p> <p>21. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance</p>	<p>20. Annually</p> <p>21. Annually</p>
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	<p>state.</p> <p>a. Numerator: Number of findings of non-compliance that were remediated by an approved CAP or other method</p> <p>b. Denominator: Number of findings of non-compliance</p>				<p>and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p>	
<p>The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.</p>	<p>Sub-Assurance: <i>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.</i></p> <p>22. Number and percent of claims verified through a review of provider documentation to have paid in accordance with the individual’s service plans.</p> <p>a. Numerator: Number of claims verified through a review of provider documentation to have paid in accordance with individuals’ waiver service plans.</p>	<p>22. ODM’s MMIS claims payment system, MITS. Claims verification audits and provider performance monitoring; 95% confidence level with a margin of error of +/- 5%</p>	<p>22. ODM or its designee.</p>	<p>22. Semi-Annually</p>	<p>22. ODM</p>	<p>22. Annually</p>

	<p>b. Denominator: Total number of claims reviewed</p> <p>23. Total number of undocumented claims identified in performance measure 22 that had payment recouped.</p> <p>a. Numerator: Total number of claims sampled in performance measure 22 that had payment recouped.</p> <p>b. Denominator: Total number of undocumented claims identified in performance measure 22.</p>	<p>23. MITS. Claims verification audits and provider performance monitoring' 95% confidence level with margin of error of +/- 5%.</p>	<p>23. ODM or its designee.</p>	<p>23. Semi-Annually</p>	<p>23. ODM</p>	<p>23. Annually</p>
<p>The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.</p>	<p><i>Sub-Assurance: The State demonstrates on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation, and unexplained death.</i></p> <p>24. Number and percent of Incident review/investigations that were initiated regarding reportable death, abuse, neglect, exploitation,</p>	<p>24. 100 % review.</p>	<p>24. ODM or its designee conducts the review.</p>	<p>24. Quarterly</p>	<p>24. Contracted Incident Management Entity aggregates and analyzes for state review.</p>	<p>24. Annually</p>

	<p>misappropriation, and unapproved restraints as required by ODM.</p> <p>a. Numerator: Number of incident review/investigations involving reportable death, abuse, neglect, exploitations, misappropriation, and unapproved restraints for participants that were initiated as required by ODM</p> <p>b. Denominator: Number of incident reviews, including reportable death, abuse, neglect, exploitation, misappropriation, and unapproved restraints.</p> <p>25. Number and percent of incident reviews/investigations involving reportable death, abuse, neglect, exploitation, misappropriation of funds, and unapproved restraints for participants that were completed as required by ODM.</p> <p>a. Numerator: Number of</p>	<p>25. 100% review.</p>	<p>25. ODM or its designee conducts the review.</p>	<p>25. Quarterly</p>	<p>25. Contracted Incident Management Entity aggregates and analyzes for state review.</p>	<p>25. Annually</p>
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	<p>incident reviews/investigations involving reportable death, abuse, neglect, misappropriation of funds, and unapproved restraints that were completed as specified as required by ODM.</p> <p>b. Denominator: Number of incident reviews/investigations involving reportable death, abuse, neglect, exploitation, misappropriation, and unapproved restraints.</p> <p>26. Number and percent incidents reviewed with an incident of abuse, neglect, exploitation, misappropriation, and unapproved restraints who had a plan of prevention/documentation of a plan, developed as a result of the incident.</p> <p>a. Numerator: Number of incidents reviewed with a plan of prevention/documentation of a plan, developed as a result of the incident.</p>	<p>26. Sample review. 95% confidence level with margin of error of +/- 5%.</p>	<p>26. ODM or its designee conducts the review.</p>	<p>26. Quarterly</p>	<p>26. Contracted Incident Management Entity aggregates and analyzes for state review.</p>	<p>26. Annually</p>
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	<p>b. Denominator: Total number of incident investigations in these categories.</p> <p>27. Number and percent of incidences of unapproved restraints, investigated as required by ODM.</p> <p>a. Numerator: Number of instances of unapproved restraints investigated as required by ODM.</p> <p>b. Denominator: Total number of instances of unapproved restraint</p> <p><i>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 1915(i) SPA.</i></p> <p>28. Number and percent of 1915(i) program participants who had an ambulatory or preventative visit</p> <p>a. Numerator: Number of 1915(i) program participants that were continuously eligible for</p>	<p>27. 100% review.</p> <p>28. Sample review. 90% confidence level with margin of error of +/- 5%.</p>	<p>27. ODM or its designee conducts the review.</p> <p>28. ODM or its designee conducts the review.</p>	<p>27. Quarterly</p> <p>28. Annually</p>	<p>27. Contracted Incident Management Entity aggregates and analyzes for state review.</p> <p>28. ODM</p>	<p>27. Annually</p> <p>28. Annually</p>
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	<p>Medicaid during the measurement year who had an ambulatory or preventative visit during the measurement year.</p> <p>b. Denominator: Number of 1915(i) program participants who were continuously eligible for Medicaid during the measurement year.</p>					
<p>Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (a)(2).</p>	<p>29. Number/percent of HCBS settings meeting appropriate licensure or certification requirements.</p> <p>a. Numerator: Number of 1915(i) participant residences and HCBS provider settings that meet HCBS setting requirements</p> <p>b. Denominator: Total number of 1915(i) participant residences and HCBS provider settings</p>	<p>29. 100% review of individuals through recovery manager visits.</p>	<p>29. ODM or its designee conducts the review.</p>	<p>29. Annually</p>	<p>29. Independent Entities under contract with the state aggregates and analyzes for the state to review.</p>	<p>29. Annually</p>

System Improvement: <i>(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)</i>			
Methods for Analyzing Data and Prioritizing Need for System Improvement	Role sand Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
Program performance data book: <ul style="list-style-type: none"> • Track and trend system performance. <ul style="list-style-type: none"> • Analyze discovery. 	The independent entities and the state will collect, collate, and review. The State Medicaid agency will review the data and have final direction over corrective action plans.	Updated and reported quarterly.	<ul style="list-style-type: none"> • Set performance benchmarks. • Review service trends. • Review program implementation. • Focus on quality improvement. The Independent Entities and the state will track and trend system performance, analyze the discovery, synthesize the data and with the State Medicaid agency, make corrective action plans regarding quality improvement. This will include reviewing QI recommendations quarterly and building upon those improvements through CQI.
Program performance data book: <ul style="list-style-type: none"> • Track and trend system performance. • Analyze discovery. 	The independent entities contracting with the state will collect, collate, and review. The State will review and conduct corrective action and oversight.	Updated and reported quarterly.	<ul style="list-style-type: none"> • Set performance benchmarks. • Review service trends. • Review program implementation. • Focus on quality improvement.
Quality management meetings: <ul style="list-style-type: none"> • Assess system changes. 	The independent entities and the State will collect, analyze, and report.	Quarterly meetings.	<ul style="list-style-type: none"> • Monitoring contract and 1915(i) HCBS compliance for service delivery. • Review of Person-Centered Plan client outcome measures (i.e. personal goals).

<ul style="list-style-type: none"> Focus on reporting requirements and refining reports. 			
<p>Onsite reviews include documentation review and onsite interviews.</p>	<p>The independent entities and the State coordinates and conducts onsite review.</p>	<p>Annually.</p>	<ul style="list-style-type: none"> Review of clinical operations (utilization management, quality management, care management) as well as fiscal reporting. Compliance issues will require the submission of a corrective action plan to the Independent Entities and the state for approval and ongoing monitoring.
<p>Corrective action plans (CAPs).</p>	<p>Developed by the provider/contractor. Submitted to the independent entities, MCPs, and ODM or its designee for approval. ODM provides oversight and direction.</p>	<p>Areas for improvement will be monitored as per CAP and presented quarterly during quality management meetings.</p>	<ul style="list-style-type: none"> Analysis of performance data book. Onsite review findings of program non-compliance follow-up.

TN: 15-014
Supersedes:
TN: New

Approved: _____
Effective: 07/01/2016

Methods and Standards for Establishing Payment Rates

1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates):*

<input type="checkbox"/>	HCBS Case Management	
<input type="checkbox"/>	HCBS Homemaker	
<input type="checkbox"/>	HCBS Home Health Aide	
<input type="checkbox"/>	HCBS Personal Care	
<input type="checkbox"/>	HCBS Adult Day Health	
<input type="checkbox"/>	HCBS Habilitation	
<input type="checkbox"/>	HCBS Respite Care	
For Individuals with Chronic Mental Illness, the following services:		
<input type="checkbox"/>	HCBS Day Treatment or Other Partial Hospitalization Services	
<input type="checkbox"/>	HCBS Psychosocial Rehabilitation	
<input type="checkbox"/>	HCBS Clinic Services (whether or not furnished in a facility for CMI)	
<input checked="" type="checkbox"/>	Other Services (specify below)	
	Payment rates for this 1915(i) program are developed based on payment rates determined for other programs that provide similar services. If payment rates are not available from the other programs that provide similar services, payment rates are determined using modeled rates.	
	The description below is the State Plan FFS reimbursement methodology for the modeled rates A. State Plan Reimbursement Methodology Reimbursements for services are based upon a Medicaid fee schedule established by the State of Ohio. The fee development methodology will build fees considering each component of provider costs as outlined below. These reimbursement methodologies will produce rates sufficient to enlist enough	

providers so that services under the Plan are available to individuals at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act 42 CFR 447.200, regarding payments and consistent with economy, efficiency and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate. Room and board costs are not included in the Medicaid fee schedule.

Except as otherwise noted in the Plan, the State-developed fee schedule is the same for both governmental and private individual providers and the fee schedule and any annual/periodic adjustments to the fee schedule are on the agency's website. The Agency's fee schedule rate was set as of July 1, 2016 and is effective for services provided on or after that date. All rates are published on the agency's website.

The fee development methodology will primarily be composed of provider cost modeling, though Ohio provider compensation studies, cost data and fees from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in fee development.

- Staffing Assumptions and Staff Wages
- Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation)
- Program-Related Expenses (e.g., supplies)
- Provider Overhead Expenses
- Program Billable Units

The fee schedule rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.

B. Standards for Payment

1. Providers must meet provider participation requirements including certification and licensure of agencies and clinic,
2. All services must be prior authorized and provided in accordance with the approved Person-Centered Plan.
3. Providers must comply with all state and federal regulations regarding subcontracts.