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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
Assisted Living - 1634 Amendment

C. Waiver Number:OH.0446
Original Base Waiver Number: OH.0446.

D. Amendment Number:

E. Proposed Effective Date: *(mm/dd/yy)*
07/01/16

Approved Effective Date of Waiver being Amended: 07/01/14

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The primary purpose of the amendment is to reflect the changes required to align with the Medicaid State Plan's conversion from a section 209(b) state to a section 1634 state.

Attachment #1 specifies the transition plan for the waiver.

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

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

In addition, the following amendments are proposed which do not pertain to the 1634 conversion:

Main 6I documents the established public input process for both the waiver renewals and the HCBS Transition Plan.

Appendix B-6 reflects the changes in the level of care determination process. No changes to level of care criteria are being proposed.

The amendment also contains all of the proposed changes found in the Assisted Living amendment submitted to CMS on December 2, 2015 and currently pending approval by CMS for a proposed effective date of April 1, 2016. These changes are

found in Main, 6I, 8A Attachment #2, 8B Optional Additional Information, Appendix B-1b, B-3a, Appendix C1-C3, Appendix G Quality Improvement, Appendix J-2a, J-2b, and J-2d. References to the Office of Medical Assistance (OMA) were replaced with the Ohio Department of Medicaid (ODM) and updated Ohio Administrative Code rule references throughout the waiver.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☑ Waiver Application	Main 6I, 8A Attachn
☐ Appendix A – Waiver Administration and Operation	
☑ Appendix B – Participant Access and Eligibility	B4, B5,B6d, B6e, B6
☐ Appendix C – Participant Services	
☐ Appendix D – Participant Centered Service Planning and Delivery	
☐ Appendix E – Participant Direction of Services	
☐ Appendix F – Participant Rights	
☐ Appendix G – Participant Safeguards	
☐ Appendix H	
☐ Appendix I – Financial Accountability	
☐ Appendix J – Cost-Neutrality Demonstration	

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

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

Specify:
The amendment also contains all of the proposed changes found in the Assisted Living amendment submitted to CMS on December 2, 2015 and currently pending approval by CMS for a proposed effective date of April 1, 2016. These changes are found in Main 6I, Main 8A Attachment #2, Main 8B Optional Additional Information, Appendix B-1b, B-3a, Appendix G Quality Improvement, Appendix J-2a, J-2b, and J-2d. References to Office of Medical Assistance (OMA)replaced with the Ohio Department of Medicaid (ODM) and updated Ohio Administrative Code rule references throughout the waiver.

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

1. Request Information (1 of 3)

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

B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
Assisted Living - 1634 Amendment

C. **Type of Request: amendment**

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: OH.0446
Draft ID: OH.009.02.02

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

E. **Proposed Effective Date of Waiver being Amended: 07/01/14**
Approved Effective Date of Waiver being Amended: 07/01/14

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

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

☑ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**
If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
n/a

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

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

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

◉ **Not applicable**

○ **Applicable**
Check the applicable authority or authorities:

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

☐ **Waiver(s) authorized under §1915(b) of the Act.**
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

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

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

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The purpose of the waiver is to support the rebalancing of resources between institutional and community services by providing an additional long term care service option.

The goal of the waiver is to provide a delivery setting that offers more services and supervision than a traditional community residence and more independence, choice, and privacy than a traditional nursing facility.

The objective of the waiver is to decrease the utilization of nursing facility care by elderly and disabled individuals who have needs that are difficult to address through the scheduled delivery of services but don't require specialized medical care provided by a nursing facility.

The organization structure of the waiver is comprised of the State Medicaid Agency Ohio Department of Medicaid (ODM), the Ohio Department of Aging (ODA), and thirteen regional entities. The ODM enters into a biennial interagency agreement with the ODA and the thirteen regional entities. ODM administers this waiver program through its oversight and supervision activities, the issuance of policies, and both adopting and authorizing rules related to the waiver. ODA is the operational entity responsible for the daily management of the waiver including: managing waiver enrollment against approved limits, monitoring waiver expenditures against approved levels, conducting utilization management functions, and monitoring the regional entities. The regional entities are responsible for participant enrollment, level of care evaluations, administrative case management, and provider procurement.

The waiver services are delivered only by Ohio licensed residential care facilities that have been certified by ODA and have a current Medicaid provider agreement with ODM.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

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

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

- ◉ **No**
- ○ **Yes**

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

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

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

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

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
Integrated Care Delivery System (ICDS) – In December 2012, Ohio reached an agreement with the Centers for Medicare and Medicaid Services (CMS) on a new initiative to better coordinate care for individuals eligible for both Medicare and Medicaid. To support the ICDS program, the State has submitted concurrent 1915(b)(c) waiver applications to require certain individuals to enroll in the ICDS as well as to ensure access to long-term care services and supports. Ohio has and continues to engage stakeholders through regional forums and ongoing stakeholder meetings on the development and implementation of this initiative.

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

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

Electronic: Ohio posts a public notice, summary of the draft waiver, the draft waiver itself on the Ohio Department of Medicaid (ODM) website. The Ohio Department of Aging (ODA) and the 13 PAAs post public notices on their websites, which link to the ODM website.

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

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

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

For this required public comment period, held February 1 through March 2, 2016, Ohio provided five methods for the public to provide input on the proposed waiver renewal or amendment and/or request a non-electronic copy of the waiver renewal or amendment:

E-mail - Submissions are received through a dedicated e-mail box: HCBSfeedback@medicaid.ohio.gov.
Written comments - U.S. Postal Service address, Ohio Department of Medicaid, P.O. Box 182709, 5th Floor, Columbus, OH 43218.
Fax - Ohio provides a fax number: (614) 466-6945.
Toll-free phone number: 1 (800) 364-3153, with a recorded message advising callers five five minutes in which to leave a message to provide input.
Video. Emailed .mov video submissions are also accepted.

Public Notification and Public Input Process for the HCBS Statewide Transition Plan

For each required public comment period, Ohio uses the following methods to notify the public of the opportunity to review and comment on the HCBS Statewide Transition Plan:

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

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

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

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

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

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

E-mail - Submissions are received through a dedicated e-mail box: HCBSfeedback@medicaid.ohio.gov.
Written comments - U.S. Postal Service address, Ohio Department of Medicaid, P.O. Box 182709, 5th Floor, Columbus, OH 43218.
Fax - Ohio provides a fax number: (614) 466-6945.
Toll-free phone number: 1 (800) 364-3153, with a recorded message advising callers five five minutes in which to leave a message to provide input.
Video. Emailed .mov video submissions are also accepted.

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

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

7. Contact Person(s)

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

Last Name: Donica

First Name: Kimberly

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

Agency: Ohio Department of Medicaid

Address: 50 West Town Street, Fifth Floor

Address 2: P.O. Box 182709

City: Columbus

State: **Ohio**

Zip: 43218

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

Fax: (614) 466-6945

E-mail: Kimberly.Donica@medicaid.ohio.gov

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

Last Name: Hobbs

First Name: Matthew

Title: Chief, Division for Community Living

Agency: Ohio Department of Aging

Address: 50 West Broad Street

Address 2: 9th Floor

City: Columbus

State: **Ohio**

Zip: 43215

Phone: (614) 752-9168 **Ext:** ☐ **TTY**

Fax: (614) 466-9812

E-mail: mhobbs@age.ohio.gov

8. Authorizing Signature

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name: McCarthy

First Name: John B.

Title: Director

Agency: Ohio Department of Medicaid

Address: 50 West Town Street, Fifth Floor

Address 2: P.O. Box 182709

City: Columbus

State: **Ohio**

Zip: 43218

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

Fax: (614) 752-3986

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

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

ICDS Transition Plan

Effective March 1, 2013, when an individual enrolled on the Assisted Living waiver is identified as dually eligible for both Medicare and Medicaid and resides in a county participating in the Integrated Care Delivery System (ICDS) demonstration, he or she will be transitioned to the ICDS waiver (OH# 1035), which is also referred to as the MyCare Ohio waiver.

Background/Waiver Providers/Services/Case Management

On December 12, 2012, Governor Kasich announced that Ohio reached an agreement with the Centers for Medicare and Medicaid Services (CMS) on a new initiative to better coordinate care for individuals eligible for both Medicare and Medicaid. This initiative is only in effect in certain counties of the State and will provide for and coordinate all long-term care in addition to primary and acute care services for participating individuals. To support the implementation of MyCare Ohio the State received approval in July 2013 of concurrent 1915(b)(c) waiver applications to require certain individuals to enroll in the demonstration as well as to ensure access to long-term care services and supports.

Ohio is sensitive to the magnitude of the proposed changes associated with the implementation of the demonstration and the 1915 b/c MyCare Ohio waiver. The State is committed to implementing this program in a manner that allows for the safe

transition of individuals currently enrolled on the Assisted Living waiver who will be required to transition to MyCare Ohio by emphasizing continuity of care and minimizing service disruption.

The initial phase-in of individuals into the MyCare Ohio waiver will occur over a 120-day period, beginning with voluntary enrollments in March 2014, and followed by regional phase-ins starting in April 2014 and running through June 2014. An individual's transition from his or her current waiver to the MyCare Ohio waiver will be completed within 90 days from the time they are identified as eligible for the MyCare Ohio demonstration until their enrollment with the plan and the MyCare Ohio waiver.
Individuals enrolled in Assisted Living who transition to the MyCare Ohio waiver program will receive advance notification of their participation in MyCare Ohio from the State. For those individuals who will transition during the program's phased enrollment period, that notice will occur as follows:

1) Introductory/initial notification letters will be sent in December 2013 to educate individuals about their participation in the demonstration program. These letters include a fact sheet catered specifically to that individual (in this instance a fact sheet for assisted living waiver consumers).

2) Voluntary enrollment letters will be sent in January 2014. These letters will notify individuals of their ability to participate in the demonstration beginning March 2014.

3) Individuals receive a mandatory enrollment letters 60 days prior to their mandatory enrollment date (there is no set date due to the staggered phase-in of the demonstration). This letter will include information about the MyCare Ohio plans that serve the individual's community and encourage the individual to select a MyCare Ohio plan.

4) Individuals who do not select a MyCare Ohio plan, at least 30 days prior to their enrollment date will receive a final notice from the state indicating that a plan has been selected for them –individuals may still choose a different plan up to the date of their enrollment and any time thereafter.

When an individual enrolled on the Assisted Living waiver is identified as dually eligible for both Medicare and Medicaid and resides in a county participating in MyCare Ohio, he or she will be transitioned to the MyCare Ohio waiver over the 90 day period. The PAA waiver case manager will support the individual through this transition. The case manager's responsibility includes discharge planning for individuals leaving the Assisted Living waiver. This level of assistance will continue to be provided to every individual transitioning to the MyCare Ohio demonstration.

The MyCare Ohio waiver offers a more robust service package than Assisted Living by making available to participating individuals all of the services available on Ohio's NF LOC waivers. In the MyCare Ohio waiver, the MyCare Ohio plans will be required to adhere to specific transition requirements. The State has developed these requirements with the assistance of individuals and providers who voiced concerns about continuity of care and risks to health outcomes if enrollment in MyCare Ohio resulted in abrupt changes in services and providers.

In accordance with the MyCare Ohio waiver's transition requirements, the MyCare Ohio plans are required to contract with each individual's established waiver service providers upon his or her enrollment in the MyCare Ohio demonstration for the time periods described below and at the rate approved under the individual's currently approved waiver service plan. Additionally, each individual's waiver service plan shall be updated to reflect the service nomenclature in the new MyCare Ohio waiver.

Transition Period – Assisted Living:

• Individuals enrolling in MyCare Ohio from Ohio's Assisted Living waiver program will continue to receive services from the same waiver provider at the same reimbursement rate for the duration of the demonstration.

Changes in Provider During Transition Periods:
Individuals may initiate a change in waiver service provider at any time during the transition period. However, any change in services or service providers (initiated by either the individual or the MyCare Ohio plan) may occur only after an in-home assessment and the development of a plan for the transition to a new provider. In cases where the health and welfare of the individual is judged to be in danger, expedited service authorization time frames will apply per 42 CFR 43 8.206(d).

A MyCare Ohio plan-initiated change from an existing provider during the transition period may occur in the following circumstances:

• The individual has a significant change in status as defined in Ohio Administrative Code (OAC) Rule 5160-45-01;

• The provider gives appropriate notice of intent to discontinue services to an individual; or

• Provider performance issues that affect an individual's health and welfare are identified.

If the MyCare Ohio plan detects a quality of care issue, the MyCare Ohio plan will work with the provider and individual to satisfactorily resolve the issue(s). If resolution is not possible, the MyCare Ohio plan will assist the individual in choosing a provider willing and able to comply with quality of care requirements.

If a change in HCBS provider is required for any reason, the individual will be provided information regarding other available providers and an individualized transition plan will be developed and integrated into the comprehensive care plan.

MyCare Ohio plans are required to notify all individuals transitioning into the MyCare Ohio waiver at the time of their enrollment and at least annually (in writing and verbally) about the process for filing grievances and appeals.

April 2016: 1634 Conversion Transition Plan

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

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

At least 90 days prior to the conversion to a section 1634 state, ODM will send letters directly to each individual enrolled on the waiver with income over the special income limit. The letter will describe the option of continuing Medicaid eligibility and waiver services through the use of a QIT/Miller Trust. The letter will include the contact information for the vendor that will assist the individual with establishing a QIT/Miller Trust.
Information about the conversion to a section 1634 state will be posted on the ODM website. In addition, the sister agency websites (Ohio Department of Developmental Disabilities and the Ohio Department of Aging) will include a link to the ODM website.

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

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

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

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

I.STATUS OF THE STATE TRANSITION PLAN

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

December 2015 The Centers for Medicare and Medicaid Services (CMS) completed its initial review of Ohio's Statewide Transition Plan and issued the findings to
the State on July 23,2015. As a result of the of the initial CMS review of the draft statewide transition plan, the plan was revised and posted for public
comment. During Ohio's second formal public comment period, copy of the full draft transition plan was posted to the website of Ohio's Office of Health
Transformation between October 15, 2015 and November 15, 2015. A summary of the public input process is described in 6I and the summary of comments on the revised draft transition plan pertaining to this waiver is described in Section 8B.

II.DESCRIPTION OF THE ASSISTED LIVING MEDICAID WAIVER SETTING

The Assisted Living waiver serves individuals age 21 or older with a NF-LOC and furnishes services only to individuals who reside in licensed residential care facilities that are certified by ODA as a home and community-based waiver provider. The purpose of the Assisted Living service is to provide a setting that offers more person-centered services and supervision than a traditional community residence and more independence, choice, and privacy than a traditional nursing facility. This setting has the capacity to provide a response to the unscheduled/unplanned needs of individuals receiving services. Only a residential care facility licensed by the Ohio Department of Health (ODH) and certified by ODA as an HCBS waiver provider may deliver the Assisted Living service to individuals enrolled on the Assisted Living Waiver.

December 2015: No modifications were made to this section in the revised draft statewide transition plan.

III.ASSESSMENT OF ASSISTED LIVING MEDICAID WAIVER SETTING

The State conducted a systematic review of applicable state statutes, administrative code rules, provider requirements (licensing, qualifications and waiver certification), service specifications, case management standards, administrative and operational processes, and monitoring and operational oversight activities for the approved Assisted Living waiver.
The state contracts with 13 regional entities (PASSPORT Administrative Agencies) to conduct initial and annual on-site compliance reviews of certified assisted living providers. A survey of the 13 PASSPORT Administrative Agencies (PAAs) was conducted to obtain information about the setting characteristics for currently certified assisted living providers. The state also conducted an on-line survey to gauge how the Assisted Living Waiver provider community assessed their level of compliance with the new regulations.

Following the public comment period for the draft State Transition Plan, the state subsequently confirmed that independent living options were available for individuals not receiving Medicaid funded HCBS services at all the currently certified assisted living providers which had been categorized as privately operated continuing care retirement communities.

December 2015: No modifications were made to this section in the revised draft statewide transition plan.

IV.ANALYSES OF THE RESIDENTIAL SETTINGS IN THE ASSISTED LIVING MEDICAID WAIVER

Settings that currently meet the HCBS setting characteristics:

ANALYSIS:
In the preliminary analysis, the State has not identified any residential settings in which the Assisted Living Waiver service is furnished that are currently 100% compliant with the new regulation.

The state will ensure that existing settings continue to meet the HCBS characteristics by adopting a new Ohio Administrative Code rule and modifying the State's HCBS ongoing provider oversight function.
In the event a setting, which previously demonstrated evidence of compliance but subsequently cannot (or does not) produce acceptable evidence of compliance, the state's established relocation team, led by the State Long-Term Care Ombudsman, will work with individuals who choose to transition to a setting of their choice which meets the HCBS characteristic.

Settings that currently do not meet HCBS characteristics for provider-owned or controlled settings, but may with modifications:

ANALYSIS:
In the preliminary analysis, the state determined 89 percent, or 298, of the currently certified HCBS assisted living waiver service providers are either free-standing communities or private continuing care retirement communities that offer independent living options for residents not receiving HCBS services. At the time of this analysis, these settings serve approximately 2,600 individuals or 94% of all individuals receiving the Assisted Living Waiver service.

REMEDIATION:
The current residential care facility (RCF) licensure standards combined with the HCBS waiver provider certification standards provide a basis for reducing the risk of isolating individuals from the broader community. Proposed modifications will ensure individuals are afforded full access to the benefits of community living across the system rather than relying on setting specific policies and practices. The state will ensure that existing settings come into full compliance with the HCBS characteristics by adopting a new HCB setting rule, modifying existing OAC rules, furnishing provider education, and modifying the State's HCBS ongoing provider oversight function.

In the event a setting, which previously demonstrated evidence of compliance but subsequently cannot (or does not) produce acceptable evidence of compliance, the state's established relocation team, led by the State Long-Term Care Ombudsman, will work with individuals who choose to transition to a setting of their choice, which meets the HCBS characteristics.

December 2015: No modifications were made to this section in the revised draft statewide transition plan.

Settings that are presumed to have the effect of isolating individuals and may be subject to heightened scrutiny process:

ANALYSIS:
CMS described settings "presumed to have the qualities of an institution" as those located in a public or private facility that provides inpatient treatment. The State's preliminary assessment identified one type of setting that may have the effect of isolating individuals and thus be subject to heightened scrutiny. There are 11%, or 36, RCFs certified as an HCBS assisted living provider located in the same building as a nursing facility. The analysis prepared for the State Transition Plan, in October 2014, revealed that these settings served 370 individuals, or 8% of the total number of individuals receiving the assisted living service on the Assisted Living and the MyCare Medicaid Waivers. Data for January 2015, 151 consumers served on the Assisted Living Medicaid waiver were located in these settings, or roughly 6% of the total number of individuals served on the Assisted Living Medicaid waiver.

REMEDIATION:
The State will ensure that existing settings that are subject to heightened scrutiny come into full compliance with HCBS characteristics requirements by adopting a new HCBS settings rule, modifying existing OAC rules, establishing standards and defining acceptable evidence of compliance, provider remediation plans, on-site assessments which includes the individual's experience residing in the setting, and modifying the State's HCBS ongoing provider oversight function.

In the event the setting cannot or does not produce acceptable evidence of compliance, the state's established relocation team, led by the State Long-Term Care Ombudsman, will work with individuals who choose to transition to a setting of their choice, which meets the HCBS characteristics.

December 2015: No modifications were made to this section in the revised draft statewide transition plan.

Settings that cannot meet the HCBS characteristics:

ANALYSIS:
In the preliminary analysis, the State has not identified any residential settings that cannot meet the HCBS characteristics.

REMEDIATION:
By adopting a new HCBS settings rule and modifying the state's initial HCBS provider certification rules, the State will ensure no new settings that cannot meet the HCBS characteristics are permitted to furnish the Medicaid funded HCBS assisted living service.
In the event a setting, which previously demonstrated evidence of compliance but subsequently cannot (or does not) produce acceptable evidence of compliance, the state's established relocation team, led by the State Long-Term Care Ombudsman, will work with individuals to transition them to a setting of their choice, which meets the HCBS characteristics.

December 2015: No modifications were made to this section in the revised draft statewide transition plan.

IV.STATUS OF THE STATE'S TRANSITION TO COMPLIANCE

Ohio submitted its Final State Transition Plan through the portal on March 13, 2015. The State awaits CMA approval of the State Transition Plan. While the State is attaching an Assisted Living Waiver Transition Plan, the State expects that language in the State's Transition Plan approved by CMS and related to the Assisted Living Waiver will take precedence over the language in the waiver transition plan.

Remediation strategies include:

Adoption of an overarching HCBS Waiver Administration rule that details the CMS HCBS settings characteristics required for all provider controlled settings, amendments to the Assisted Living Service OAC 173-39-02.16, and modifications to the provider oversight process are slated for 7/2015-7/2016.

December 2015: No modifications were made to this section in the revised draft statewide transition plan.

Provider Education and compliance monitoring will include development of a provider self-assessment tool, development of a standardized compliance monitoring tool, and modification of provider and case management operational manuals and forms, as well as guidance to impacted providers and case management entities. Proposed Time Frame: 1/2016-6/2016.

December 2015: No modifications were made to this section in the revised draft statewide transition plan.

Conduct on-site assessments for settings subject to heightened scrutiny. Proposed Time Frame: 7/2016-12/2016

December 2015: The following modifications were made to the action steps and time frames in the revised draft statewide transition plan.

Site Specific Self-Assessment. Proposed time frame: 1/2016-6/2016
Site Specific Remediation Plans submitted to the state. Proposed time frame: July 2016-Sept 2016
On-Site Assessments of settings subject to heightened scrutiny. Proposed time frame: October 2016-October 2017.

For those locations that compliance reviews show they continue to have the effect of isolating individuals from the broader community, the state's established relocation team, led by the State Long Term Care Ombudsman office, will work with individuals who choose to transition to a setting of their choice. Proposed Time Frame: 1/2017 and ongoing.

December 2015: No modifications were made to this section in the revised draft statewide transition plan.

Ongoing Compliance achieved via on site provider reviews, which include experience of individuals residing in the setting, are slated for 7/2016 and ongoing.

December 2015: No modifications were made to this section in the revised draft statewide transition plan.

The state's Quality Strategy will include the results from a nationally recognized, statistically valid consumer survey, such as the National Core Indicators-Aging and Disability and the findings from the Long Term Care Consumer Guide Resident Satisfaction Survey to assess waiver participants' experience with community integration and access. Proposed time Frame: 2016 and ongoing.

December 2015: Modification was made to the proposed time frame in the revised draft statewide transition plan.

Proposed Time Frame: 2017 and ongoing

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

December 2015: Public Comment Summary for the Revised Draft Statewide Transition Plan
Dates of the formal public comment period for the revised draft statewide transition plan: October 15, 2015 through November 15, 2015.
Active Link used to post the entire plan:
http://www.healthtransformation.ohio.gov/CurrentInitiatives/ExpandandStreamlineHCBS.aspx.

The state received 8 unduplicated comments on the revised draft statewide transition plan during the formal public comment period. Some submissions addressed a variety of themes. The following is a summary of the comments germane to this waiver:

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

Comment: The principle that individuals and families determine what integration means must permeate the plan.
Response: The plan provides opportunities for the experience of individuals to inform the implementation and ongoing assessment of compliance. No change made to the plan.

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

Comment: Benchmarks and timelines are needed to make sure sufficient progress is made and process is transparent.
Response: The plan outlines the proposed timelines for each component. The State will use existing stakeholder communication avenues to report on implementation progress. No change made to the plan.

Comment: Enforcement mechanism for individuals to challenge any setting not compliant.
Response: Using the existing complaint processes, individuals have the right to file a complaint regarding a specific setting and/or to report directly to the State any concerns with a setting's ability to comply. Upon receiving a report by an individual or another entity, the State will initiate a formal review, as appropriate.

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

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

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

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

December 2015: Public Comment Summary for a Waiver Amendment, submitted 12/2/2015.

Dates of the formal public comment period: October 15, 2015 through November 15, 2015.
Active Link used to post the waiver amendment:

http://www.medicaid.ohio.gov/RESOURCES/PublicNotices/PassportAssistedLiving.aspx.

The state received two comments on the Assisted Living waiver amendment during the formal public comment period. The comments were as follows:

Appendix B

Comment: A representative of a PASSPORT Administrative Agency asks why access to the Assisted Living waiver from hospice is prohibited,
but access to the PASSPORT waiver from hospice was recently approved.
Response: No change was made to the waiver. Ohio Administrative Code Rule 5160-33-03, effective date October 4, 2015, adopted the policy allowing access to the
Assisted Living Waiver from hospice.

Comment: A representative of a PASSPORT Administrative Agency states that all individuals on the Assisted Living waiver are required
to pay a room and board fee, which poses a hardship for married couples when one spouse can afford the room and board fee and
the other cannot. The individual asks why the state does not add a "couple standard" similar to the couple standard for SSI
recipients.
Response: No change was made to the waiver. The state's guidelines for spousal impoverishment currently account for the needs of the
community spouse. The state will take the establishment of a couples standard under consideration and determine if feasible
as a future design consideration for the program.

April 2016: Public Comment Summary for a Waiver Amendment submited 4/1/2016.

Appendix A: Waiver Administration and Operation

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

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

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

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

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

   (Complete item A-2-a).

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

   Specify the division/unit name:
   Ohio Department of Aging

   In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency

agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   The Ohio Department of Medicaid (ODM) maintains oversight of operational and policy development at the Ohio Department of Aging (ODA) through an interagency agreement between ODM and ODA, and thirteen three party agreements with ODM, ODA and the PAAs. These agreements provide for ODM reviews of programmatic compliance with federal and state laws and regulations and in addition to auditing and fiscal compliance. The PAA's, which serve as ODA's designee as outlined in the agreement, are delegated responsibility for the daily operation of the Assisted Living waiver as designated regional entities. ODA is primarily responsible for monitoring the PAAs compliance with state and federal law and policies relative to waiver operations.

   The single State Medicaid Agency's (ODM) oversight of the Operating Agency's (ODA) performance occurs through a combination of on-site assessment, reviews of performance data and management reports, interagency quality briefings, quarterly interagency quality forums, and fiscal reviews.

   ODM monitors ODA's compliance and performance by:

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

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

   3) Assuring the resolution of case-specific problems;

   4) Generating and compiling quarterly performance data;

   5) Convening operating agency Quality Briefings twice a year;

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

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

   ODM's primary means for monitoring waiver compliance with federal waiver assurances occurs through both targeted in person reviews of HCBS waiver consumers and the ongoing review of performance data gathered by ODA and ODM. Through the targeted review process, ODM will identify a target group of waiver consumers using claims and diagnosis information. ODM's staff will perform reviews of the target group to identify best practices as well as areas for improvement in waiver operations, including both service delivery and case management. These reviews will help the State identify and implement system changes that address

vulnerabilities and improve individuals' experiences and health outcomes. If areas of non-compliance or opportunities to improve program performance are identified through this process, ODM may require ODA to develop and implement quality improvement plans and monitor their effectiveness at achieving desired outcomes.

In addition to the information gathered through the State's targeted reviews, ODM will also examine performance data and other information gathered both by ODM and ODA to measure compliance and performance with respect to the federal waiver assurances including service planning, care management, free choice of provider, level of care, health and welfare, hearing rights, participant satisfaction, and validation of service delivery. This data and any remediation (if necessary) will be submitted in accordance with the approved performance measures in the waiver. This information will also be used by ODM to complete the quality sections of the CMS 372 report (submitted to CMS annually) required to demonstrate cost neutrality in the waiver. Similar to the targeted review, if areas of non-compliance or opportunities to improve program performance are identified through this process, ODM may require ODA to develop and implement quality improvement plans and monitor their effectiveness at achieving desired outcomes.

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

ODM also convenes the interagency HCBS waiver quality steering committee (QSC). The committee collects, compiles, and reports aggregate waiver-specific performance data. The committee uses this data to conduct additional analysis as a means to assess and compare performance across Ohio's Medicaid waiver systems, to identify cross-system structural weaknesses, to support collaborative efforts to improve waiver systems, and to help Ohio move toward a more unified quality management system. In 2012, at CMS' recommendation, Ohio engaged with the NQE to update and revise the performance measures used in the State's approved HCBS waivers. The QSC was instrumental in facilitating collaborative interaction across state agencies and with the NQE to support the development of the "core measures" that are reflected in this waiver application.

ODM will receive Assisted Living management reports on a regular basis and discuss the content of these reports with ODA staff at least annually to assess waiver performance and compliance. Assisted Living management reports include monthly enrollment, disenrollment & census reports; data gathered through the waiver's approved performance measures; financial reports, and annual provider certification & activity reports.

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

Lastly, ODM will be informed of all Assisted Living provider certification issues and may participate in the conferences/discussions. The certification process will be facilitated by ODA or its designee. ODA will enter into an agreement with its designee to specify expectations and requirements associated with certification. The PASSPORT Administrative Agency (PAA) is ODA's designee for the Assisted Living program.

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

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

- ( ) **Not applicable**
- (●) **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
  - [x] **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

    Waiver operational and administrative functions are conducted by thirteen regional entities (PASSPORT Administrative Agencies/PAA). Twelve of the regional entities are Area Agencies on Aging and one is a not for profit social service agency. Two PAAs are non-state public agencies, one is a city agency and the other is a federally designated Regional Planning and Development Commission. The remaining eleven are regional non-governmental, non-state entities. The roles and responsibilities of ODM, ODA and these 13 regional entities (the PAAs) are established and documented in an interagency agreement, one with each PAA, referred to as the three party agreements.

    Through the three party agreements operational responsibility for Screening and Level of Care (LOC) Evaluations, Assessments, and Administrative Case Management is delegated to the PAAs and is subject to the quality control and oversight of ODA and ODM. The PAAs are responsible for testifying at state hearings regarding appeals of LOC and PASSPORT services etc., and are bound by the hearing officer's' decisions.

    The PAA is responsible for recruiting, screening and facilitating the certification and enrollment of HCBS waiver providers to ensure an adequate supply of services are available meet the long term care service needs of PASSPORT enrollees. The PAA maintains waiver provider quality assurance processes to ensure that provider claims for PASSPORT waiver services do not exceed authorized limits as specified in approved care plans, that enrollees were eligible PASSPORT services on service claim dates, and that services were delivered on the claim dates as claimed by providers.

    The state Medicaid agency (ODM) has authority in the three party agreements to review and conduct oversight activities to monitor all programmatic responsibilities delegated to ODA and the PAAs. These reviews can be regularly scheduled or occur as needed. Reviews are specific to ODA performance and the performance of the regional entities overseen by ODA. Both financial and program audits are authorized in the agreements which includes audits of the regional entities.
  - [x] **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

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

The relationship, roles, and responsibilities of the REs, ODA, and ODM are defined in an interagency agreement, referred to as the three-party agreement. This agreement gives ODM the authority to review and provide oversight to all programmatic functions.

Through the three party agreement, operational responsibility is delegated to the REs for screening and level of care evaluations, assessment, and administrative case management. The regional entities are responsible for testifying at state hearings and are bound by the hearing officer decisions. All functions are subject to the quality control oversight of ODM and ODA.

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

The ODM conducts scheduled, and as needed, reviews of ODA's oversight of the regional entities.

The Office of Research, Assessment and Accountability (ORAA) conduct audits of the regional entities at least every three years based on risk.

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
The three-party agreement outlines the responsibilities of each entity and the processes established to assure compliance with operational and administrative functions.

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

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

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
The three-party agreements between the ODM, ODA, and the PAAs outline the responsibilities of the two state agencies for assessing the performance of the PAAs. ODM is responsible for ensuring ODA and PAA compliance with federal regulations, including the amount, duration and scope of services, free choice of providers, timeliness of delivery of services to waiver eligible participants and the availability of services statewide. Additionally, ODM conducts A-133 audits of the regional entities at least once every three years.

   In addition, the ODM Bureau of Long Term Care Services and Supports (BLTCSS) performs reviews of performance data and other information, facilitates interagency quality briefings, and convenes the interagency Quality Steering Committee (QSC).

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

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

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. **Performance Measures**

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

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver

- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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

Performance Measure:
Number and percentage of Quality Briefings conducted between ODM and ODA to review performance data submitted by ODA as specified in the waiver application

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quality Briefing minutes and performance measure data

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percentage of performance measure reports with performance measure data submitted to ODM by ODA as specified in the waiver application that were submitted on time and in the correct format

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percentage of incident alerts closed by ODM

Data Source (Select one):
Other
If 'Other' is selected, specify:
ODM Protection from Harm Alert Database

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percentage of Adverse Outcomes for which a plan of correction was required and received from ODA within specified time frames by type of finding. (Imminent, Serious, Moderate, Failure to Report, LOC and Care Planning)

Data Source (Select one):
Other
If 'Other' is selected, specify:
ODM adverse outcome database

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of PAA activity reports submitted by ODA to ODM

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of quality improvement plans required by ODM that were submitted by ODA and accepted by ODM

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

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

	☑ **Other** Specify: As required by ODM	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of PAA monitoring reports submitted by ODA to ODM

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Activities by ODM for addressing individual problems include:

Adverse Outcomes Reporting and Tracking - During the course of any review conducted by ODM, when staff encounter a situation in which a waiver recipient's health or welfare is at risk, or when case management deficiencies are identified, the staff follow a protocol to report these observations. Adverse outcomes are prioritized based upon seven reporting levels: Imminent, Serious, Moderate, Failure to Report, Level of Care, Care Planning and Complaint. Depending on the severity of the situation, the staff will take immediate action, coordinate intervention with providers or case managers, and report the finding to ODM managers. ODM communicates findings to ODA for further review and appropriate intervention, and with explicit variable timeframes within which a report back to ODM is expected. ODM logs and tracks all such findings and referrals to assure appropriate case-specific resolution. ODM convenes an internal Adverse Outcomes committee to determine when an Adverse Outcome is fully resolved and can be closed. Adverse Outcomes data is also aggregated to identify trends and systemic issues.

Activities by ODM and ODA to support systems level remediation include:

1) Bi-annual Quality Briefings - ODM convenes a bi-annual Quality Briefing with ODA in which the agencies share and review performance data. This data includes performance data reflecting ODA's monitoring activities, what, if any, problems were identified, and what corrective actions were initiated. ODM will also report on any findings from its ongoing review in this forum. This Quality Improvement process is described in greater detail in Appendix H.

2) Quality Steering Committee – on a quarterly basis, ODM convenes an interagency, HCBS waiver Quality Steering Committee (QSC). The QSC compiles quarterly waiver-specific performance data to compare performance across waivers and to observe trends. This data, and supplemental data resulting from additional analysis, is used by the QSC to support interagency identification of, and response to, broad-system opportunities for improvement. Depending on the type of opportunity for improvement discovered, remedial action may be initiated by each individual agency or by the committee as a whole. This Quality Improvement process is described in greater detail in Appendix H.

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

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

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

Specify:

Once a disabled (physical) participant reaches the maximum age limit, they become part of the Aged category and waiver enrollment continues.

Appendix B: Participant Access and Eligibility

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

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

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

○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to

that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

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

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

Specify the percentage:

○ **Other**

Specify:

○ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

◉ **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

This waiver consists of two services: assisted living services and community transition service. The community transition service can cost no more than $1,500.00 and the assisted living service is paid on a daily rate, based on the tier assignment. The highest cost tier is $69.98 per day. Therefore, the highest cost for an individual is $27,112.68($69.98 per day X 366 days and a one time Community Transition Service of up to $1,500.00) which is lower than the average institutional cost in Ohio.

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

◉ **The following dollar amount:**

Specify dollar amount: 27113

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

All individuals participate in an assessment that reviews their health status, their behavioral and emotional status, and available support systems. The assessment will also review all potential informal and formal supports that would/could be used to meet the individualÂ's needs. The assessment results in the development of a care plan that identifies services needed to assure the individualÂ's health and welfare. If the cost of the care plan exceeds the individual cost limit, the individual will not be enrolled onto the waiver. The individual will be referred to other options such as other community resources or nursing facility placement. Regardless of the outcome of the assessment, the assessor/case manager will provide the individual with notification regarding fair hearing rights and processes.

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

- [ ] **The participant is referred to another waiver that can accommodate the individual's needs.**
- [ ] **Additional services in excess of the individual cost limit may be authorized.**

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

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

Specify:

Individuals may be referred to other state or local home and community-based services to supplement the waiver services. If no other alternatives are appropriate or available to meet the individual's needs, he/she will be referred for institutional services and fair hearing rights are offered, including an explanation of how to access these rights.

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	4176
Year 2	4545
Year 3	4842
Year 4	4983
Year 5	5078

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

- (●) **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ( ) **The State limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

- (●) **Not applicable. The state does not reserve capacity.**
- ( ) **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

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

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

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

e. **Allocation of Waiver Capacity.**

Select one:

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

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

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

Individuals seeking to enroll in the Assisted Living waiver may enroll in the waiver and receive waiver services no earlier than the date the individual meets all of the following criteria:

1. Basic Medicaid eligibility has been established (Medicaid effective date);

2. Meets the level of care requirements to participate in the waiver;

3. Meets special waiver requirements (e.g. the individual is determined to be included in the target group and has been found to meet other requirements of eligibility specified in the approved waiver including documentation from the individual that he or she chooses to receive waiver services); and

4. Has an approved service plan developed that includes at least one waiver service.

The process for enrollment in the Assisted Living waiver is outlined in the following Ohio Administrative Code rules: 5160-33-03 (Eligibility); 5160-33-04 (Enrollment), and 173-38-03 (Enrollment). In accordance with these rules, entry to the waiver is offered to individuals based on the date of application for waiver services. Entry to the waiver is not prioritized based on the imminent need for services or place of residence at the time of application.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

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

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

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

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

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

Select one:

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

Specify percentage: [ ]

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

Specify:

Sec. 1902(a)(10)(A)(i)(VIII); Sec.1902(a)(10)(A)(i)(IX); 42 CFR 435.110; 42 CFR 435.116; 42 CFR 435.210

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- [x] **A special income level equal to:**

Select one:

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

Specify percentage: [ ]

- ( ) **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

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

Select one:

- ( ) **100% of FPL**
- ( ) **% of FPL, which is lower than 100%.**

Specify percentage amount: [ ]

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☑ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

○ **The following standard included under the State plan**

Select one:

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

(*select one*):

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

Specify the percentage:

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

Specify dollar amount:

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

Specify percentage:

- ○ **Other standard included under the State Plan**

Specify:

- ○ **The following dollar amount**

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

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

Specify:

- ◉ **Other**

Specify:

Supplemental Security Income Benefit

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

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

Specify:

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

- ○ **SSI standard**
- ○ **Optional State supplement standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

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

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

Specify:

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

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

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

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

Specify:

○ **Other**

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

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

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

  Specify formula:

  [ ]
- ( ) **Other**

  Specify:

  [ ]

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

Select one:

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

Explanation of difference:

[ ]

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. **Minimum number of services.**

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

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

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

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

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

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

Specify the entity:

13 regional entities

- ( ) **Other**

Specify:

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

Registered nurses (RN) and social workers (LSW, or LISW)licensed to practice in the State of Ohio complete the initial level of care evaluation for waiver applicants.

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

As a condition of waiver eligibility, applicants must meet a NF LOC as defined in OAC rule 5160-3-08. The nursing facility level of care includes both the skilled level of care (SLOC) and intermediate level of care (ILOC). The criteria for both are described below.

The ILOC criteria is met when long-term care services and supports needs exceed the criteria for protective level of care. ILOC criteria includes skilled nursing service needs, skilled rehabilitation service needs, ADL assistance needs, assistance with medication self-administration, and the need for twenty-four hour support in order to prevent harm due to a cognitive impairment, and can be met in one of the following ways:
• Assistance with a minimum of at least two ADLs.
• Assistance with a minimum of at least one ADL and assistance with medication self-administration.
• A minimum of at least one skilled nursing service or skilled rehabilitation service.
• Twenty-four hour support in order to prevent harm due to a cognitive impairment.

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

The level of care for an adult seeking ODM-administered nursing facility-based waiver services is determined through the ODM 10125 "Adult Comprehensive Assessment Tool" (ACAT).

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

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

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

The ODM 10127 "Adult Level of Care Questionnaire" will assess the needs of individuals 21 and older requesting Medicaid payment for a nursing facility stay. The form identifies the medical and ADL/IADL needs of the individual, including skilled nursing and medication management.

The ODM 10125 "Adult Comprehensive Assessment Tool" (ACAT) is a comprehensive case management tool that will be used in nursing facility-based level of care waiver administration. ODM 10125 includes all of the questions on the ODM 10127 and also includes an evaluation of the individual's living arrangements, family circumstances, caregiver needs, and formal/informal supports.

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

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

Using the ODM 10125, an RN, LSW or LISW completes the assessment and determines whether the applicant meets the SLOC or ILOC criteria set forth in OAC rules 5160-3-08. The individual is also assessed for PASSPORT eligibility pursuant to OAC rule 5160-31-03.

At the time the determination is made, the individual is informed of fair hearing/appeal rights in accordance with OAC Division 5101:6.

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

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

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

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

Specify the other schedule:

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

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

Specify the qualifications:

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

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

In addition, ODA requires the PAAs to submit quarterly record reviews that include data elements related to timeliness of annual re-evaluations. ODA generates and analyzes the PAAs quarterly reports in aggregate to ensure accuracy and to check for anomalies. It is through this analysis that participants who are not receiving timely re-evaluations would be identified. In the event that ODA finds this type of discrepancy, ODA would provide remediation (technical assistance in the form of calls, emails if needed, on-site visits) to the individual PAA. If a statewide pattern or trend is noted, ODA would provide training and monitor through ad hoc visits to the PAAs.

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

Electronically retrievable documentation of all level of care evaluations and reevaluations are maintained in accordance with state and federal regulations. ODA's Information Service Division houses this information in an ODM-approved assessment and case management system in a centralized State server.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
Number and percent of new enrollees who had a LOC indicating the need for institutional LOC prior to receipt of services

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

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

☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of participants with a level of care redetermination completed within 12 months of the previous level of care determination.

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

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of participants with LOC determinations/redeterminations reviewed that were completed using the processes and instruments required by the approved waiver.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Activities for identification and remediation of participant specific problems include:
1) ODM- Periodic performance data collected and analyzed by the ODM Quality Steering committee;
2) ODM- Targeted reviews. Consumer interviews identify participant-specific issues and problems;
3) ODA- On-site monitoring of the regional entities
4) ODA- Quarterly performance data review

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

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
13 regional entities	
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: once per waiver cycle

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

◉ **No**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

At the initial assessment, the assessor (RN or SW) identifies the individual's long term care needs, establishes the individual's level of care, and confirms the individual meets the non-financial program eligibility criteria for waiver enrollment.

All available long term care service options are presented including: waiver enrollment, alternative community options, and nursing facility services.

The individual is and/or the authorized representative is offered the choice of institutional services or home and community based waiver services. If waiver services are selected, the scope of services provided under the waiver are described.

The individual's (or authorized representative's) signature on the Agency-Client agreement form documents the individual's decision to enroll in a waiver program.

The waiver participant is provided the freedom of choice information at the annual re-assessment evaluation, as an option for resolution of service delivery concerns, and upon request.

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

Written copies of the Agency-Client agreement are maintained in a paper file by the regional entities in accordance with state and federal regulations.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
Individuals with limited English proficiency have access to a range of supportive services at the time of application and throughout waiver enrollment. Accommodations for limited English speaking participants are provided at the time of application for Medicaid, at the time of assessment for waiver services, and in conjunction with routine case management and Medicaid determination activities

The Ohio Department of Medicaid (ODM) ensure interpretation services are available at the county and state level for Medicaid applicants and recipients. A variety of ODJFS materials have been translated into Spanish and Somali, including the Medicaid Participant guide and state hearing rights documents. Individuals are informed about how to access interpretation services through the County Department of Medicaid and the regional entities' assessors and case managers.

The regional entities, acting as the operating agency's designee, assures interpretation services are available to participants through sub-contracts with local immigrant and refugee agencies and organizations serving the hearing impaired. Each regional entity adapts program and educational materials to accommodate the language needs of the participants served the specific geographical location.

Appendix C: Participant Services

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

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

Service Type	Service		
Other Service	Assisted Living Service		
Other Service	Community Transition Service		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02013 group living, other

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

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

Service Definition *(Scope)*:
Waiver participants reside in single occupancy living units with full bathrooms in a setting that provides supervision and staffing to meet planned and unscheduled needs.

The scope of the service includes personal care, supportive services (homemaker and chore), 24 hour on site response capability, social and recreational programming, nonmedical transportation and the coordination of the provision of three meals a day and snacks.

Nursing and skilled therapy services are incidental, rather than integral, to the provision of the assisted living service. Required nursing services include health assessment and monitoring, medication management including medication administration, and the delivery of part-time intermittent nursing and skilled nursing up to the maximum allowed in Ohio Administrative Code (OAC) Rule 3701:17-59 and 3701-17-59.1., when not available through a third party.

The scope of the service does not include 24 hour skilled care, one on one supervision, or the provision of items of comfort or convenience, disposable medical supplies, durable medical equipment, prescription medications or over the counter medications.

Double occupancy of a living unit is only permitted under these circumstances:
- Waiver participant requests the double occupancy at the time of the assessment AND
-there is an existing relationship between the waiver participant and the individual.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The service is limited to one unit per calendar day.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Residential Care Facility

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assisted Living Service

Provider Category:
Agency
Provider Type:
Residential Care Facility
Provider Qualifications
License *(specify)*:

Ohio Department of Health
Residential Care Facility (RCF) License
Ohio Administrative Code 3701-17-50 through 3701-17-68.
Certificate *(specify):*
Ohio Department of Aging (ODA)

Ohio Administrative Code 173-39-03 ODA Long Term Care Provider Certification

This rule describes the certification process for community-based long-term care service providers beginning with the request for the application by the licensed RCF and concluding with the final description of how ODA issues the certification

OAC 173-39-02 Conditions of Participation

This rule establishes the requirements and scope of responsibility of licensed residential care facility certified to provide the waiver service.

OAC 173-39-02.16 Assisted Living Service Specification

This rule establishes the guidelines for the living unit requirements to ensure a homelike, non-institutional setting, service scope, and staff orientation, training and supervision.
Other Standard *(specify):*
Ohio Department of Job and Family Services (ODJFS)

OAC 5160-1-17.2
This rule describes the Medicaid Provider Agreement the ODJFS has with the licensed residential care facility certified by the Ohio Department of Aging to provide the assisted living waiver service.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional Entities
Ohio Department of Aging (ODA)
Ohio Department of Job and Family Services (ODJFS)

The verification of provider qualifications for waiver participation begins with the regional entities. The process begins when an Ohio licensed residential care facility completes and submits a waiver provider application packet to the regional entity. An on-site review is conducted by the regional entity to establish the provider can offer home-like single occupancy living units and has the ability to deliver all the elements of the service. The regional entity submits to ODA a recommendation for certification that is substantiated by the facility's application materials. The ODA reviews the materials and recommendation and issues the certification. ODJFS issues a Medicaid Provider Agreement.

Frequency of Verification:
Ohio Department of Health (ODH)
Annual surveys are conducted by the ODH to ensure ongoing compliance with residential care facility license rules.

Regional Entities
Annual on-site reviews are conducted by the regional entity to ensure the waiver services are delivered in accordance with program rules.

Ohio Department of Aging (ODA)
Biennial on-site reviews are conducted by ODA to ensure the waiver providers are delivering the service in accordance with the program rules.

Ohio Department of Job and Family Services (ODJFS)

The Medicaid provider agreement is renewed every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transition Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope)*:

Community Transition Services are non-recurring set-up expenses for individuals who are transitioning from an institutional setting to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

Essential household furnishing needed to occupancy and use a community residence, including furniture, window coverings, food preparation items, and bed/bath linens; set up fees or deposits for utility or service access, including telephone service; moving expenses; and activities to arrange for and procure needed resources.

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

This service may be used one time per waiver enrollment, is delivered within the first 90 days of the initial enrollment date and the total cost of all items/services purchased with the service may not exceed $1500.00.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title

Provider Category	Provider Type Title
Agency	Human Service Agencies, Social Service Agencies, Senior Centers, Community Action Organizations, Home Health Agencies
Individual	Social Workers, Healthcare Professionals, Community-based social service provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Service

Provider Category:
Agency
Provider Type:
Human Service Agencies, Social Service Agencies, Senior Centers, Community Action Organizations, Home Health Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Ohio Administrative Code 173-39-03 ODA Long Term Care Provider Certification

This rule describes the certification process for community-based long-term care service providers beginning with the request for the certification and concluding with the final description of how ODA issues the certification

OAC 173-39-02 Conditions of Participation

This rule establishes the requirements and scope of responsibility of licensed residential care facility certified to provide the waiver service.
This rule describes the Medicaid Provider Agreement the ODJFS has with the licensed residential care facility certified by the Ohio Department of Aging to provide the community transition service
Other Standard *(specify):*
Ohio Department of Job and Family Services
OAC Rule 5160-1-17.2

This rule describes the Medicaid Provider Agreement the ODJFS has with the individual provider certified by the Ohio Department of Aging to provide the community transition service.
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional Entities
Ohio Department of Aging (ODA)
Ohio Department of Job and Family Services (ODJFS)

The verification of provider qualifications for waiver participation begins with the regional entities. The process begins when an Ohio licensed residential care facility completes and submits a waiver provider application packet to the regional entity. An on-site review is conducted by the regional entity has the ability to deliver all the elements of the service. The regional entity submits to ODA a recommendation for certification that is substantiated by the facility's application materials. The ODA reviews the materials and recommendation and issues the certification. Ohio Department of Job and Family Services (ODJFS) enters into a Medicaid provider agreement.
Frequency of Verification:
Regional Entities
Initial and annual on-site reviews are conducted by the regional entity to ensure the waiver services are delivered in accordance with program rules.

Ohio Department of Aging (ODA)

Initial record review and biennial on-site reviews are conducted by ODA to ensure the waiver providers are delivering the service in accordance with the program rules.

Ohio Department of Job and Family Services (ODJFS)

The Medicaid provider agreement is renewed every two years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Service

Provider Category:
Individual
Provider Type:
Social Workers, Healthcare Professionals, Community-based social service provider
Provider Qualifications
License *(specify):*
License as required by profession
Certificate *(specify):*
Ohio Administrative Code 173-39-03 ODA Long Term Care Provider Certification

This rule describes the certification process for community-based long-term care service providers beginning with the request for the certification and concluding with the final description of how ODA issues the certification

OAC 173-39-02 Conditions of Participation

This rule establishes the requirements and scope of responsibility of licensed residential care facility certified to provide the waiver service.
Other Standard *(specify):*
Ohio Department of Job and Family Services

OAC Rule 5160-1-17.2
This rule describes the Medicaid Provider Agreement the ODJFS has with the individual provider certified by the Ohio Department of Aging to provide the community transition service.
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional Entities
Ohio Department of Aging (ODA)
Ohio Department of Job and Family Services

The verification of provider qualifications for waiver participation begins with the regional entities. The process begins when the applicant submits a waiver provider application packet to the regional entity. An on-site review is conducted by the regional entity to establish the applicant has the ability to deliver all the elements of the service. The regional entity submits to ODA a recommendation for certification that is substantiated by the application materials. The ODA reviews the materials and recommendation and issues the certification. ODJFS issues a Medicaid Provider Agreement.
Frequency of Verification:
Regional Entities
Initial and annual on-site reviews are conducted by the regional entity to ensure the waiver services are delivered in accordance with program rules.

Ohio Department of Aging (ODA)
Initial record review and biennial on-site reviews are conducted by ODA to ensure the waiver providers are delivering the service in accordance with the program rules.

Appendix C: Participant Services

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

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

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☑ **As an administrative activity.** *Complete item C-1-c.*

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

Case management activities are conducted by the regional entities as outlined in the three-party agreement signed by Ohio Department of Medicaid, Ohio Department of Aging, and the thirteen regional entities.

Appendix C: Participant Services

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

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

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

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

Ohio requires all providers of community-based long term care services to ensure that employees for paid positions that provide direct care undergo a criminal background investigation through the Ohio Bureau of Criminal Identification and Investigation (BCI & I) criminal background check for all individuals who provide direct care to a waiver participant
The SFY 2013-2014 biennial budget bill (H.B. 59) made significant improvements to the Ohio Revised Code and the Ohio Administrative Code rules clearly establishing both who is subject to the criminal background investigations and how the investigations shall be conducted. These changes also allowed reciprocity between state agencies to reduce duplicative background checks on direct care staff who serve consumers in multiple systems
Assisted Living Service Providers
An eligible provider of this service is required to be a licensed residential care facility by the Ohio Department of Health (ODH) in accordance with Ohio Administrative Code (OAC) 3710-17-50 through 3701-17-68. In order to obtain and retain this licensure, the provider conducts criminal background checks in accordance with Ohio Revised Code 3721.12.1 (Criminal Records Check) and Ohio Administrative Code 3701-13 (Hiring of Direct Care Employees)
Ohio ensures the process for mandatory investigation through an onsite quality review of the provider. Prior to certification, the regional entity confirms the provider's compliance with applicable with the OAC rules referenced above by conducting an on-site employee record review which includes viewing the completed background check conducted the provider and the original results of the background check. The findings are documented in the provider's electronic record maintained by the regional entity and accessible to ODA for retrospective review. In the event there is no evidence the background checks were conducted, the provider's certification is not issued and a complaint referral for potential licensure violation is filed with ODH. The provider's continued compliance with

the background check requirement is established both by the ODH survey process and at the annual structural compliance review conducted by the regional entity. Background check documentation is reviewed for employees hired since the last on-site compliance review.
Community Transition Service
An eligible provider of this service must ensure that employees for paid positions that provide direct care undergo a criminal background investigation through the Ohio Bureau of Criminal Identification and Investigation (BCI&I). Chapter 173-9 of the OAC establishes the requirements and procedures for conducting free database reviews and criminal records checks on applicants and employees for paid positions that provide direct care.

a). Beginning 1/1/2013, all direct care employee applicants need to be screened against relevant abuse and fraud databases. If a prospective provider, or existing agency or non-agency provider meets certain criteria based on the results of their registry screen, the person will not be permitted to furnish services to individuals enrolled on the PASSPORT Waiver.

b). All direct care employee applicants need to have BCI&I checks completed. If the criminal record check with BCI&I does find criminal convictions in the PASSPORT HCBS workerâ€™s past, there are tiered exclusionary periods for disqualifying offenses during which individuals convicted of certain crimes may not be hired. These exclusionary periods apply to both agency and non-agency providers. The exclusionary periods include five, seven and ten-year bars, as well as a permanent exclusion for certain disqualifying offenses.

c). Ohio BCI&I scope of investigation is the state of Ohio. For prospective employees who have resided in Ohio for less than five years, a criminal records check by the FBI is required.

d). Beginning 1/1/2013, the process to ensure mandatory investigations have been conducted includes: statutory authority to ODA, OMA and the Ohio Attorney General to review criminal records checks; a criminal background check log roster to be maintained by the certified provider (173-9-08); and the review of criminal background reports by ODA and its designees for purposes of certification and ongoing monitoring activities (OAC 173-39-03 and 173-39-04 respectively). Specific criminal background check procedures, including disqualifying offenses, are found in ORC 173.394 and OAC 173-9-06.

e). If found, any repeated or pervasive lack of compliance with the background check requirements may result in taking an adverse action against the provider including suspension of new referrals, transfer of participants to another provider, and revocation of the provider certification.

, Ohio ensures the process for mandatory investigation through an onsite quality review of the provider. Prior to certification, the regional entity confirms the provider's compliance with applicable OAC rule requirements by conducting an on-site employee record review which includes viewing the completed background check log and the original results of the background check. The findings are documented in the provider's electronic record maintained by the regional entity and accessible to ODA for retrospective review. The provider's certification is not issued unless compliance with the background check requirements is established. The provider's continued compliance with the background check requirement is established at the annual structural compliance review conducted by the regional entity. Background check documentation is reviewed for employees hired since the last on-site compliance review.

Repeated, pervasive lack of compliance with the background check requirements may result in ODA taking an adverse action against the provider including: suspension of new referrals, transfer of participants to another provider, and revocation of the provider certification.

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

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

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

Appendix C: Participant Services

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

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

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Residential Care Facility	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Ohio defines a residential care facility (RCF) as "a home that provides either of the following: accommodations for 17 or more unrelated individuals and supervision and personal care services for three or more, or accommodations for three or more unrelated individuals who are dependent on the services of others by reasons of age, physical or mental impairment, and provides to a least one of those individuals authorized skilled nursing care." (Source: Ohio Administrative Code (OAC) 3710-17-50 GG)

The average size of an Ohio licensed RCF is 50-60 individuals. The RCF must offer a minimum of 100 square feet for single occupancy living units, a central dining room, living room or parlor, and a common activity area.

In addition to the RCF licensure requirements, an RCF certified to deliver the assisted living waiver service must provide a single occupancy living unit with identifiable eating and living areas and must include a full private bathroom located in the unit. The living unit must be lockable (both inside and outside) at the discretion of the waiver participant unless a physician has certified in writing that the participant is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door.

Double occupancy is not at the provider's discretion and is only allowed when requested by the waiver participant at the time of assessment and is with an individual the waiver participant has an existing relationship with.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Residential Care Facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Assisted Living Service	☑
Community Transition Service	☑

Facility Capacity Limit:

N/A

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☐
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

The Ohio Department of Health (ODH) Residential Care Facility (RCF) rules (3710-17-50 through 3701-17-68) establishes staffing levels must be based on individuals' needs, not on a ratio of the number of individuals residing in the setting. The following requirements assure health and welfare of waiver participants: 24 hour on-site staff, awake and immediately available; a minimum of one staff member on duty at all times qualified to deliver personal care and an additional staff person with the same qualifications to be on call.

Appendix C: Participant Services

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

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

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

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

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

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

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

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

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

- ( ) **Other policy.**

  Specify:

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

The provider procurement and enrollment is a continuous, open process that begins with the regional entities. The number and location of certified waiver providers is not limited by the operating agency or the regional entities. Any licensed residential care facility that meets the Conditions of Participation (Ohio Administrative Code 173-39-03) and demonstrates the capacity to deliver the waiver services according to the service specifications (OAC 173-39.02-16 and 173-39.02-17) and executes a Medicaid Provider Agreement with the Ohio Department Medicaid is eligible to provide waiver services to eligible participants.

The provider application material can be obtained by contacting the regional entities or downloading materials from their websites. For more specific instruction on the certification process, a Provider Certification Guide is maintained on the Ohio Department of Aging's website (http://aging.ohio.gov/providers/al.html)

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of providers that continue to meet certification requirements at time of Structural Compliance Review.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of new providers that meet initial certification requirements prior to providing waiver services

Data Source (Select one):
Program logs
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
N/A

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

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

		Confidence Interval =
☑ **Other** Specify: N/A	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: N/A
	☑ **Other** Specify: N/A	

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
Number and percent of providers who have been verified at the time of their structural compliance review to have met training requirements.

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Using quarterly reports submitted by PAAs, ODA is able to address individual problems as they are discovered and provide technical assistance that may include plans of corrective action. When problems are discovered, the individual PAA is notified and technical assistance is provided using on-site technical assistance, e-mail, phone contact and/or letters to PAA Director.

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: 13 regional entities	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: once per waiver cycle

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

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

Specific settings where individuals reside
• Individuals enrolled on this waiver may only reside in an approved living unit located in a licensed residential care facility certified by the ODA to furnish the assisted living service.

Specific settings where individuals receive services
• Individuals enrolled on this waiver may only receive HCB services when they reside in an approved living unit located in a licensed residential care facility certified by ODA to furnish the assisted living service.

Process to assess and determine all waiver settings meet the HCB settings requirements
• Residential settings: The State has not yet determined whether or not any specific residential setting furnishing the assisted

living service in this waiver currently meets 42 CFR 441.301(c)(4)-(5). Attachment 2 describes the remediation strategies, outlined in the statewide transition plan, for determining the level of compliance

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Service Plan

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

- [x] **Registered nurse, licensed to practice in the State**
- [ ] **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- [ ] **Licensed physician (M.D. or D.O)**
- [ ] **Case Manager** (qualifications specified in Appendix C-1/C-3)
- [ ] **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

- [x] **Social Worker**

Specify qualifications:

Licensed Social Worker (LSW) or Licensed Independent Social worker (LISW)

Valid Ohio license
least one year prior experience in health care, medical social work, or geriatrics.

- [ ] **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

A participant-focused service plan that acknowledges individual preferences, values, and the right to self-determination is developed with each waiver participant. The participant, individuals selected by the participant, if applicable, and the regional entity case manager (RN or LSW/LISW) participate in the initial and ongoing assessment, coordination, and monitoring of a participant's needs, strengths, circumstances, and services to assure the service plan continue to be appropriate.

The process includes the following tasks:

1) Initial assessment to identify participant goals and unmet needs.
2) Development of an individualized written service plan that includes goals and interventions.
3) Participant education to ensure informed choice, understanding the risks and benefits of care options, and decisions and confidentiality standards.
4) Participant education related to the role of the regional entity case manager and how to contact him/her.
5) Participant education regarding the services provided by the Long Term Care Ombudsman, the Ohio Department of Health Complaint Hotline Line, and the Ohio Medicaid Hotline.

The regional entity case manager documents, in the electronic record, who the waiver participant has selected to be involved in the service planning process and identifies, when appropriate, the appointment/involvement of an authorized representative, a durable power of attorney, or a legal guardian. This information is obtained at the initial assessment and updated annually and when changes occur.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

A. At the point the individual selects a waiver provider, the service plan is reviewed by the service planning team comprised of: the participant, individuals selected by the participant, the RE case manager, and the waiver provider's licensed nurse who will be supervising the service delivery. The plan is modified, as needed, by the service planning team within the initial 30 days.

B. The service plan assessment includes: a psycho-social assessment (including consideration of the participant's cultural and spiritual preferences and informal support systems), a functionality assessment (including ADLs/IADLs, and risk factors that may require an individual risk agreement) and a health status assessment (including medical history).

An evaluation of level of cognitive functioning, and when applicable, a mental health assessment is completed to establish that the individual's health and welfare can be ensured in a setting that does not provide 24 hour supervision.

C. Written and verbal descriptions of the services available under the waiver are provided to the participant by the regional entity case manager.

D. The service plan includes the following components: the identified participant need(s), identification of risk factors and participant behaviors/preferences that may require an individual risk agreement, the service(s) ordered to meet the need(s) identified, the goal of the intervention(s), the desired outcome(s), the frequency of the service delivery, the individual or entity responsible for service delivery, and the funding source.

The service plan must always address how waiver participant needs in the following areas are met: medication management, financial management, transportation, and behavioral health needs.

E. The regional entity case manager authorizes and oversees the delivery of waiver services to ensure participant health

and welfare and through a collaborative relationship with the facility staff (ex: licensed nurse), coordinates the community based services identified in the service plan.

F. The regional entity case manager is responsible for oversight and monitoring of the service delivery described in the service plan. Documentation by the case manager, maintained in the participant's record, will address progress made toward the identified goals/outcomes, and/or changes made to accommodate the participant's needs, and to ensure health and welfare.

G. The Service Planning Team will meet on an ongoing basis to review and update the service plan, at a minimum, every twelve months and when an individual risk agreement is indicated and/or modified; or if there is a change in care needs or service provision.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Risk Assessment and mitigation is an integral component of the care plan development process and remains an ongoing consideration when evaluating the effectiveness of the waiver participant's plan.

The service planning team is responsible for the identification of risk factors, the evaluation of the level of risk posed to the participant and/or other residents of the facility, development of an individual risk agreement and ongoing review of the agreement to assess the effectiveness of the plan.

Within the care plan process, the psycho-social assessment and the functional assessment are the primary tools that provide information to substantiate the need for a shared responsibility agreement. The shared responsibility agreement is developed when a risk factor and/or the participant's preference or behavior:

• Deviates from an accepted standard of care;
• Increases the likelihood of an adverse reaction; and
• Results in the lack of consensus on the preferred course of action

The care plan includes the following components:

• Identified risk factor and/or participant preference/behavior;
• Description of the parameters set to mitigate the risk; and
• Corresponding goals, outcomes, services/supports to be provided.

The waiver participants reside in licensed residential care facilities that are required, by residential care facility rules and waiver provider qualifications, to provide on-site, awake staff twenty four hours a day to meet in a timely manner, the participants' total care, supervisory, and emotional needs (OAC 3701-17-54 paragraph C). When only one staff member is on duty, the facility is required to designate another staff member who meets the same qualifications to be on call. In addition, the facility is required to have a written disaster preparedness plan (3701-17-63 paragraph I,) that includes a provision for evacuating residents, provisions for transporting all residents to pre-determined appropriate facility(ies) equipped to meet the residents' needs, and written transfer agreements with these facilities. The staff required to implement the evacuation plan shall be present in the facility at all times (3701-17-63 paragraph C).

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The participant accesses assisted living services by choosing to reside in a licensed residential care facility certified to deliver waiver services. The participant selects the provider from a list of certified facilities provided by the assessor/case manager at the time of enrollment. The selection of a different provider is available to the participant

throughout the enrollment span. The waiver participant and/or their authorized representative can also access the current list of licensed residential care facilities certified as waiver providers at the Long Term Care Consumer Guide website, (www.ltcohio.org.) This resource is maintained by the State Ombudsman Office and in addition to the information listed above, provides information about the facility's most recent licensure survey and the results of resident satisfaction surveys.

The Regional Entity Case Manager will make available to the participant, prior to enrollment, at annual re-assessment, and at any time upon request, the following information about each certified provider that includes:
• facility location, size, and general demographics;
• current licensure and certification reports;
• description of specialty units;
• description of ancillary services; and
• discharge criteria.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The ODM conducts ongoing audits of plans of care maintained by the designated regional entity responsible for participant care plans. Participants who are not in agreement with the current plan of care may request a State Hearing with the ODM. ODM has general authority to provide oversight of the Administering Agency actions regarding the waiver, which includes plans of care.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

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

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

The service plan is a comprehensive description of all the participant's needs, the waiver and non-waiver resources designated to meet the needs, including health services and community integration opportunities. Per residential care facility licensure rules, the provider is responsible for developing an effective back up plan that includes a provision for evacuating residents, provisions for transporting all residents to pre-determined appropriate facilities equipped to meet the residents' needs, and written transfer agreements with these facilities.

The regional entity case manager is responsible for maintaining regular contact with the waiver participant and the facility to ensure timely identification of unmet participant needs or service delivery problems.

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

Documentation of all planning and ongoing monitoring conducted by the case manager is maintained in the ODA's electronic data base.

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

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

Monitoring methods/activities and frequency:

Regional Entity Case Manager

In-person contacts

An individualized contact schedule, based on preferences and circumstances, is developed with the waiver participant. The agreed upon contact schedule is documented in the service plan.

At a minimum, the regional entity case manager conducts quarterly in-person visits with the participant. An in-person visit with the participant is still required even when the individual has a power of attorney or legal guardian who functions as the designated contact for the waiver participant.

Quarterly in-person contact with the facility's licensed nurse to ensure timely identification of unmet participant needs or service delivery problems.

Periodic and ongoing review of documentation completed by the facility staff to ensure the service delivery plan described in the service plan is being implemented.

Periodic and ongoing contact with the participant, authorized representative, facility staff, contracted and/or community-based service providers.

Quarterly record review process with the regional entities. The retrospective review collects and analyzes data elements related to service planning activities. The ODA aggregates and analyzes the data elements related to service planning, implementation, and modification. The reports are used to identify trends, identify areas for process improvement, and establish practice standards.

ODA conducts on-site monitoring of each regional entity and informs the regional entities of the type of follow-up and/or corrective actions required, depending upon the nature of the findings, from the monitoring visit. The regional entity has 30 days to submit a written plan of correction. ODA approves all plans of correction and tracks implementation and outcomes of the approved plans.

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

b. Monitoring Safeguards. *Select one:*

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

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of participants whose service plans have appropriate strategies to address their health and safety risks.

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

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

		☑ **Representative Sample** Confidence Interval = 95% CI with +/-5% MOE
☑ **Other** Specify: PASSPORT Administrative Agency	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participants whose service plans adequately addresses their assessed needs and personal goals, including health and safety risk factors.

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

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

☐ **State Medicaid Agency**		
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% CI with +/-5% MOE
☑ **Other** Specify: PASSPORT Administrative Agency	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of service plans that were developed according to the policies and procedures described in the approved waiver

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

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of service plans reviewed that were updated when the participant's needs changed

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of service plans reviewed that were updated at least annually

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of participants reviewed who received services in the type, scope, amount and frequency specified in the service plan

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

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

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% CI with +/-5% MOE
☑ **Other** Specify: PASSPORT Administrative Agency	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of participants with a signed application for waiver services that indicates choice was offered between waiver services and institutional care.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of participants notified of their rights to choose among waiver services and/or providers.

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Using quarterly reports submitted by PAAs, ODA is able to address individual problems as they are discovered and provide technical assistance that may include plans of corrective action. When problems are discovered, the individual PAA is notified and technical assistance is provided using on-site technical assistance, e-mail, phone contact and/or letters to PAA Director.

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: 13 regional entities	☐ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: once per waiver cycle

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

- (●) **No**
- ( ) **Yes**

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

Appendix E: Participant Direction of Services

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

- ( ) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- (●) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

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

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

- ( ) **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- ( ) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

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

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

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

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

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

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

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

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

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

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

At the time of enrollment in the waiver, the regional entity case manager provides the waiver participant with the following information in both written and verbal formats:

• the right to choose HCBS as an alternative to institutional care; and
• the right to appeal any decision regarding benefits (e.g., failure to be given a choice of HCBS as an alternative to institutional care, denial of choice of services and/or providers, and/or denial, suspension, reduction or termination of benefits, etc.).

In the event of an adverse action, the waiver participant receives a:

• written notice regarding proposed adverse action;
• written notice of the right to a state hearing on the ODJFS 04065;
• written explanation of state hearing procedures on the ODJFS 04059; and
• written confirmation that the request for a hearing must be made with 90 days of the mailing date of the prior notice;

If someone other than the waiver participant submits a written hearing request, the request must also include a written statement signed by the waiver participant authorizing the person to act on their behalf. If a hearing request is made during that time, the proposed action will not be taken until the state hearing is decided.

The waiver participant receives written information regarding:

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

hearing.

The regional entity maintains a copy of the Formal Notice of Approval 4064 in the participant's file. Computer-generated adverse action notices are stored in ODJFS' CRIS-E system.

When an enrolled participant requests an appeal in a timely manner, the regional entity waiver services, as outlined in the care plan, are continued pending resolution of the appeal.The ODJFS form 4065 (Notice of Hearing Rights) is the formal mechanism used to notify participants that services will continue during an appeal. The regional entity case manager also notifies the participant that there is no disruption in services during the appeal period.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

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

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

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

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

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

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

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

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

The Ohio Department of Health (ODH) is responsible for the operation of a complaint system when the issue is pertaining to the residential care facility licensure rules Ohio Administrative Code (OAC) 3701-17-50 through 3701-17-68. ODH maintains a centralized contact point and a coordinated information source regarding allegations submitted through the complaint hotline. Any residential care facility resident, or their representative, may file a complaint with the ODH using a toll-free number. The caller may choose to remain anonymous. Complaints are investigated within thirty days by ODH facility surveyors as outlined in Ohio Revised Code (ORC) 3721.031 regarding the investigation of

complaints; ORC 3721.16 pertaining to discharge and transfer, and ORC 3721.17 which focuses on grievances.

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

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

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

The regional entity case manager is responsible for educating participants regarding the right to voice dissatisfaction and/or register a grievance at any time. The participant is informed that a grievance is not a pre-requisite to a fair hearing nor does filing a complaint/grievance prevent the participant from exercising fair hearing rights. The purpose of the complaint/grievance process is to ensure identified issues are addressed in a timely, thorough manner.

A. Types of complaints to be addressed include, but aren't limited to:
• Health and safety issues;
• General quality of life issues;
• Civil Rights issues;
• Service delivery issues with Medicaid providers;
• Code of Ethics violations; and
• Dissatisfaction with services provided by the regional entity case manager.

Individuals involved in the resolution of the complaint/grievance may include, but aren't limited to:
• Participant, and designated representative;
• Regional entity case manager;
• Regional entity case manager supervisor;
• Regional entity Quality Improvement staff; and
• Medicaid provider staff.

B. Process for addressing the grievance/complaint

Although there are multiple points of entry for a participant to initiate the complaint/grievance process, generally, the participant begins by contacting the assigned regional entity case manager. If the complaint involves the case manager, the participant will contact the case manager's supervisor. Documentation of the participant's stated concerns and subsequent action taken by the regional entity case manager are maintained in the case note section of the electronic participant record.

C. The regional entity case manager or the case manager supervisor will initiate the problem solving process. Problem solving includes determining the exact nature of the concern, assessing probable cause, planning appropriate corrective action, informing all individuals involved of the investigatory findings and corrective action to be implemented, implementing the corrective action, and documenting interventions to resolve the issue.

If the participant is not satisfied with the outcome, the participant may request further review to be completed by:

• Regional Entity Clinical Manager;
• Regional Entity Site Director;
• Operating agency's Community Long Care Division;
• Long Term Care Ombudsman Program; and
• ODH Complaint Hot Line.

At any point in the problem-solving process, the participant may elect to request a fair hearing.

D. Time frames

Within seven days of receipt of the grievance/complaint, the problem-solving process will be initiated.

Documentation of the outcome must occur no later than 30 days from receipt of the grievance/complaint.

Mechanisms Used to Resolve Grievances/Complaints

The operating agency and the regional entities have policies, procedures, and reporting tracking systems. Data collected by the operating agency and/or the regional entity permits the analysis of patterns by type of grievance, time taken to resolve the grievance, and implementation of corrective action.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

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

Ohio has an established incident reporting system that all REs are required to use. Review and response of all critical incidents is required and may be conducted by one or more individuals and/or entities depending on the type of critical incident.

Type of Critical Incidents:
• Unnatural or Suspicious death;
• Abuse, neglect or exploitation allegations;
• Abuse, neglect allegations resulting in emergency room treatment, hospitalization, or removal from the residence;
• Hospitalization as a result of injury or illness of unknown origin;
• Incident or accident resulting in harm to multiple participants;
• Medication errors with health and welfare implications; and
• Theft allegations.

Entity Responsible for Investigation
1st line: Ohio Department of Health, local law enforcement, local prosecutor's office, regional entity case manager;
2nd line: ODA staff;
3rd line: ODJFS staff.

Regional Entity reporting Time Frame to ODA
Critical Incidents: Maximum of two business days upon discovery

Method of Reporting:
ODH reports are made via the Complaint Hotline (phone or email)
ODA reports are made via the web-based interactive data entry system

Other Reportable Incidents
• Adverse media coverage related to a participant;
• Allegations involving a participant which implicate RE or ODA staff;
• Any incidents involving correspondence with the Ohio General Assembly, Governor's office, and
• Centers for Medicare and Medicaid, or the Office of Civil Rights.

Entity Responsible for Investigation
1st line: Regional entity, long term care ombudsman, local law enforcement, local prosecutor's office,
2nd line: ODJFS staff, ODA staff
3rd line: Office of the Inspector General

Regional Entity reporting Time Frame to ODA
Other reportable incidents: Maximum of two business days upon discovery

Although anyone who sees, or has knowledge of, an incident occurring to a waiver participant can report the incident to the regional entity case manager or the Ohio Department of Health, the Ohio Revised Code (ORC) 5101.61 identifies mandatory reporters in Ohio of abuse, neglect, or exploitation as licensed professional staff that includes physicians, nurses, social workers, residential care facility owners and staff with professional licenses, and law enforcement professionals. Ohio Administrative Code (OAC) rule 3701-64-02 gives the responsibility for investigating abuse and neglect or misappropriation of property of residents of a licensed facility to the Ohio Department of Health. A standardized communication process between ODH and ODA regarding allegations of abuse, neglect, and/or misappropriations and any other identified issues of waiver participant's well-being is in place.

Waiver providers are required, through a formal operating agreement and as a condition of participation, to report to the regional entity (RE) any incident that involves a waiver participant using the Ohio Department of Aging (ODA) established incident reporting process. ODA reviews all available information to determine if the actions taken by the first line responders constitute in adequate safeguards to protect participants' health and welfare. Providers who experience continued patterns of inadequate care due to failure to protect the health and welfare of participants are subject to the ODA provider sanctioning procedures and ODM's termination of the Medicaid provider agreement.

Waiver providers report all incidents to the RE by phone at time of discovery or during a face-to-face visit with the Case Manager at time of discovery. The RE is required by ODA to report all critical incidents to ODA via the ODA prescribed data entry system within 2 business days. ODA monitors the critical incident reporting data base daily to assure all incidents are reviewed and to advise the RE of any additional preventative safety actions deemed necessary.

Once alerted to the event of a critical incident, REs are required to submit critical incident reports to ODA within 2 business days upon of knowledge of, or notification of any allegations or critical incidents of: abuse, neglect or exploitation; unnatural or suspicious death; medication errors with health and welfare implications; theft allegations; any incident or allegation involving a participant who alleges abuse or neglect and is hospitalized, or is removed from their residence, or visits an emergency room; hospitalization as a result of injury or illness of an unknown cause or origin; any incident or accident resulting in harm to multiple participants; any adverse media coverage related to a participant; any allegation or incident that involves a participant and implicates a RE or ODA staff member or official; any incidents involving correspondence with any member of the Ohio General Assembly, Governor's Office, CMS or the Ohio Office of Civil Rights; and any other incident deemed immediately reportable to ODA staff for protection of participants from harm. Once ODA had been alerted regarding a critical incident, ODA will notify Ohio Department of Medicaid (ODM) within 2 business days of the event of the critical incident and update ODJFS until resolved.

ODA reports to ODM on a quarterly basis the aggregate number of incidents and total number by incident category reported during the review period statewide and by RE. Incident reporting is calculated on a statewide and regional basis of the total number of incident reports and by category.

ODA reviews any RE with incident reporting or management issues or plans of correction required during ODA's monitoring process. If issues or concerns continue to be noted, the RE would be monitored and/or reviewed for the next 6-12 months. ODA provides ODM a list of technical assistance and/or training conducted to the RE or provider staff.

Ohio Department of Health (ODH) has statutory authority to investigate incidents of alleged abuse, neglect, that have resulted in harm to AL participants, and/or misappropriations of waiver participants' property that occur in Residential Care Facilities (RCF). ODH's rules require that participants have an opportunity for a hearing regarding a transfer or

discharge. A standardized communication process between ODH and ODA regarding allegations of abuse, neglect, and/or misappropriations and any other identified issues of waiver

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

The regional entity staff provide participants and/or authorized representatives with information (verbally and in written format) about reporting policy and procedures for incidents at the time of enrollment, annually, and any time the participant's perceives that his/her rights have been violated.

The regional entity case manager instructs the waiver participant and any informal caregivers about the types of critical incidents and all the options for reporting incidents of abuse, neglect, or exploitation to public authorities, ODM' Medicaid Hotline, ODH's Complaint Hotline (ODH conducts complaint investigations through the year), the State Long Term Care Ombudsman Program, local law enforcement, and the case manager's name and direct number. The case manager reinforces the training on critical incidents during each contact or face-to face visit. The case manager would assist the waiver participant and/or informal caregiver with any formal notification necessary.

The regional entity provides staff with orientation on incidents and reporting procedures. Waiver providers are informed or training occurs at the time of initial certification, during structural compliance reviews and whenever necessary. Waiver providers receive notification of the policy and procedures for incident reporting practices outlined in the Ohio Administrative Code rules that establish the requirements a provider must meet in order to furnish services and assure the health and welfare of the participant.

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

Critical incidents for which ODA has oversight responsibility must be reported to ODA by the regional entity within 2 business days of the knowledge or the notification of a critical incident.

For other reportable non-critical incidents, the regional entity must report to ODA within a maximum of 2 business days of the knowledge or the notification of an incident.

ODA operates an electronic incident reporting database (WIRED)that allows ODA and the regional entities to share information and track the incidents in order to assure the appropriate and timely follow-up and planning. ODA and/or regional entities review critical incidents with waiver participants, ODM, ODH and public authorities, as appropriate.

ODA reviews the reported incidents for completeness of information the remediation plan and makes a determination regarding the need for additional follow-up. The initiation of review would be immediate in response to the type of incident and should be completed within 30 days. A maximum of 180 days is allowed in order for information from outside entities (i.e. waiting for the final outcome of the coroner's office or court proceedings).

ODA and ODM have a collaborative exchange of information privilege through an inter-agency agreement and ODA's risk manager is responsible for responding to inquires by ODJFS related to incidents.

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

ODM, the single state Medicaid Agency, maintains oversight of ODA critical incident operations. ODA has responsibility for oversight and follow-up of critical incidents and events involving waiver participants. ODA provides information about critical incidents to ODM including summary reports of individual incidents meeting high level criteria within two business days; a quarterly report of incidence rates of abuse, neglect and exploitation and holds a semi-annual meeting with ODM to review all incident data, trends and patterns, monitoring of REs and quality improvement activities undertaken during the period. Additional information or actions may be requested from REs by ODA or on behalf of ODM at any time.

Regional entities are required to report to ODA within 2 business days of notification of, or knowledge of, a critical incident as listed in G-1-b. The RE will research all critical incidents listed in G-1-b through waiver participant

interviews, waiver provider interviews, review of pertinent records and case conferences with all necessary parties. ODA may request that further follow-up be provided by RE and/or in some cases, by other appropriate investigatory agencies.

On a quarterly basis, ODA provides ODM with data reports regarding incidents for their review. The two state agencies meet face-to-face on a semi-annual basis to review information that has been previously provided and discuss any findings related to incident reporting or other related issues or concerns. This meeting may occur more frequently if needed. ODM, as the administrative agency, may request additional information of ODA regarding incidents at any time. ODA as the operating agency may request additional information from all of the REs regarding incidents at any time. At a minimum, ODA monitoring will be conducted on an annual basis or as needed in response to a specific event or incident.

ODA's recent implementation of a web-based incident report entry and database (WIRED) provides data entry and tracking functions, as well as a produces a variety of real time report features to enhance ODA's ability to analyze critical incident occurrence and intervention. These report features are available for use by the REs as well as ODA. ODA routinely uses data analysis to identify trends and patterns of incident types to identify opportunities for systemic responses for improvement activities. WIRED enhances the ability to conduct analysis more quickly, more frequently and in more targeted ways, including tracking incidents by provider.

ODA has established a standard to evaluate the REs management of incident reporting. The standard requires all REs to submit at least 90% of incident reports to ODA within two business days or, if the percentage is less than 90% then in an average of no more than three business days. During the second year of the waiver cycle, 89.65% of the critical incidents were reported within two business days. This represents a 9% improvement and a decrease of a half day in the average number days. As the regional entities refine management practices and performance, ODA will continue to increase the performance standard toward 100%.

The Ohio Department of Health (ODH) has a process for facility investigation that includes review of critical incidents. ODH conducts on-site surveys at least once every fifteen months per facility or more often if the number and type of complaints warrant more immediate review. The identification of harmful practices cited by ODH requires the development and approval of a plan of correction. The regional entity is responsible for notifying ODH of any alleged abuse, neglect, or misappropriation of property. ODH provides a written response to the individual/entity filing the complaint regarding the outcome of the investigation. In addition, the Long Term Care Consumer Guide (www.ltc.ohio.org) provides ODA access to the most recent licensure and complaint survey findings.

Appendix G: Participant Safeguards

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

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

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

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

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

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

ODH monitors for unauthorized use of restraints or seclusion in the RCFs through standard survey activities conducted at least every fifteen months and complaint surveys which may take place more frequently than the standard survey. The identification by ODH of the use of restraints or seclusion requires the development and approval of a plan of correction. ODH will provides a report to the State Long Term Care Ombudsman Office

regarding the outcome of survey activity and plans of corrections to ODA. These reports are maintained on the Long Term Care Consumer Guide website (www.ltcohio.org) and are available for public review.

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The only type of restrictive intervention permitted in a licensed residential care facility is the use of a specialized care unit that restricts the individual's freedom of movement throughout the facility. The specialized care unit provides private occupancy living accommodations in a setting that enhances safety and promotes decisional autonomy for waiver participants at all levels of cognitive and physical functioning.

The use of physical and chemical restraints, including emergency use of restraints, is specifically prohibited in a licensed residential care facility. (OAC 3710-17-59 (L)).

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

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

The consumer may choose a private occupancy living unit on a specialized care unit under these conditions:

-Prior to the move, a physician determination must been made that the environment and services provided on the special care unit is needed (OAC 3701-17-58 (F));

-The care and services provided are in accordance with the consumer's needs and preferences, not for staff convenience (OAC 3701-17-59 (L)(2)(c)(i));

-The continued need for a private occupancy living unit on a specialized care unit is established during periodic assessments completed by the RE case manager, facility staff, and the physician. (OAC 3701-17-59 (L)(2)(c)(ii)); and

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

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

The methods used by the regional entity to detect unauthorized use of restrictive interventions include:

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

The initial and subsequent ongoing care planning process assesses consumer needs and identifies the intervention planned to meet the needs. The non-aversive interventions employed to promote independence and choice while ensuring safety of a cognitively impaired individual include, but are not limited to: environmental engineering, predictable daily schedules, prompting, and modeling.

The RE case manager authorizes the use of a private occupancy unit on a specialty care unit. The care plan must reflect a need for Tier III Services. The tier assignment and authorization of a specialty care unit is documented on the consumer's care plan.

The RCF obtains the Physician's determination that a private occupancy living unit on a specialty care unit is required. This documentation is kept in the consumer's medical record maintained by the RCF.

The RE entities are required to maintain initial and annual assessments, which include a functional assessment of ADL/IADLS, and care plans which document the selection of a private occupancy living unit on a specialized care unit.

The facility that operates a specialized care unit is required by state law to disclose to the consumer and/or authorized representative the following information about the specialized care unit: scope of services provided, staff training, and a description of the physical environment and design features (OAC 3701-17-52(D))

The facility is also required to maintain:

An initial and annual health assessment for the consumer, including a functional assessment of ADL/IADLs.

A physician's determination the services of a specialty care unit are required.

The RE case manager responsible for conducting assessments and developing the care plans are registered nurses and licensed social workers.

The RCF licensure rules (OAC 3701-17-55 G, H, I) require initial training and continuing education requirements of direct care staff of specialty care units to include training in Alzheimer's and/or dementia care.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Individual consumer service delivery oversight occurs at RE level in accordance with ODA's established service plan monitoring process outlined in Appendix D. Service delivery records will be reviewed quarterly by the RE for evidence of compliance with the care plan, including the appropriate use of restrictive interventions.

ODA will conduct annual assessment and service plan data reviews via its information management system to ensure restrictive interventions are used as appropriate and is documented.

Issues identified by ODA and/or the REs that are within the jurisdiction of ODH by statute, and rule will be referred to ODH for investigation and follow-up.

ODH monitors the use of restrictive interventions in the RCFs through standard survey activities conducted at least every fifteen months and complaint surveys which may take place more frequently than the standard survey. The identification of mis-use of restrictive interventions by ODH requires the development and approval of a plan of correction. ODH will provide a report regarding the outcome of survey activity and plans of corrections to ODA.

Appendix G: Participant Safeguards

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

c. **Use of Seclusion.** *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The State does not permit or prohibits the use of seclusion**

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

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

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

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

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

i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. **Applicability.** Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. **Medication Management and Follow-Up**

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The waiver participant's physician and waiver provider nursing staff have first line responsibility for assuring that waiver participant's medication regimens are prescribed appropriately and managed effectively. This responsibility includes:
-ensuring medication regimens (including self-administration, medication supervision, and medication administration) are delivered as ordered by the prescribing medical professionals:
-documenting oversight and implementation of the medication regimen outlined in the care plan;
-identifying risk factors to management of the medication regimen (ex: cognitive limitations, multiple medications and/or prescribing medical professionals;
-reporting to the prescribing medical professionals any issues related to the medication regimen, including but not limited to participant compliance and reported and/or observed changes in the participant's response to the medications;

The RE (Case manager) is responsible for conducting an initial comprehensive assessment to determine medication management needs. A reassessment of medication management needs is conducted at least annually and as needed. At each quarterly contact, and as needed, the RE case manager confirms the level of medication management ordered in the participant's care plan is being delivered and reviews the facility record to determine if there have been changes in the medication regimen.

ODH is responsible for on-site monitoring of medication management processes through annual survey activities and through the investigation of complaints related to medication management issues.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

ODH monitors medication management through regular survey activities and complaints. The ODH survey activities are conducted at least once every fifteen months per facility or more often if number and type of complaints warrant more immediate review. The identification of harmful practices cited by ODH requires the development and approval of a plan of correction. The RE and ODA collaborate with the ODH to advise the regulatory agency of any concerns or adverse experiences regarding medication errors.

ODH provides a report to the entity which filed the complaint regarding the outcome of any complaints investigation, as well as the outcomes of annual surveys. The findings were maintained on ODA's Long Term Care Consumer Guide website (www.ltc.ohio.org).

ODA is responsible for conducting annual monitoring of the REs and a review and remediation of medication management issues identified through the critical incident reporting process outlined in Appendix G-1-a.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Ohio Department of Health's residential care facility rule OAC 3701-17-59 limits the administration of medication to a physician, a registered nurse, and a licensed practical nurse holding proof of successful completion of a course in medication administration under the direction or a registered nurse or physician, or a person authorized by law to administer medication (ie: certified medication aide).

A medication record for each participant is maintained which identifies each medication administered and any medication refused by the participant. Observations of negative reactions are recorded in the record and the participant's physician is contacted.

iii. Medication Error Reporting. *Select one of the following:*

- ○ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  Complete the following three items:

  (a) Specify State agency (or agencies) to which errors are reported:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the State:

- ◉ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

  Specify the types of medication errors that providers are required to record:

  The Ohio Department of Health (ODH) licensed residential care facility rules (Ohio Administrative Code OAC 3701-17-62) outlines the action a facility must take when an accident or episode occurs that presents a risk to the health, safety or well-being of a waiver participant.

  The Conditions of Participation (OAC 173-39-02) for require the waiver provider to report, within 2

business days to the regional entity (RE), medication errors with health and welfare implications. The RE and the ODA follow the critical incident reporting process outlined in Appendix G-1.

iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Waiver providers that employ medical professionals with responsibility for the administration of medication to participants are monitored by the regional entity (RE) on a quarterly basis as a part of the RE's ongoing case management. At each quarterly contact, and as needed, the RE case manager confirms the level of medication management ordered in the participant's care plan is being delivered, confirms any changes in the medication regiment, reports to ODA any medication management errors, and assists the waiver provider and consumer with the development of interventions to ensure medication management is delivered as ordered by the prescribing physician.

ODA monitors the waiver provider's management of the participants' medication management on at least an annual basis or as needed. Daily incident report oversight occurs at the RE level in accordance with ODA's established incident reporting process. ODA and the REs will incorporate survey reports and information into its monitoring process.

ODH monitors medication management in the RCFs through standard survey activities conducted at least every fifteen months and complaint surveys which may take place more frequently than the standard survey. The identification of harmful practices cited by ODH requires the development and approval of a plan of correction. ODH will provide a report regarding the outcome of survey activity and plans of corrections to ODA.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Number and percent of critical incidents that were reported within the required time frames as specified in the waiver application

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participants with a critical incident who had a plan of prevention/documentation of a plan, developed as a result of the incident

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of critical incident reviews/investigations that were completed as specified in the approved waiver

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of participants (and/or family or guardian) reviewed who received information regarding how to report abuse, neglect, exploitation and other critical incidents, as specified in the waiver application

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of incidents of unapproved restraint, seclusion or other restrictive interventions with a prevention plan developed as a result of the incident.

Data Source (Select one):
Other
If 'Other' is selected, specify:
WIRED data system

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and Percent of incidents for abuse, neglect and exploitation involving paid caregivers that involved paid caregivers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
WIRED data system

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Activities for identification and remediation of participant specific problems include:
1) ODM Periodic performance data collected and analyzed by the ODM Quality Steering committee;
2) ODM monitoring reviews. Consumer interviews identify participant-specific issues and problems;
3) ODA On-site monitoring of the regional entities
3) ODA Quarterly performance data review
4) ODA Participant complaint process

The state has a variety of methods available to address individual provider-related problems.

The regional entity (the PAAs) provides technical assistance (remote and on-site); this intervention is documented in the provider record maintained by the regional entity. Depending on the issue, the regional entity may request the operating agency become involved with the problem-resolution process.

The operating agency (ODA) may provide technical assistance to a provider and the regional entity; this intervention is generally followed by a written summary of the action plan, with associated time lines and is maintained by the regional entity and accessible to the operating agency.

The regional entity may request written corrective action plans followed by written documentation the plan was implemented, the proposed changes have been sustained, and are achieving the desired outcomes. This documentation is maintained by the regional entity and accessible to the operating agency.

In accordance with the Ohio Administrative Code 173-39-05, the operating agency may, temporarily suspend any new referrals to the provider until the problems that are the basis for the action have been resolved, order the removal of the provider's existing clients, deny reimbursement for undocumented services; and/or order that unearned funds be repaid, and revoke the provider's certification. Written documentation of these actions are maintained in the provider record.

As a final course of action, the administrative agency (ODJFS) may elect to revoke the provider's Medicaid agreement. Documentation of this action is maintained by the administrative agency.

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

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

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

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

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The State's quality oversight strategy for the Assisted Living waiver relies on the collaborative efforts of staff at ODM and ODA to generate and analyze both data and other performance related information to measure compliance with federal waiver assurances and to assure consumer health and welfare.

Role of the State Medicaid Agency (SMA)

Ohio Medicaid has crafted a broad quality strategy that creates a framework for the program to achieve the following aims:

1. Better Care: Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe.

2. Healthy People/Healthy Communities: Improve the health of the Ohio Medicaid population by supporting proven interventions to address behavioral, social and, environmental determinants of health; and

3. Practice Best Evidence Medicine: Facilitate the implementation of best clinical practices to Medicaid providers through collaboration and improvement science approaches.

Within this framework, the State is pursuing program and process changes intended to make care safer, improve care coordination, promote evidence-based prevention and treatment practices, support person and family centered care, and ensure effective and efficient administration. For Ohio's HCBS waivers, this approach to quality builds upon the processes and infrastructure currently in place to measure compliance with federal waiver assurances.

ODM Oversight of Assisted Living

ODM oversees the operation and performance of ODA to ensure the Assisted Living program is operated in accordance with the approved waiver, and to assess the effectiveness of ODA's oversight of the PAAs operating Assisted Living locally. Operation of the Assisted Living waiver is delegated by ODM to ODA and the PAAs through interagency agreements between ODM, ODA, and the State's thirteen PAAs. These agreements include language authorizing ODM to perform oversight activities to establish the program's compliance with federal and state laws and regulations as well as auditing and fiscal compliance. In the Assisted Living waiver, Ohio will integrate the State's Medicaid quality strategy into HCBS waivers by aligning ODM's waiver quality processes with that work. To implement this approach to quality, ODM will employ a multifaceted monitoring and oversight process that includes the following activities:

Targeted Review - ODM places a priority on maintaining a presence in the community to monitor consumer health outcomes and to identify opportunities for program improvement. ODM will initiate a series of targeted reviews of waiver consumers across populations. These reviews will be performed on a subset of consumers enrolled on all of the State's HCBS waivers. Ohio will use claims data and other criteria to identify a target

group on the basis of, for example, diagnosis, service utilization (over or under), Medications, and care management. The goal of these targeted reviews will be to locate "hot spots" within the program and identify at risk consumers who, with the assistance of our partners (sister agencies, case managers, and providers etc.), we can help to avoid or mitigate negative health outcomes. Through this process, ODM may identify opportunities for program improvement and or increased oversight within Assisted Living. Should ODM have findings from the targeted review the department may require ODA to develop and implement corrective action as needed.

Continuous Review of ODA Performance Data- Under the Continuous Review process, ODM will regularly review, monitor, and dialogue with ODA about data generated through the approved waiver's performance measures to gauge performance and compliance with federal waiver assurances including service planning, care management, free choice of provider, level of care, health and welfare, hearing rights, participant satisfaction, and validation of service delivery. Through its review of this data, ODM may request additional information as well as remediation and/or corrective action as appropriate.

Quality Briefings - Twice per year, ODM and ODA will meet to dialogue about data generated through the departments' quality processes. In these meetings, the departments' will review performance data generated through the Targeted Review process and discuss remediation and/or corrective action. These Quality Briefings will also be informed by data presented by ODA on the oversight activities conducted by that department including but not limited to problems detected, corrective measures taken, and how the operating agency verified, or intends to verify, that the actions were effective. The Quality Briefings will also serve as the forum for ODM and ODA to share and review performance metrics identified in the interagency Quality Steering Committee and this application.

Case Specific Resolution - ODM will continue to assure case-specific resolution through "Alert Monitoring" and its "Adverse Outcomes" process.

Quarterly Performance Data and Multi-Agency Quality Forums - ODM convenes the multi-agency HCBS waiver Quality Steering Committee (QSC). The committee collects, compiles, and reports aggregate waiver-specific performance data. The committee uses this data as a means to assess and compare performance across Ohio's Medicaid waiver systems to identify cross-waiver structural weaknesses, support collaborative efforts to improve waiver systems, and to help move Ohio toward a more unified quality management system.

Fiscal Reviews – ODM staff perform regular desk reviews of administrative costs, with A-133 Audits being performed every one to three years based on risk. On a biennial basis, ODM staff conduct audits of PAAs prepared cost reports. Additional detail about Ohio's practice for maintaining fiscal oversight of the Assisted Living waiver can be found in Appendix I.

Open Lines of Communication - ODM and ODA schedule monthly managers meetings in which the departments discuss issues related to program operations including but not limited to: consumer health and safety, program administration, budgeting, enrollment, providers and provider enrollment, provider reimbursement, issues pertaining to Medicaid state plan services, pending legislation, statute and rule changes etc.

Role of the Operating Agency

ODA, in collaboration with ODM, as the SMA, work cooperatively to:
• Assess trends and patterns in the Assisted Living HCBS waiver system;
• Assign priority of essential system changes; and
• To evaluate whether desired outcomes are met.

ODA's system improvement activities are built around the following components:
Data obtained from the PASSPORT Information Management System (PIMS), a monthly report of established performance indicators is compiled to identify both statewide and PAA specific trends. The results are analyzed by ODA and distributed to the PAAs. When indicated, remediation plans are initiated.

Using data derived from the PAA quarterly retrospective case review, quarterly reports are compiled to identify both state-wide and PAA specific trends. The review elements include:

1) The assessment findings supports the level of care(LOC) determination;
2) The LOC criterion was applied correctly;
3) The documentation in the case record supports the determination;
4) All assessed needs and interventions are identified and met;

5) Appropriate interventions are implemented as needed;
6) Follow-up and monitoring of the intervention occurs;
7) Documentation in PIMS case notes of compliance with contact schedule requirements; and
8) Documentation of correspondence and actions through case notes.

The results are distributed to the PAAs and when indicated, remediation plans are initiated.

Using data derived primarily from PIMS, Web-based Incident Report Entry and Database (WIRED), and the PAA quarterly record review, a report is compiled twice a year to analyze the waiver performance measure trends.
Using data derived from the Annual on-site review of each PAA's performance, results of the review are analyzed by ODA and distributed to the PAA. When indicated, remediation plans are initiated.
There are two processes occurring simultaneously each month at ODA:

1) The annual review of a specific PAA and;
2) The analysis and evaluation of the system data compiled from the sources described above.

Monthly meetings are held at ODA to analyze the data; identify any findings/recommendations from the PAA review and make a determination whether remediation is warranted for a specific PAA or statewide. Dissemination of data is shared with all the PAAs to incorporate the findings into the PAA specific system improvement processes. ODA is responsible for monitoring and evaluating the effectiveness and the sustainability of remediation plans developed to address areas of both under-performing and non-compliance by the PAA.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Quality Improvement Committee**	☑ **Annually**
☑ **Other** Specify: 13 regional entities (RE)	☑ **Other** Specify: Continuous and ongoing

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

ODM monitoring and oversight responsibilities include ensuring that ODA is exercising its authority for the day-to-day operation of the waiver in accordance with federal Medicaid requirements. ODM supports and facilitates ongoing qualitative improvements in the systems, procedures, and protocols ODA employs to ensure conformity of providers, recipients, and other entities with federal Medicaid requirements. When a program component is determined to be out of compliance with federal Medicaid requirements, ODM will work with ODA to assess the root cause and develop and implement an appropriate course of action to remedy the program.

ODA monitoring and oversight and responsibilities include ensuring that the regional entities are establishing and implementing systems, procedures and protocols to ensure conformity of providers, recipients, staff, or other entities with federal Medicaid requirements. The ODA will support and facilitate ongoing qualitative improvements in the systems, procedures, and protocols at the PAA level. When a program component is determined to be out of compliance with federal Medicaid requirements, ODM will work with ODA to assess the root cause and develop and implement an appropriate course of action to remedy the problem.

ODM is responsible for ensuring ODA and PAA compliance with federal regulations, including the amount,

duration and scope of services, free choice of providers, timeliness of delivery of services to waiver eligible participant and the availability of services statewide and conducts A-133 audits of the regional entities at least once every three years based on risk.

ODA is responsible for ensuring the PAAs performance is in accordance with the following, in order precedence: Code of Federal Regulations, Ohio's HCBS waivers, Ohio Revised Code, ODM Administrative Code rules and ODA Administrative Code rules, and operational policies.

The assessment methods and frequency include: on-site operational reviews conducted annually; on-site technical assistance visits performed as needed; monthly review of performance data related to assessment, case management, and provider network management.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

On at least an annual basis, ODA in conjunction with ODM, will review the effectiveness of performance measures and any plans of correction, technical assistance provided and training.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Each of the PASSPORT Administrative Agencies (PAA) that the Department of Medicaid (ODM) passes funds on to receive and expend sufficient funding require an annual Single Audit as required by OMB Circular A-133. The Single Audits are performed by independent public accounting firms. The results of these audits are forwarded to ODA along with a corrective action plan to address any audit findings. ODA reviews the results of the audits and follows up with the PAA regarding their corrective action plans. ODA has achieved the goal of reviewing the Single Audit results within 45 days of receiving them.

In addition to the Single Audits, OMB Circular A-133 requires that ODA engage in a sub- recipient monitoring process. Each PAA is fiscally monitored by ODA's Fiscal Management Division on an annual basis and programmatically monitored by ODA's Performance Center division every year. ODA requires the PAAs to submit corrective action plans when the results of the monitoring visit identify noncompliance with laws, rules, regulations and/or ODA policy or weaknesses in internal accounting controls.

Each PAA also receives a financial and compliance audit performed by ODM, the Single State Medicaid Agency in Ohio.

ODM audits cost reports from ODA and the regional PAAs to establish that ODA and the PAA operations are compliant with applicable federal and state requirements, and with the terms and conditions established in three-party agreements between ODM, ODA, and each PAA. The state is currently utilizing a risk-based auditing approach. Under this approach, individual PAAs are audited at least once every three years and ODM determines which PAAs to audit by assessing various risk factors, including: percentage of program dollars, significant changes in expense levels, operational concerns, and the significance of prior audit findings. ODM will continue the practice of performing monthly desk reviews of PAA cost reports.

Additionally as part of the subrecipient monitoring audit, the ODM assesses the fiscal and programmatic monitoring efforts of ODA to assure they satisfy the requirements of OMB Circular A-133. Incorporated within ODM's testing is an assessment as to whether ODA monitors the PAA's activities related to services rendered to beneficiaries and that ODA personnel verifies, on a sample basis, the accuracy and allowability of paid service units. ODM also examines and analyzes data from ODA's claims authorization system as a means to evaluate statewide compliance of paid claims. These sub-recipient audits are conducted annually, and may be for a period of six months to one year based on risk.

ODM performs ongoing audits and reviews to verify the medical necessity and legitimacy of Medicaid paid claims, including whether claims are allowable, reasonable, and compliant with applicable requirements. On an annual basis ODM staff conduct a risk-assessment to determine which types of Medicaid providers and services represent higher risk for

potential fraud, waste, abuse, or noncompliance with other requirements. To determine risk, ODM considers the amount of funds dispersed (materiality), reimbursement changes, fraud risk factors (opportunity, attitude, incentive, and pervasiveness), the strength of Ohio Administrative Code rules, recent rule changes, recent industry changes, control factors, and the program's age. All Risk Factors are rated on a scale of 1 to 10 and then weighted to generate a total risk assessment by category of service.

ODM relies on the outcomes of this risk assessment to guide its strategy for data mining (to identify abnormalities and/or outliers in relation to Medicaid paid claims) and to inform the design of direct audit and review activities. All Medicaid services provided under any Medicaid waiver are subject to the risk-based assessment and review.

ODM communicates the amount of monetary findings to ODM for tracking as an accounts receivable and for collection. ODM staff refer any provider suspected of engaging in fraudulent activities to the Attorney General's Medicaid Fraud Control Unit. Final resolution of these recovery efforts is managed by ODM and/or the office of the Attorney General as appropriate.
ODA also receives an annual Single Audit as performed by the Ohio Auditor of State and is audited under the same guidelines as the PAAs by ODM.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*
   i. **Sub-Assurances:**

      a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Number and percent of waiver claims paid using the correct input rate

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

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

		☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of claims paid for individuals who were enrolled on the waiver on the date of services.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of waiver claims submitted supported by required documentation at time of review

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Findings that result from audits performed by ODM are addressed through corrective action plans and the initiation of recovery activities as appropriate.

In addition, through quarterly reports submitted by PAAs, ODA is able to address individual problems as they are discovered and provide technical assistance that may include plans of corrective action. When problems are discovered, the individual PAA is notified and technical assistance is provided using e-mail, phone contact and/or letters to the PAA's Director. When issues are noted that are systemic, ODA will provide statewide training and monitor during the next monitoring cycle.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**
○ **Yes**

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The Ohio Department of Medicaid and the Ohio Department of Aging are responsible for the development of the provider rates. ODM provides oversight in developing the methodology used to establish the rate and reviewing the data and analysis used compiled by ODA to determine the rates. The provider payment rates are set in Ohio Administrative Code (OAC) 5160-33-07 and, as part of the process of adopting Administrative Code.

Assisted Living Service:
A statewide, acuity-based rate setting methodology is used for the Assisted Living Service. One unit of assisted living service equals one calendar day. The payment rate is based on a three tier model. The tier assignment reflects the level of service the participant requires. Factors that distinguish the tier are the degree of need for supervision to prevent harm to the consumer and the amount of direct care service.

In order to determine the amount of service for each tier, the state analyzed patterns and trends of service use data and expenditures available for the stateÃƒÂƒÃ‚,ÂƒÃƒÂ‚,Ã‚,Â‚ÃƒÂƒÃ‚,Â‚ÃƒÂ‚,Ã‚,Â’s PASSPORT HCBS waiver. A subset of individuals within this waiver who would most likely choose an assisted living waiver option were selected. This subset consists of individuals who disenrolled from the waiver to enter a nursing facility. The state then identified services provided in the waiver (personal care, homemaker, and transportation) which are similar in nature to the tasks performed within the definition of the assisted living service. The state analyzed the service usage of the subset of individuals to establish the amount of service to be provided in each tier.

The Bureau of Labor Statistics Employer Costs for Employee Compensation Report (June 2005), released 9/21/05, was used to determine the total compensation costs (hourly wage and benefit costs) for registered nurses and direct care staff. The OMB Circular A-87 is the source used to establish the administrative costs.

Community Transition Service:
A flat statewide ceiling rate is used for the Community Transition Service. A unit of service is per bid per job. The rate for community transitions services is a maximum rate available to the participant and is based upon experience with the Ohio Access Success grant project.

b. **Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

All provider billings are submitted for review through ODAÃƒÂƒÃ‚,ÂƒÃƒÂ‚,Ã‚,Â‚ÃƒÂƒÃ‚,Â‚ÃƒÂ‚,Ã‚,Â’s PASSPORT Information Management System. Providers can either use a direct data entry module into the database or use a HIPAA compliant electronic data interchange. The regional entities (as described in A-4) will process the billings to determine the extent of payment to the providers. Payment to providers comes from advances provided to the regional entities from state GRF dollars. After the payments are documented, ODA will compile a claim from these payment records and submit it through OhioÃƒÂƒÃ‚,ÂƒÃƒÂ‚,Ã‚,Â‚ÃƒÂƒÃ‚,Â‚ÃƒÂ‚,Ã‚,Â’s MMIS in order for the state to obtain the federal share.

All providers are given the option to bill and be directly reimbursed by ODM. They may choose to exercise this right during the provider certification process.

The OMB Circular A-87 is the source used to establish the administrative costs.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Provider claims are initially reviewed using ODAÂ's PASSPORT Information Management claims processing system. This system contains edits to assure that the participant is enrolled, that the service is prior authorized and is delivered according to the participantÂ's service plan using certified providers with a Medicaid provider agreement. The system identifies an approved payment amount for each service. ODA compiles claims from these approved payment records and submits an electronic file to OhioÂ's MMIS. The MMIS provides controls to ensure that participants are Medicaid eligible and entitled to receive certain waiver services at a certain maximum cost for a given period of time; that providers are eligible to receive payment for those waiver services; and that providers are eligible to provide the certain waiver services.

The annual provider structural compliance reviews, conducted by the regional entities for every waiver provider, include a record review to verify the services authorized and paid were delivered.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [ ] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [ ] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [x] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

ODM is responsible for ensuring ODA and the regional entities are in compliance with federal regulations. The ODM assessment methods and frequency include an ongoing review of a statistically valid sample of waiver consumers and biannual interagency quality briefings facilitated by ODM' Bureau of Community Services Policy. The department's Office of Research, Assessment, and Accountability (ORAA) performs annual A-133 audits of the operating agency (ODA) and the regional entities (the PAAs) at least once every three years based on risk. In addition, Ohio's Auditor of State conducts an Ohio Single State Audit on an annual basis.

ODM uses the ODA and its regional entities as a limited fiscal agent to pay providers for assisted living waiver claims. Providers have the option of submitting their billings directly to the MITS system or to the regional entities for payment. The providers are given the opportunity to select either option at the time they sign their waiver provider agreement. The regional entity adjudicates the claims using the ODA payment system edits to assure appropriateness and accuracy of payment. Subsequently, ODA compiles the claims for submission to MITS in order for the state to gain the FFP. ODM through its MITS will adjudicate the ODA claim.

The regional entities recruit and recommend residential care facilities for certification as waiver providers. During the certification process, providers are informed of the available methods that can be used to submit invoices to the regional entity. The invoices will provide sufficient detail of delivered services including units of service, service dates, and the consumer who received the service. Provider claims are initially adjudicated through ODA's PASSPORT Information Management System (PIMS). This system adjudicates claims to assure several factors are met for the service dates including:

- Consumer is enrolled in the Assisted Living waiver;
- Service is prior authorized as shown through the service plan;
- Units billed are included within the service plan;
- The provider is certified by the local regional entity and has a Medicaid provider number;
- Payments to the provider are limited to the rates identified for each service & tier;
- Provider claims are initially reviewed using ODA's PASSPORT Information Management claims processing system. This system contains edits to assure that the participant is enrolled, that the service is prior authorized and it is delivered according to the participant's service plan using certified providers who have a Medicaid provider agreement;
- The system identifies an approved payment amount for each service;
- ODA then compiles its claim for FFP from these approved payment records and submits an electronic file to Ohio's MITS; and
- The MITS provides controls to ensure that participants are Medicaid eligible and entitled to receive the waiver services provided at a certain cost for a given period of time; that providers are eligible to receive payment for those waiver services; and that providers are eligible to provide the waiver services provided to participants.

The regional entities administrative costs are paid by ODM pursuant to the provisions in the Three Party Agreements and pursuant to the standards of OMB Circular A-133. ODJFS performs audits of those costs as indicated in the Three Party Agreement and each RE at least once every three years based on risk.

As part of ODM's on-going review process, to determine whether ODA complies with financial accountability requirements for waiver enrollees ODM selects a sample of enrollees and associated claims and verifies whether services were delivered within service limits as recorded in PIMS. For enrollees with a recorded patient liability, claims data is reviewed to determine whether patient liability amounts were appropriately accounted for before claims were submitted to ODM for payment. Once patient liability is met, services are eligible for payment through Medicaid. To test the delivery of services in compliance with patient liability and assessed needs, PIMS service authorization and claims data is used for a sample of waiver enrollees. This data is used to review all authorized services for the selected enrollees to assure only those services were delivered. The data was tested to verify that patient liability was appropriately tracked and applied to claims and only authorized services were delivered within authorized limits and denied otherwise.

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ○ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ◉ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Local Senior centers, human and social service agencies that provide community transition services. State or local government providers do no receive payments that in the aggregate exceed the cost of the waiver services.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- ◉ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. **Additional Payment Arrangements**

i. **Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- ( ) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- (●) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

Ohio Department of Aging

ii. **Organized Health Care Delivery System.** *Select one:*

- (●) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ( ) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. **Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

☑ **Appropriation of State Tax Revenues to the State Medicaid agency**

☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

☑ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

To the extent these funds are used for waiver services, the source of funds is a horse racing excise tax (ORC 3769) and some moneys from a nursing facility franchise fee (ORC 3727.51) These funds are allocated directly to ODM through the state's biennial budget process.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- ○ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ◉ **The following source(s) are used**

  Check each that applies:
  - ☑ **Health care-related taxes or fees**
  - ☐ **Provider-related donations**
  - ☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Nursing facility franchise fee.

The authority to use nursing home franchise fee funds currently exists in the CMS approved PASSPORT and Choices waiver programs. In this amendment, the state is seeking to extend that authority to the Assisted Living waiver. This proposed change results from the state legislature's consolidation and appropriation of Assisted Living, PASSPORT and Choices waiver funds into the budget of the Ohio Department of Medicaid.

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- ○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The waiver provider receives two separate payments: the monthly room and board payment and the service payment. These payments come from two different sources. The authorized service payments are paid to the provider by the regional entities, adjudicated through ODA's Information Management System and then through ODMs MMIS system. The room and board payment is made by the waiver participant directly to the waiver provider. The state does not play any role in collecting or paying the room and board payment.

The state's role in the cost of room and board furnished in a residential setting to a waiver consumer is limited to establishing the maximum monthly rate paid by a waiver consumer. The provider may not charge the waiver participant a security deposit or an additional fee above the maximum monthly room and board rate to hold the living unit during a temporary absence (ie: hospital or short term nursing facility stay).

The room and board rate is the current Supplemental Security Income (SSI) federal benefit minus a $50.00 personal needs allowance. The room and board rate increases annually when the SSI benefit cost of living adjustment is applied. The state set the rate to coincide with the Supplemental Security Income to allow for participation in the assisted living waiver of the lowest income individuals. The room and board rate may not exceed the rate established by the state.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. **Co-Payment Requirements.**

ii. **Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	10592.12	5875.00	16467.12	28117.00	16231.00	44348.00	27880.88
2	10720.71	6169.00	16889.71	28117.00	16718.00	44835.00	27945.29
3	10917.21	6477.00	17394.21	28117.00	17219.00	45336.00	27941.79
4	11047.16	6801.00	17848.16	28117.00	17736.00	45853.00	28004.84
5	11242.57	7141.00	18383.57	28117.00	18268.00	46385.00	28001.43

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	4176		4176
Year 2	4545		4545
Year 3	4842		4842
Year 4	4983		4983
Year 5	5078		5078

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay equals all client months in a given program year divided by the total unduplicated clients. In projecting the average length of stay for each program year of this wavier application, client months are estimated by summing beginning monthly caseload plus new enrolls.

For each year, monthly beginning census plus new enrolls are summed and divided by the sum of all new enrolls to generate average length of stay in months per unduplicated participant: sum (monthly census + new enrolls)/sum (monthly new enrolls) = average monthly length of stay per unduplicated participant. This result (average monthly length of stay) is multiplied by 30.4 (average days per month) to produce average length of stay per unduplicated participant expressed in days.

Average Length of Stay (Client months) = [sum of beginning caseload by month)+ (sum of enrollments by month)]/ (total unduplicated clients).

Year 1 Average Length of Stay in client months per unduplicated participant= 7.7 months
[(30525) + (1613)/4176)] = 7.7

Average length of stay in client days per unduplicated participant = 234 days
(7.7 x 30.4) = 234

Year 2 Average Length of Stay in client months per unduplicated participant= 7.52 months
[(32276) + (1925)/4545)] = 7.52

Average length of stay in client days per unduplicated participant = 229
(7.52 x 30.4) = 229

Year 3 Average Length of Stay in client months per unduplicated participant= 7.36 months
[(33406) + (2207)/4848)] = 7.36

Average length of stay in client days per unduplicated participant = 224 days
(7.36 x 30.4) = 224

Year 4 Average Length of Stay in client months per unduplicated participant= 7.36 months
[(34528) + (2142)/4983)] = 7.36

Average length of stay in client days per unduplicated participant = 224 days
(7.36 x 30.4) = 224

Year 5 Average Length of Stay in client months per unduplicated participant= 7.29 months
[(34892 + 2176)/5078)] = 7.29

Average length of stay in client days per unduplicated participant = 222 days
(7.30 x 30.4) = 222

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

   i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

      For each waiver year, Factor D is calculated by dividing the estimated grand total waiver service cost by the estimated unduplicated participants. This factor is calculated using all individuals who would be eligible for the waiver, not a sample. This includes individuals aged 21 and older on the PASSPORT, Choices and Ohio Home Care Waivers and individuals residing in nursing facilities.

   ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

      Projected service utilization for non-waiver services is based on actual utilization of the Assisted Living waiver population during state fiscal years 2011 and 2012, excluding consumers who will be transitioning to the MyCare Ohio waiver. An annual inflation factor of 3% was applied to the historical expenditures to project costs for future waiver years. Eligibility data was used to identify dual eligibles. Drug expenditures were then removed for the dual eligible waiver consumers.

   iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

      The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:
      The control group includes individuals age 21 and older who were institutionalized in a nursing facility during state fiscal year 2012, excluding consumers who are eligible for the MyCare Ohio waiver. Factor G estimates are based on an analysis of nursing facility claims for dates of service during state fiscal years 2011 and 2012. The costs are expected to remain static for all years of the waiver, based on typical nursing facility trends.

   iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

      The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:
      The control group is specified in c-iii. G prime estimates are based on an analysis of non-institutional claims for dates of service during state fiscal years 2011 and 2012. An annual inflation factor of 3% was applied to the historical expenditures to project costs for future waiver years. Eligibility data was used to identify dual eligibles. Drug expenditures were then removed for the dual eligible control group consumers.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	

Waiver Services	
Assisted Living Service	
Community Transition Service	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Service Total:						**44024915.40**
Assisted Living Service Tier 1	day	27	116.00	49.98	**156537.36**	
Assisted Living Service Tier 2	day	166	160.00	60.00	**1593600.00**	
Assisted Living Service Tier 3	day	3729	162.00	69.98	**42274778.04**	
Community Transition Service Total:						**207772.00**
Community Transition Service	items per move	254	1.00	818.00	**207772.00**	
				GRAND TOTAL:		**44232687.40**
				Total Estimated Unduplicated Participants:		**4176**
				Factor D (Divide total by number of participants):		**10592.12**
				Average Length of Stay on the Waiver:		234

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Service Total:						**48499058.96**
Assisted Living Service Tier 1	day	30	118.00	49.98	**176929.20**	
				GRAND TOTAL:		**48725644.96**
				Total Estimated Unduplicated Participants:		**4545**
				Factor D (Divide total by number of participants):		**10720.71**
				Average Length of Stay on the Waiver:		229

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Service Tier 2	day	180	162.00	60.00	1749600.00	
Assisted Living Service Tier 3	day	4058	164.00	69.98	46572529.76	
Community Transition Service Total:						226586.00
Community Transition Service	items per move	277	1.00	818.00	226586.00	
				GRAND TOTAL:		48725644.96
				Total Estimated Unduplicated Participants:		4545
				Factor D (Divide total by number of participants):		10720.71
				Average Length of Stay on the Waiver:		229

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Service Total:						52619843.44
Assisted Living Service Tier 1	day	31	120.00	49.98	185925.60	
Assisted Living Service Tier 2	day	192	165.00	60.00	1900800.00	
Assisted Living Service Tier 3	day	4324	167.00	69.98	50533117.84	
Community Transition Service Total:						241310.00
Community Transition Service	items per move	295	1.00	818.00	241310.00	
				GRAND TOTAL:		52861153.44
				Total Estimated Unduplicated Participants:		4842
				Factor D (Divide total by number of participants):		10917.21
				Average Length of Stay on the Waiver:		224

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Service Total:						**54800162.52**
Assisted Living Service Tier 1	day	33	121.00	49.98	**199570.14**	
Assisted Living Service Tier 2	day	198	167.00	60.00	**1983960.00**	
Assisted Living Service Tier 3	day	4449	169.00	69.98	**52616632.38**	
Community Transition Service Total:						**247854.00**
Community Transition Service	items per move	303	1.00	818.00	**247854.00**	
				GRAND TOTAL:		**55048016.52**
				Total Estimated Unduplicated Participants:		**4983**
				Factor D (Divide total by number of participants):		**11047.16**
				Average Length of Stay on the Waiver:		224

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Service Total:						**56837031.86**
Assisted Living Service Tier 1	day	33	123.00	49.98	**202868.82**	
Assisted Living Service Tier 2	day	202	170.00	60.00	**2060400.00**	
Assisted Living Service Tier 3	day	4534	172.00	69.98	**54573763.04**	
Community Transition Service Total:						**252762.00**
Community Transition Service	items per move	309	1.00	818.00	**252762.00**	
				GRAND TOTAL:		**57089793.86**
				Total Estimated Unduplicated Participants:		**5078**
				Factor D (Divide total by number of participants):		**11242.57**
				Average Length of Stay on the Waiver:		222