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State/Territory Name: Ohio

State Plan Amendment (SPA) #: 21-0006

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

April 27, 2021

Maureen M. Corcoran, Director
Ohio Department of Medicaid
P.O. Box 182709
50 West Town Street, Suite 400
Columbus, Ohio 43218

RE: Ohio 21-0006 HCBS Option-Specialized Recovery Services Program §1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal

Dear Ms. Corcoran:

The Centers for Medicare & Medicaid Services (CMS) is approving the Ohio's 1915(i) state plan home and community-based services (HCBS) benefit state plan amendment (SPA), transmittal number 21-0006. The purpose of this amendment is to renew Ohio's 1915(i) State Plan HCBS benefit. The effective date for this renewal is August 1, 2021. Enclosed is a copy of the approved SPA.

Since the state has elected to target the population who can receive these §1915(i) State Plan HCBS, CMS approves this SPA for a five-year period expiring July 31, 2026, in accordance with §1915(i)(7) of the Social Security Act. To renew the §1915(i) State Plan HCBS benefit for an additional five-year period, the state must submit a renewal application to CMS at least 180 days prior to the end of the approval period. CMS' approval of a renewal request is contingent upon state adherence to federal requirements and the state meeting its objectives with respect to quality improvement and beneficiary outcomes.

Per 42 CFR §441.745(a)(i), the state will annually provide CMS with the projected number of individuals to be enrolled in the benefit and the actual number of unduplicated individuals enrolled in the §1915(i) State Plan HCBS in the previous year. Additionally, at least 21 months prior to the end of the five-year approval period, the state must submit evidence of the state's quality monitoring in accordance with the Quality Improvement Strategy in their approved SPA. The evidence must include data analysis, findings, remediation, and describe any system improvement for each of the §1915(i) requirements.

It is important to note that CMS' approval of this 1915(i) HCBS state plan benefit renewal solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, or the

Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

If there are any questions concerning this approval, please contact me at (312) 353-3653 or your staff may contact Dell Gist at dell.gist@cms.hhs.gov or 312-886-2568.

Sincerely,

[redacted]

Jackie Glaze, Acting Director
Division of HCBS Operations and Oversight

Enclosure

cc:
Carolyn Humphrey, ODM
Rebecca Jackson, ODM
Gregory Niehoff, ODM
Dell Gist, CMS
Cynthia Nanes, CMS
Christine Davidson, CMS
Lynell Sanderson, CMS
Leslie Campbell, CMS
Deborah Benson, CMS

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES**	1. TRANSMITTAL NUMBER: **21-006 (Revised)**	2. STATE **OHIO**
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **August 01, 2021**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ **AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
Section 1915(i) of the Social Security Act; 42 CFR 441.710	a. FFY 2021 $0 b. FFY 2022 $0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-i, pages 1 through 59 Attachment 4.19-B, pages 2, 3	Attachment 3.1-i, pages 1 through 13 (TN 18-015) Attachment 3.1-i, pages 14 through 16a (TN 19-022) Attachment 3.1-i, pages 17 through 58 (TN 18-015) Attachment 4.19-B, pages 2, 3 (TN 15-014)

10. SUBJECT OF AMENDMENT: Renewal of the 1915(i) Home and Community Based Services Option--Specialized Recovery Services Program

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The State Medicaid Director is the Governor's designee

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO:
13. TYPED NAME: **MAUREEN M. CORCORAN**	**Carolyn Humphrey** **Ohio Department of Medicaid** **P.O. BOX 182709** **Columbus, Ohio 43218**
14. TITLE: **STATE MEDICAID DIRECTOR**	
15. DATE SUBMITTED: Jan. 27, 2021	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: January 27, 2021	18. DATE APPROVED: April 27, 2021
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: August 1, 2021	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: Jackie Glaze	22. TITLE: Acting Director, Medicaid & CHIP Operations Group

23. REMARKS:

Instructions on Back

FORM CMS-179 (07-92)

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

Administration and Operation

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

1. Services. *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

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

2. Concurrent Operation with Other Programs. (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*:

***Select one*:**

○	**Not applicable**
●	**Applicable**

Check the applicable authority or authorities:

☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act.** 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 1915(i) State plan HCBS. 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. *Specify:* *(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 specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the 1915(a) contract has been submitted or previously approved.*
☑	**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:*
	The 1915(b)(1) and 1915(b)(4) waivers, specified below, have both been submitted and 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)(3) (employ cost savings to furnish additional services)
☐	§1915(b)(2) (central broker)	☑	§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 §1115 of the Act.** *Specify the program*:

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

●	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	●	The Medical Assistance Unit *(name of unit)*:	Ohio Department of Medicaid
	○	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
		(name of division/unit) *This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.*	
○	The State plan HCBS benefit is operated by *(name of agency)*		
	a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

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

☑ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the

entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

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

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☑	☑	☑
2 Eligibility evaluation	☑	☐	☑	☑
3 Review of participant service plans	☑	☐	☑	☐
4 Prior authorization of State plan HCBS	☑	☐	☑	☐
5 Utilization management	☑	☐	☑	☐
6 Qualified provider enrollment	☑	☑	☐	☐
7 Execution of Medicaid provider agreement	☑	☐	☐	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☑	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☑	☐	☐
10 Quality assurance and quality improvement activities	☑	☑	☑	☐

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

1. Information for potential enrollees will be disseminated by the Medicaid Agency (the Ohio Department of Medicaid [ODM]), the Ohio Department of Mental Health and Addiction Services (OhioMHAS) (collectively referred to as the state), the independent entities contracted to perform enrollments/re-enrollments and to provide the recovery management service, Single Entry Points (SEPs) under Ohio Benefits Long Term-Services & Supports (LTSS), and enrolled provider agencies.
2. ODM makes the final 1915(i) enrollment eligibility decision. Program eligibility determinations and re-determinations, except for financial, will be performed by the independent entities. The Medicaid financial eligibility reviews and the final 1915(i) enrollment will be performed by ODM. Targeting, risk, and needs-based criteria assessments and person-centered planning will be performed by Recovery Managers employed by statewide independent entities, pursuant to state issued policies and procedures. Utilization management staff who report through different lines of authority within the independent entities will serve as the evaluator for verifying program eligibility and for approving the Person-Centered Plan (PCP).

3. Review of participant PCPs will be conducted by the independent entity contracted with the state, pursuant to state-approved policies and procedures. When 1915(i) services are the responsibility of a managed care plan, the plan will review PCPs as part of the managed care plans' utilization management activities. If an individual in the 1915(i) is assigned to/enrolled in a comprehensive care management program operated by an accountable entity (e.g., patient centered medical home, or managed care plan) the individual and the Recovery Manager will participate in the care planning process as a member of the trans-disciplinary team which is directed by the accountable entity's care manager. The PCP developed by the individual and the Recovery Manager will be incorporated into the individualized care plan developed and maintained by the entity accountable for the comprehensive care management. The entity accountable for comprehensive care management will work with the Recovery Manager to coordinate the individual's full set of Medicaid (and Medicare) benefits and community resources across the continuum of care, including behavioral, medical, LTSS, and social services.
4. Prior Authorization of PCPs will be conducted by the independent entity contracted with the state, pursuant to state-approved policies and procedures, or by a managed care plan when the 1915(i) services are the responsibility of the managed care plan.
5. Utilization management will be conducted by the independent entity contracted with the state pursuant to state-approved policies and procedures, and by a managed care plan when the 1915(i) services are the responsibility of the plan.
6. Qualified provider enrollment will be conducted by the state.
7. Execution of Medicaid provider agreements with 1915(i) providers will be conducted by ODM.
8. Establishment of a consistent rate methodology for each State plan HCBS is completed by the Medicaid agency. Managed care plans will establish contracted rates when the 1915(i) services are the responsibility of the plan.
9. State rules governing the State plan HCBS benefit are promulgated by ODM. Policies, procedures and information will be jointly developed by ODM and OhioMHAS.
10. Quality assurance and quality improvement activities will be conducted by ODM and/or its designee pursuant to the quality improvement strategy (QIS) and state-approved policies and procedures.

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

5. ☑ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

6. ☑ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☑ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

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

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

Annual Period	From	To	Projected Number of Participants
Year 1	08/01/2021	07/31/2022	26,509
Year 2	08/01/2022	07/31/2023	35,581
Year 3	08/01/2023	07/31/2024	46,608
Year 4	08/01/2024	07/31/2025	59,110
Year 5	08/01/2025	07/31/2026	74,965

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

Financial Eligibility

1. ☑ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

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

☑ The State does not provide State plan HCBS to the medically needy.
☐ The State provides State plan HCBS to the medically needy. (*Select one*):
☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services. ☐ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

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

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

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

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

Supervision of staff at the independent entities who are performing eligibility determinations/redeterminations and authorizing PCPs is provided by clinically licensed staff from the fields of nursing, social work, psychology, or psychiatry.

All individuals must be trained on the eligibility evaluation and assessment tools and criteria used by the State.

3. Process for Performing Evaluation/Reevaluation. Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

Information about 1915(i) services is posted on the ODM public website at https://medicaid.ohio.gov/FOR-OHIOANS/Programs/Specialized-Recovery-Services. This website summarizes the eligibility criteria, the available services, how to access the independent entities and Recovery Managers, locations where potential enrollees may go to apply, and how to access assessments and services. There is no wrong door for an individual to enter the 1915(i) program:

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

Depending on the entry point, if the individual is new to the system, the SEP or independent entity will perform a brief screen with the individual to determine if an individual will potentially meet eligibility criteria (targeting, risk, and financial criteria). If the individual is already receiving mental health services, the individual's referring provider can perform this brief screen. All individuals meeting targeting, risk, and financial criteria contained within the brief screen can choose an independent entity; those who do not choose one are referred to ODM, who randomly assigns an independent entity. Once referred individuals are assigned to a Recovery Management Agency, a Recovery Manager completes the face-to-face assessment, determines if the individual meets the needs-based criteria, and completes the

initial person-centered planning process.

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

The Recovery Managers and the applicant jointly develop a proposed PCP that includes all federally required elements including desired goals and services requested and deemed necessary to address these goals. All service plans are finalized and approved by the Independent Entity, or, if the individual is assigned to/enrolled in a comprehensive care management program operated by an accountable entity (e.g., patient centered medical home, or managed care plan), by the accountable entity's care manager.

Please see the section 'Supporting the Participant in PCP Development' for further details regarding person-centered care planning. Upon completion of the referral packet (including but not limited to the ANSA, verification of HCBS compliant living arrangement, documentation supporting the SPMI diagnosis or diagnosed chronic condition and initial PCP), the Recovery Manager submits the documents to the utilization management staff at the independent entity through a secure, HIPAA compliant process.

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

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

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

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

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

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

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

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

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

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

1. Have been assessed using the Adult Needs and Strengths Assessment (ANSA) and scored a 2 or higher on the 'Behavioral/Emotional Needs' or 'Risk Behaviors' domains, or scored a 3 on the 'Life Functioning' domain.
2. Demonstrate needs related to the management of his or her behavioral health or diagnosed chronic condition as documented in the ANSA.
3. Demonstrate a need for home and community-based services outlined in the State Plan 1915(i) application and would not otherwise receive that service.
4. Have at least one of the following risk factors prior to enrollment in the program:
   (a) One or more psychiatric inpatient admissions at an inpatient psychiatric hospital; or
   (b) A discharge from a correctional facility with a history of inpatient or outpatient behavioral health treatment; or
   (c) Two or more emergency department visits with a psychiatric diagnosis or diagnosed chronic condition; or
   (d) A history of treatment in an intensive outpatient rehabilitation program for greater than ninety days; or
   (e) One or more inpatient/outpatient admissions due to a diagnosed chronic condition.

And either

5. Have one of the following needs based risk factors: requires the HCBS level of service to maintain stability, improve functioning, prevent relapse, maintain residence in the community, AND who is assessed and found that, but for the provision of

HCBS for stabilization and maintenance purposes, would decline to prior levels of need (i.e., subsequent medically necessary services and coordination of care for stabilization and maintenance is needed to prevent decline to previous needs-based functioning).

Or

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

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

Qualifying Adult Needs and Strengths Assessment (ANSA) Criteria

Persons scoring a 2 or higher on at least one of the items in the 'Behavioral/Emotional Needs' or 'Risk Behaviors' domains of the ANSA or persons scoring a 3 on at least one of the items in the 'Life Functioning' domain may be eligible for 1915(i) services.

The ANSA tool consists of groupings of basic core items that are rated as follows:

- '0' No evidence of need; no need for action
- '1' Significant history or possible need that is not interfering with functioning
- '2' Need interferes with functioning and action is required to ensure identified need is addressed
- '3' Need is dangerous or disabling; requires immediate and/or intensive action

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

The "Behavioral/Emotional Needs" domain includes scoring on psychosis, impulse control, depression, mood disturbance, anxiety, interpersonal problems, antisocial behavior, adjustment to trauma, anger control, substance use, and eating disturbances.

The 'Risk Behaviors' domain includes scoring on suicide risk, non-suicidal self-injurious behavior, other self-harm, victimization/exploitation, danger to others, addictive behaviors, sexual aggression, and criminal behavior.

The "Life Functioning" domain includes scoring on family functioning, medical/physical, employment functioning, social functioning, recreational; developmental/intellectual,

sexuality, independent living skills, residential stability, legal, sleep, basic activities of daily living, medication adherence, transportation, living situation, school, decision making, involvement in recovery, and parental/ caregiving role.

The user's manual for the ANSA is available online at https://praedfoundation.org/tools/the-adult-needs-and-strengths-assessment-ansa/general-manuals-ansa/.

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

State plan HCBS needs-based eligibility criteria	**NF (& NF LOC** waivers)**	**ICF/IID (& ICF/IID LOC waivers)**	**Applicable Hospital* (& Hospital LOC waivers)**
Individuals must: • Have been assessed using the Adult Needs and Strengths Assessment (ANSA) and scored a 2 or higher on the 'Behavioral/Emotional Needs' or 'Risk Behaviors' domains, or scored a 3 on the 'Life Functioning' domain. • Demonstrate needs related to the management of his or her behavioral health or diagnosed chronic condition as documented in the ANSA. • Demonstrate a need for home and community-based services outlined in the State Plan 1915(i)	Need for a minimum of one of the following: • Assistance with the completion of a minimum of 2 ADLs including: ○ **Bathing** (The adult needs assistance with applying cleansing agent and/or rinsing and/or drying.) ○ **Dressing** (The adult needs assistance with putting on and taking off an item of clothing/prosthesis and/or fastening and unfastening an item of clothing/prosthesis.) ○ **Eating** (The adult needs assistance with getting food into his or her mouth and/or	For individuals age 10 and older, the criteria for a developmental disability level of care is met when: (a) The individual has been diagnosed with a severe, chronic disability that: i. Is attributable to a mental or physical impairment or combination of mental and physical impairments, other than an impairment caused solely by mental illness; ii. Is manifested before the individual is age 22; and	Admission criteria for an inpatient psychiatric stay: Ohio has let a contract with a vendor to pre-certify inpatient psychiatric stays. The vendor uses nationally-recognized proprietary care management guidelines for this process. Inpatient psychiatric admission criteria include the need for inpatient treatment because of imminent danger to self or others (as evidenced by imminent risk of additional attempt

application and would not otherwise receive that service. • Have at least one of the following risk factors prior to enrollment in the program: a. One or more psychiatric inpatient admissions at an inpatient psychiatric hospital; or b. A discharge from a correctional facility with a history of inpatient or outpatient behavioral health treatment; or c. Two or more emergency department visits related to a psychiatric diagnosis or diagnosed chronic condition; or d. A history of treatment in an intensive outpatient rehabilitation program for greater than ninety days; or e. One or more inpatient/outpatient admissions related to a diagnosed chronic condition. And either: • Have one of the following needs based risk factors: requires	chewing and/or swallowing.) ○ **Grooming** (The adult needs assistance with oral hygiene and hair care (either washing or brushing/combing hair) and nail care (either cutting fingernails or toenails.)) ○ **Mobility** (The adult needs assistance with bed mobility and/or locomotion and/or transfers inside the house.) ○ **Toileting** (The adult needs assistance with using a toilet/urinal/bedpan and/or changing incontinence supplies/feminine hygiene products and/or cleansing him- or herself.) **OR** • Assistance with the completion of 1 ADL as listed above and with medication self-administration. OR • A minimum of 1 skilled nursing service or skilled rehabilitation service. OR • 24 Hour support, in order to prevent harm, due to a cognitive impairment, as diagnosed by a physician or other licensed health	iii. Is likely to continue indefinitely. (b) The condition is substantial functional limitations in at least three of the following major life activities, as determined through use of the developmental disabilities level of care assessment: i. Self-care; ii. Receptive and expressive communication; iii. Learning; iv. Mobility; v. Self-direction; vi. Capacity for independent living; and vii. Economic self-sufficiency. (c) The condition reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance of lifelong or extended duration that are individually planned and coordinated.	of suicide/homicide or to seriously harm self or others, current plan for suicide/homicide or serious harm to self or others, command auditory hallucinations for suicide/homicide or serious harm to self or others, etc.); or a behavioral health disorder characterized by severe psychiatric or behavioral symptoms (including hallucinations or delusions that are very bothersome to the patient or are associated with severe pressure to respond or act, severely disorganized speech, severe mania, depression, anxiety or comorbid substance use disorder, etc.) accompanied by severe dysfunction in daily living (as evidenced by complete neglect of self-care, complete withdrawal from all social interactions, complete inability to maintain any appropriate aspect of personal responsibility in any

the HCBS level of service to maintain stability, improve functioning, prevent relapse, maintain residence in the community, AND who is assessed and found that, but for the provision of HCBS for stabilization and maintenance purposes, would decline to prior levels of need (i.e., subsequent medically necessary services and coordination of care for stabilization and maintenance is needed to prevent decline to previous needs-based functioning). Or • Previously have met the needs-based criteria above AND who is assessed and found that, but for the provision of HCBS for stabilization and maintenance purposes, would decline to prior levels of need (i.e., subsequent medically necessary services and coordination of care for stabilization and maintenance is needed to prevent decline to previous needs-based functioning).	professional.		adult roles, etc.); or because the patient will not participate in treatment voluntarily and requires involuntary commitment, needs physical restraint, seclusion or other involuntary control, is significantly delirious, or has a behavioral health disorder and requires around-the-clock medical or nursing care for somatic treatment.

*Long Term Care/Chronic Care Hospital

**LOC= level of care

7. ☑ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

A. Severe and Persistent Mental Illness (SPMI) target group:
This 1915(i) State plan HCBS benefit is targeted to persons who have been determined to meet the Social Security Administration's definition of disability who are age 21 and over and who are diagnosed with one of the following behavioral health diagnoses.

ICD-10 CODES	DIAGNOSIS CATEGORY DESCRIPTION
F06.0	Psychotic disorders with hallucinations or delusions
F06.2	Psychotic disorder with delusions
F06.30-F06.34	Mood disorders
F06.4	Anxiety disorders
F07.0	Personality change
F20.0-F29	Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders
F30.10-F30.9	Manic episodes
F31.0-F31.9	Bipolar disorder
F32.0-F39	Major depressive and mood disorders
F40.00-F40.11	Phobic and other anxiety disorders
F40.240	Claustrophobia
F40.241	Acrophobia
F40.8	Other phobic anxiety disorders
F41.0	Panic disorder without agoraphobia
F41.1	Generalized anxiety disorder
F42.2-F42.9	Obsessive-compulsive disorder
F43.10-F43.12	Post-traumatic stress disorder
F43.20-F43.25	Adjustment disorders
F44.0	Dissociative amnesia
F44.1	Dissociative fugue
F44.2	Dissociative stupor
F44.4-F44.9	Dissociative and conversion disorders
F45.0-F45.9	Somatoform disorders
F48.1, F48.9	Other nonpsychotic mental disorders
F50.00-F50.9	Eating disorders
F53	Postpartum depression
F60.3	Borderline Personality Disorder
F63.3-F63.9	Impulse disorders
F64.1-F64.9	Gender identity disorders
F68.10-F68.8	Disorders of adult personality and behavior
F90.0-F90.9	Attention-deficit hyperactivity disorders
F91.0-F91.9	Conduct disorders
F93.0-F93.9	Emotional disorders with onset specific to childhood

F94.0-F94.9	Disorders of social functioning with onset specific to childhood and adolescence

B. Diagnosed Chronic Conditions (DCC) target group:
This 1915(i) State plan HCBS benefit is targeted to persons with one or more of the following Diagnosed Chronic Conditions (DCC), who have been determined to meet the Social Security Administration's definition of disability who are 21 to 64 years of age. A disability determination is NOT required for individuals in the DCC population that are 65 years of age or older, or under age 65 and diagnosed with end-stage renal disease (ESRD).

ICD-10 CODE	DESCRIPTION OF QUALIFYING DCC ICD-10 CODE
B20	Human immunodeficiency virus [HIV] disease
B91	Sequelae of poliomyelitis
C15	Malignant neoplasm of esophagus
C16	Malignant neoplasm of stomach
C17	Malignant neoplasm of small intestine
C18	Malignant neoplasm of colon
C19	Malignant neoplasm of rectosigmoid junction
C20	Malignant neoplasm of rectum
C21	Malignant neoplasm of anus and anal canal
C22	Malignant neoplasm of liver and intrahepatic bile ducts
C23	Malignant neoplasm of gallbladder
C24	Malignant neoplasm of other and unspecified parts of biliary tract
C25	Malignant neoplasm of pancreas
C26	Malignant neoplasm of other and ill-defined digestive organs
C30	Malignant neoplasm of nasal cavity and middle ear
C31	Malignant neoplasm of accessory sinuses
C32	Malignant neoplasm of larynx
C33	Malignant neoplasm of trachea
C34	Malignant neoplasm of bronchus and lung
C37	Malignant neoplasm of thymus
C38	Malignant neoplasm of heart, mediastinum and pleura
C39	Malignant neoplasm of other and ill-defined sites in the respiratory system and intrathoracic organs
C40	Malignant neoplasm of bone and articular cartilage of limbs
C41	Malignant neoplasm of bone and articular cartilage of other and unspecified sites
C43	Malignant melanoma of skin
C45	Mesothelioma
C46	Kaposi's sarcoma
C47	Malignant neoplasm of peripheral nerves and autonomic nervous system
C48	Malignant neoplasm of retroperitoneum and peritoneum
C49	Malignant neoplasm of other connective and soft tissue
C50	Malignant neoplasm of breast
C51	Malignant neoplasm of vulva

C52	Malignant neoplasm of vagina
C53	Malignant neoplasm of cervix uteri
C54	Malignant neoplasm of corpus uteri
C55	Malignant neoplasm of uterus, part unspecified
C56	Malignant neoplasm of ovary
C57	Malignant neoplasm of other unspecified ovary
C58	Malignant neoplasm of placenta
C60	Malignant neoplasm of penis
C61	Malignant neoplasm of prostate
C62	Malignant neoplasm of testis
C63	Malignant neoplasm of other and unspecified male genital organs
C64	Malignant neoplasm of kidney, except renal pelvis
C65	Malignant neoplasm of renal pelvis
C66	Malignant neoplasm of ureter
C67	Malignant neoplasm of bladder
C68	Malignant neoplasm of other and unspecified urinary organs
C70	Malignant neoplasm of meninges
C71	Malignant neoplasm of brain
C72	Malignant neoplasm of spinal cord, cranial nerves and other parts of central nervous system
C73	Malignant neoplasm of thyroid gland
C74	Malignant neoplasm of adrenal gland
C7A	Malignant neuroendocrine tumors
C7B	Secondary neuroendocrine tumors
C77	Secondary and unspecified malignant neoplasm of lymph nodes
C78	Secondary malignant neoplasm of respiratory and digestive organs
C79	Secondary malignant neoplasm of other unspecified sites
C80	Malignant neoplasm without specification of site
C81	Hodgkin lymphoma
C82	Follicular lymphoma
C83	Non-follicular lymphoma
C84	Mature T/NK-cell lymphomas
C85	Other specified and unspecified types of non-Hodgkin lymphoma
C86	Other specified types of T/NK-cell lymphoma
C88	Malignant immunoproliferative diseases and certain other B-cell lymphomas
C90	Multiple myeloma and malignant plasma cell neoplasms
C91	Lymphoid leukemia
C92	Myeloid leukemia
C93	Monocytic leukemia
C94	Other leukemias of specified cell type
C95	Leukemia of unspecified cell type
C96	Other and unspecified malignant neoplasms of lymphoid, hematopoietic and related tissue
D57	Sickle-cell disorders
D58	Other hereditary hemolytic anemias

D65	Disseminated intravascular coagulation [defibrination syndrome]
D66	Hereditary factor VIII deficiency
D67	Hereditary factor IX deficiency
E84	Cystic fibrosis
K72.1	Chronic hepatic failure
K72.10	Chronic hepatic failure without coma
K72.11	Chronic hepatic failure with coma
K72.9	Hepatic failure, unspecified
K72.90	Hepatic failure, unspecified without coma
K72.91	Hepatic failure, unspecified with coma
N18.6	End Stage Renal Disease (ESRD)
Q85	Phakomatoses, not elsewhere classified
Z76.82	Awaiting organ transplant status
Z94	Transplanted organ and tissue status
Z21	Asymptomatic human immunodeficiency virus [HIV] infection status

Individuals in the 1915(i) cannot be concurrently enrolled in another HCBS authority (e.g., a 1915(c) waiver). The individual will be enrolled in the HCBS authority best meeting the totality of the individual's needs regardless of the order in which the individual applied or became eligible for the HCBS authority subject to the choice of the individual (e.g., if the individual was on the 1915(i) but became eligible to be enrolled for a 1915(c) waiver that better met his or her needs, then the individual, at his or her option, could be enrolled in the 1915(c) waiver and disenrolled from the 1915(i) – conversely, an individual on a 1915(c) waiver whose needs are better met by the 1915(i) may choose to be enrolled in the 1915(i) and disenrolled from the 1915(c) waiver).

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

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

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

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) 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 person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*:* One	
ii.	**Frequency of services**. The state requires (select one):	
	●	**The provision of 1915(i) 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 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

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

1. ☑ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

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

All 1915(i) services are provided to individuals who reside in home and community-based settings meeting HCBS characteristics in 42 CFR 441.710. These individuals must also receive their 1915(i) services in their home or the community.

Prior to any enrollment into the 1915(i), the Recovery Manager will review the HCBS living and provider settings of all individuals receiving State Plan 1915(i) services to ensure that all individuals live and receive services in settings that meet the standards outlined in 42 CFR 441.710 (a)(1)(i) through (a)(1)(v). The recovery manager's scope of responsibilities include on-going monitoring of the settings for compliance with HCBS regulations. The independent entity will review and validate compliance with setting requirements. ODM, or its designee, will ensure HCBS compliance through its regulatory oversight activities of the contracted independent entities and will enforce compliance actions as necessary.

In settings that are provider-owned and -controlled, the Recovery Manager's responsibility is to

ensure the settings demonstrate the home and community-based qualities outlined in 42 CFR 441.710 (a)(1)(vi). Please note: the certified residential settings are intended to be homes where the individual lives. The majority of services and behavioral healthcare is provided in other locations outside of the residence, such as in the community at large or in a clinic setting. The 1915(i) services are designed to be delivered in community settings including, but not exclusively, in the individual's home.

At the time of assessment, reassessment or when a permanent change of residence occurs, the Recovery Manager uses the HCBS verification checklist to gather information regarding an individual's residence. The purpose of the checklist is to provide a consistent method for determining an individual's experience with community integration through the HCBS characteristics of his or her residence. The content of the checklist is based on the federal HCBS regulations and the CMS Exploratory Questions, and includes two sections of inquiry: qualities required for all home- and community-based settings and additional conditions required for provider-owned and -controlled settings. The checklist includes a series of questions directed to the individual, their guardian or authorized representative about the individual's experience residing in that setting.

The Recovery Manager does not make a determination about whether the setting is compliant during the time of the visit. For settings that appear compliant, the Recovery Manager forwards the checklist along with all other relevant eligibility and enrollment information to the independent entity for review and approval prior to enrollment in the program. The independent entity reviews the information documented by the HCBS verification checklist to ensure that compliance with HCBS setting requirements has been demonstrated.

If the setting does not appear to be compliant with the HCBS regulations, prior to an individual's enrollment in the 1915(i), the Recovery Manager convenes a meeting of the individual's transdisciplinary team to discuss specific options available to the individual. Options may include: actions that could be taken by the housing provider to make the setting compliant with HCBS requirements, remaining in the setting without the support of the 1915(i), or, prior to enrollment in the 1915(i), relocation to a different setting that is an HCBS-compliant setting. Tasks are assigned to team members and timelines are established to ensure that the action steps for the individual's preferred option are followed up on in a timely manner and prior to the individual's enrollment in the 1915(i).

The independent entity reviews the information documented on the HCBS verification checklist. If that review indicates that the setting is not compliant with HCBS settings requirements, the independent entity will submit the proposed denial of enrollment to ODM for review. Once received, ODM will review the setting information in accordance with the HCBS settings criteria set forth in 42 CFR 441.710 (a) to determine compliance, and will inform the independent entity of the determination. If a setting is ultimately determined not to be an HCBS setting, the individual is denied enrollment and afforded due process.

Most persons eligible for the 1915(i) services live in their own home or with families or friends that are either owned or leased by the individuals their family or friend in the same manner as any adult who does not have a mental illness or diagnosed chronic condition. There are some persons

seeking these services who do not have family or friends with whom they can live or are not functioning at a level where their health and safety can be supported in a totally independent setting. Depending upon the person's level of need and functioning, he or she may choose to live in a licensed Adult Care Facility which is a provider-owned or controlled setting that furnishes the level of support and supervision the individual needs in order to live in the community.

Peer recovery support is provided in a variety of HCBS settings including: the individual's home, a community mental health center, a peer recovery center and other community settings where an individual and a peer may meet and interact i.e. community center, park, grocery store, etc. IPS-SE services may be provided in an individual's home, a community mental health center, an IPS-SE provider's office, at an individual's place of competitive employment. Peer and IPS-SE services may not be provided in hospitals, nursing facilities, IMD's and other settings which isolate people with severe and persistent mental illness from the community at large.

In order to be considered community-based, these settings must meet the additional conditions outlined in 42 CFR 441.710 (a)(1)(vi).

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

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

Person-Centered Planning & Service Delivery

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

1. ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☑ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☑ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

Recovery Managers conducting the face-to-face* evaluation for eligibility determination/ redetermination must meet state conflict of interest standards and have:

- A bachelor's degree in social work, counseling, psychology, or similar field or be a Registered Nurse (RN) with a current, unrestricted license;
- A minimum of three years post-degree experience working with individuals with severe and persistent mental illness (SPMI) or one year post-degree experience working with individuals with diagnosed chronic conditions;
- Training in administering the ANSA,
- Training in person-centered planning,
- Training in evaluating HCBS living arrangements,
- Training in HIPAA privacy requirements,
- Training in 42 CFR part 2 confidentiality of alcohol and drug abuse patient records,
- Training in incident reporting.

*When applicable, evaluations may be conducted by video conference or telephonically in lieu of a face-to-face visit.

5. Responsibility for Development of Person-Centered Service Plan. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

Individualized PCPs are developed by individuals meeting the requirements in number 4 above.

6. Supporting the Participant in Development of Person-Centered Service Plan. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the*

supports and information made available, and (b) the participant's authority to determine who is included in the process):

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

The following process and expectations are adhered to by Recovery Managers developing the PCP with individuals:

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

- Review, discussion and documentation of the applicant/individual's desires, needs, and goals.
- Goals are recovery, habilitative or rehabilitative in nature with outcomes specific to the needs identified by the applicant/individual.
- Review of psychiatric symptoms and how they affect the applicant/individual's functioning, and ability to attain desires, needs and goals and to self-manage health services.
- Review of the applicant/individual's skills and the support needed for the applicant/individual to manage his or her health condition and services.
- Review of the applicant/individual's strengths and needs, including medical and behavioral.
- Including all people the individual has identified.

Recommendations for the individualized PCP are developed by the individual and the Recovery Manager and the trans-disciplinary care team, when the 1915(i) services are the responsibility of a managed care plan and includes:

- The short- and long-term goals as defined by the individual.
- The strengths, needs, and preferences as identified by the individual
- The identified Medicaid and non-Medicaid services
- The nature, amount and scope of the identified 1915(i) services.
- The nature of the non-Medicaid services and supports
- The PCP reflects that the setting in which the individual resides is chosen by the

individual and is an HCBS setting. The setting chosen by the individual is integrated in, and supports full access of, individuals receiving 1915(i) services to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving 1915(i) services.

- The PCP reflects the individual's strengths and weaknesses.
- The PCP reflects the clinical and support needs as identified through an assessment of functional need.
- The PCP includes individually identified goals and desired outcomes.
- The PCP reflects the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports.
- The PCP reflects risk factors and measures to minimize them, including individualized back up plans and strategies when needed.
- The PCP is understandable to the individual and others. The PCP is written in plain language and in a manner that is accessible to individuals with disabilities and persons with limited English proficiency.
- The PCP identifies the Recovery Manager responsible for monitoring the plan.
- The PCP was finalized and agreed to, with the individual's informed consent in writing, and signed by the individual and the 1915(i) service providers responsible for its implementation and explains how the final PCP will be distributed to the individual and providers.
- The PCP prevents the provision of unnecessary or inappropriate services and supports.
- If any restrictive interventions or supports to address a risk were identified then the PCP must include the following:
    - Identify the specific and individualized assessed need.
    - Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
    - Document less intrusive methods of meeting the need that have been tried but did not work.
    - Include a clear description of the condition that is directly proportionate to the specific assessed need.
    - Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
    - Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
    - Informed consent of the individual or legal representative or guardian.
    - Assurance that interventions and supports will cause no harm to the individual.

The Recovery Manager who assists the individual in developing recommendations for his or her PCP does so with the active involvement of the individual. The Recovery Manager will then:

- Provide the applicant/individual of 1915(i) services a list of eligible provider

agencies and services offered in his or her geographic area, or which are under contract with the managed care plan.
- Support the individual in selecting providers of choice.
- Link the individual to his or her selected providers.

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

If an individual in the 1915(i) is assigned to/enrolled in a comprehensive care management program operated by an accountable entity (e.g., patient centered medical home, or managed care plan) the individual and the Recovery Manager will participate in the care planning process as a member of the trans-disciplinary team, which is directed by the accountable entity's care manager. The PCP developed by the individual and the Recovery Manager will be incorporated into the individualized care plan developed and maintained by the entity accountable for the comprehensive care management. The entity accountable for comprehensive care management will work with the Recovery Manager to coordinate the individual's full set of Medicaid and Medicare benefits and community resources across the continuum of care, including behavioral, medical, LTSS, and social services.

Each eligible 1915(i) Recovery Manager and managed care plan is required to provide a written statement of rights to each individual. The statement shall include:
(1) The toll-free consumer hotline number and the telephone number for Ohio protection and advocacy, including any ombudsman assigned to the individual's managed care program.
(2) Document that the Recovery Manager provides both a written and an oral explanation of these rights to each applicant/individual.

All complaints/grievances regarding 1915(i) provider agencies may be submitted to:
- The individual's managed care plan or
- The "Ohio Medicaid Consumer Hotline" (1-800-324-8680)

7. Informed Choice of Providers. *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

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

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

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

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

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

"Person-Centered Services Plan" is the document that identifies person-centered goals, objectives, and interventions selected by the individual and team to support him or her in his or her community of choice. The plan addresses the assessed needs of the individual by identifying medically-necessary services and supports provided by natural supports, medical and processional staff, and community resources.

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

9. Maintenance of Person-Centered 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 §74.53. Service plans are maintained by the following *(check each that applies):*

☑	Medicaid agency	☐	Operating agency	☑	Case manager
☑	Other (*specify):*	Managed Care Plan			

Services

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

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Recovery Management
Service Definition (Scope):	

Recovery Management includes coordinating all services received by an individual and assisting the individual in gaining access to needed Medicaid State Plan and 1915(i) services, as well as medical, social, educational, and other resources, regardless of funding source. Recovery Managers are responsible for monitoring the provision of services included in the PCP to ensure that the individual's needs, preferences, health, and welfare are promoted. Time spent by the Recovery Manager for the referral, eligibility evaluation, person-centered planning recommendations cannot be billed or reimbursed under the 1915(i) benefit before eligibility for this benefit has been determined. The Recovery Manager:

- Assists the individual in making recommendations for the PCP using a person-centered planning approach which supports the individual in directing and making informed choices according to the individual's assessed needs, preferences, and personal goals, and considers health and safety risk factors;
- Coordinates all services received by the individual including logistical support, advocacy and education to assist individuals in navigating the healthcare system.
- Provides supporting documentation to be considered by the independent entity in the review and approval process;
- Identifies services / providers, brokers to obtain and integrate services, facilitates, and advocates to resolve issues that impede access to needed services;
- Develops / pursues resources to support the individual's recovery goals including non-HCBS Medicaid, Medicare, and/or private insurance or other community resources;
- Assists the individual in identifying and developing natural supports (family, friends, and other community members) and resources to promote the individual's recovery;
- Informs individuals of fair hearing rights;
- Assists the individual with fair hearing requests when needed and upon request;
- Assists the individual with retaining HCBS and Medicaid eligibility;
- Educates and informs individuals about services, the individual person-centered planning process, resources for recovery, rights, and responsibilities;
- Actively coordinates with other people and/or entities essential to physical and/or behavioral services for the individual (including the individual's managed care plan or patient-centered medical home) to ensure that other services are integrated and support the individual's recovery goals, health, welfare, and wellness. The goal of active coordination is to ensure that there are no gaps in or duplication of services. Coordination includes activities that help individuals gain access to needed health (physical and behavioral health) services, manage their health conditions such as adhering to health regimens, scheduling and keeping medical appointments, obtaining

and maintaining a primary medical provider and facilitating communication across providers.

- Actively participates in the care planning process as a member of the trans-disciplinary team which is directed by the accountable entity's care manager when an individual in the 1915(i) program is assigned to/enrolled in a comprehensive care management program operated by an accountable entity (e.g. patient centered medical home or managed care plan). The PCP will be incorporated into the individualized care plan developed and maintained by the entity accountable for the comprehensive care management. The entity accountable for comprehensive care management will work with the Recovery Manager to coordinate the individual's full set of Medicaid and Medicare benefits and community resources across the continuum of care, including behavioral, medical, LTSS, and social services.
- Coordination of health services across systems, including but not limited to:
    - Physician consults
    - Serving as a communication conduit between the consumer and specialty medical and behavioral health providers
    - Notification, with the individual's permission, of changes in medication regimens and health status
    - Coaching to individuals to help them interact more effectively with providers
- Monitors health, welfare, wellness, and safety through regular monthly contacts (calls and visits with the individual, paid and unpaid supports, and natural supports) wherever the individual lives, works, or has activities;
- Responds to and assesses emergency situations and incidents and assures that appropriate actions are taken to protect the health, welfare, wellness, and safety of individuals;
- Monitors Plan of Care services, which includes but is not limited to review of providers' service documentation, the individual's participation and satisfaction with services and evaluating appropriate utilization, quality of services, gaps in care. Through the ongoing monitoring process, if there is discovery of a significant change event (e.g., inpatient hospital admission), the Recovery Manager will contact the individual by telephone by the end of the next calendar day. If there is confirmation of a significant change event, then a face to face visit must take place by the end of the third calendar day following the discovery.
- Updates the assessment, as applicable, and makes recommendations to the independent entity, or, if the individual is assigned to/enrolled in a comprehensive care management program operated by an accountable entity (e.g., patient centered medical home, or managed care plan), the accountable entity's care manager for the individual updates the PCP, based on information discovered during ongoing monitoring, which must occur as expeditiously as the individual's needs warrant but no later than fourteen (14) calendar days from the date the change in need/status is identified. Revisions to the PCP should occur no less frequently than annually.
- Initiates PCP or trans-disciplinary team discussions and meetings when services are not achieving desired outcomes;
- Advocates for continuity of services, system flexibility and integration, proper utilization of facilities and resources, accessibility, and individual rights; and

- Participates in any activities related to quality oversight and provides reporting as required.

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

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

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

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

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

N/A

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑	Categorically needy *(specify limits):*

	The following activities are excluded from recovery management as a billable 1915(i) service: • Travel time incurred by the Recovery Manager may not be billed as a discrete unit of service; • Services that constitute the administration of another program such as child welfare or child protective services, parole and probation functions, legal services, public guardianship, special education, and foster care; • Representative payee functions; and • Other activities identified by ODM
☐	Medically needy *(specify limits):*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Recovery Manager (RM) enrolled and contracted with ODM or its designee (a managed care plan) to provide recovery management services, or a recovery management entity which employs or contracts with individual recovery management providers (RMs).			RMs must: • Demonstrate knowledge of issues affecting people with severe and persistent mental illness or diagnosed chronic conditions and community-based interventions/resources for this population. • Complete ODM-required training in the 1915(i) program. • Hold a bachelor's degree in social work, counseling, psychology, or similar field or be an RN. • Have a minimum of 3 years post degree experience working with individuals with severe and persistent mental illness (SPMI) or one year post-degree experience working with individuals with diagnosed chronic conditions. • Be trained in administering the eligibility evaluation and assessment tools used by the State • Be trained in person-centered planning. • Be trained in incident

			management, including incident reporting, prevention planning, and risk mitigation. • Be trained in evaluating HCBS living arrangements. • Be trained in health insurance portability and accountability act (HIPAA) privacy requirements, 42 CFR part 2 confidentiality of alcohol and drug abuse patient records. Supervisors will have supervisory experience related to the scope of work and will have a Bachelor's degree or be an RN plus 5 years of experience.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
HCBS provider agency	ODM or its designee	Annually

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

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

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

Service Definition (Scope)*:*

Individualized Placement and Support-Supported Employment (IPS-SE) promotes recovery through the implementation of evidence-based and best practices which allow individuals to obtain and maintain integrated competitive meaningful employment by providing training, ongoing individualized support, and skill development that honor client choice. The outcome of an employment service is that individuals will obtain and maintain a job of their choosing through rapid job placement which will increase their self-sufficiency and further their recovery. Employment services should be coordinated with mental health services and substance use treatment and services.

Consistent with the purpose and intent of this service definition, IPS-SE shall include at least one of the following evidence based and best practice employment activities, as provided by

the Qualified IPS-SE provider and as listed below:

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

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

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

IPS-SE:
Individualized Placement and Support- Supported Employment (IPS-SE):
Providers who chose to offer IPS-SE employment service shall meet the following requirements to be OhioMHAS qualified providers:

1. IPS-SE is an evidence based practice which is integrated and coordinated with mental health treatment and rehabilitation designed to provide individualized placement and support to assist individuals with a severe and persistent mental illness obtain, maintain, and advance within competitive community integrated employment positions.

2. In order to be an IPS-SE qualified provider, the provider must:
   (a) Provide the evidence-based practice of IPS-SE after completion of training/certification on the model;
   (b) Have current fidelity reviews completed by an OhioMHAS approved fidelity reviewer as required by the developer of the practice; and,
   (c) Achieve the minimum fidelity score necessary to maintain fidelity, as defined by the developer of the practice.

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

N/A	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☑	Categorically needy *(specify limits):*

	Federal Financial Participation (FFP) is not claimed for incentive payments, subsidies, or unrelated vocational training expenses. • Services do not include payment for the supervisory activities rendered as a normal part of the business setting. • Services do not include payment for supervision, training, support, and adaptations typically available to other non-disabled workers filling similar positions in the business. • Transportation to and from the work site will be a component of - and the cost of this transportation will be included in - the rate paid to providers, unless the individual can access public transportation or has other means of transportation available to them. If public transportation is available, then it should be utilized by the individual, if at all possible. • Employment Services may be used for an individual to gain work-related experience considered crucial for job placement (e.g., unpaid internship), only if such experience is vital to the person to achieve his or her vocational goal. • Documentation must be maintained for each individual receiving this service that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973, relating to vocational rehabilitation services, or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), relating to special education. • Services may not be for job placements paying below minimum wage. • Services must be delivered in a manner that supports and respects the individual's communication needs including translation services, assistance with, and use of communication devices. • Services may not be provided on the same day and at the same time as services that contain elements integral to the delivery of Employment Services (e.g., rehabilitation). • Services must be provided in regular integrated settings and do not include sheltered work or other types of vocational services in specialized facilities, or incentive payments, subsidies, or unrelated vocational training expenses such as the following: • Incentive payments made to an employer to encourage hiring the individual; • Payments that are passed through to the individual; o Payments for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business; or o Payments used to defray the expenses associated with starting up or operating a business. Services do not include adaptations, assistance, and training used to meet an employer's responsibility to fulfill requirements for reasonable accommodations under the Americans with Disabilities Act.
☐	Medically needy *(specify limits):*

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

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	ODM or its designee	Initially and annually or based on individual service monitoring concerns.

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Peer Recovery Support (PRS)
Service Definition (Scope)*:*	
PRS service provides community-based supports to individuals with or in recovery from a mental illness with individualized and recovery focused activities that promote recovery, self-determination, self-advocacy, well-being and independence through a relationship that supports a person's ability to promote his or her own recovery. Peer Recovery Supporters use their own experiences with mental illness, to help individuals reach their recovery goals. Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's individualized care plan, which delineates specific goals that are flexibly tailored to the individual and attempt to utilize community and natural supports. The structured, scheduled activities provided by this service emphasize the opportunity for individuals to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery.	

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

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

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

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

N/A

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑	Categorically needy *(specify limits):*
	Federal Financial Participation (FFP) is not claimed for incentive payments, subsidies or unrelated vocational training expenses. Peers should not be involved in managing medications and should not generally be expected to perform tasks that other team members are trained to do. Peer Recovery Supporters do not generally assist with activities of daily living (ADLs). Peers should be supervised by other senior peers or non-peer staff that has been certified to supervise peers and receive regularly scheduled clinical supervision from a person meeting the qualifications of a mental health professional with experience regarding this specialized mental health service. Non-peer staff that wishes to supervise peers must

	complete the 16-hour OhioMHAS E-Based Academy Pre-Course Work for peer services. The Peer Support provider must receive regularly scheduled supervision from a competent behavioral health professional meeting the qualifications of either: a professional meeting the qualifications who meets the criteria for a "qualified behavioral health staff person" or a supervisor who is an individual working as a certified Peer Support provider for a minimum of five years, in which two years should have been as a credentialed peer advocate or its equivalent including specialized training and/or experience as a supervisor. The individual providing consultation, guidance, mentoring, and on-going training need not be employed by the same agency. Supervision of these activities may be delivered in person or by distance communication methods. It is the expectation that 1 hour of supervision will be delivered for every 40 hours of Peer Support Services duties performed. There may be an administrative supervisor who signs the family peer specialist's timesheet and is the primary contact on other related human resource management issues. Supervisors must also be aware of and sensitive to the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues. The team must have training in the general training requirements required by ODM, including cultural competence and trauma informed care. Any practitioner providing behavioral health services must operate within an agency designated as a CMHC. The Caseload Size must be based on the needs of the clients/families with an emphasis on successful outcomes and individual satisfaction and must meet the needs identified in the individual treatment plan. PRS is available daily, limited to no more than four hours per day for an individual client. Progress notes document the individual's progress relative to goals identified in the PCP. PRS services are not a substitute for or adjunct to other HCBS or similar State Plan service. The frequency and duration of PRS will be identified on the PCP and must be supported by an identified need and recovery goal. PRS will not substitute or supplant natural supports. Emerging evidence indicates peer recovery support can be instrumental in an individual achieving identified recovery goals, and it can be individualized to meet the changing needs of the individual. For instance, an individual who has transitioned to the community from extended tenure in the psychiatric hospital may benefit from multiple hours of daily peer support until they are acclimated to life outside an institution. The frequency and duration of peer recovery support encounters is anticipated to decline as the individual progresses in his or her recovery, builds natural supports and strengths, and is better able to navigate recovery in his or her community of choice.
☐	Medically needy *(specify limits):*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	Certified Ohio Peer Recovery	HCBS provider agency enrolled and contracted with ODM to provide

		Supporters with lived experience with mental illnesses	1915(i) services, which employs or has agreements with registered Ohio Peer Recovery Supporters. Agencies may provide any component of the services listed and must employ/contract and utilize the qualified 1915(i) service providers necessary to maintain individuals in the community including Peer specialists. Peer Recovery Supporter • Must be at least 18 years old, and have a high school diploma or equivalent • Must be certified in the State of Ohio to provide the service, which includes criminal, abuse/neglect registry and professional background checks, and completion of a state approved standardized basic training program. Individuals with histories of criminal justice involvement are not necessarily disqualified from being a peer, but must be reviewed on a case-by-case basis. • Must self-identify as having a lived experience of mental illness as a present or former recipient of mental health services. • Must have taken and passed the state-approved standardized peer recovery supporter training that includes academic information as well as practical knowledge and creative activities focused on the principles and concepts of peer support and how it differs from clinical support. The training provides

			practical tools for promoting wellness and recovery, knowledge about individual rights advocacy, confidentiality, and boundaries as well as approaches to care that incorporate creativity. In addition to a personal lived experience of mental health and/or substance use disorder, peer recovery supporters must: • Successfully complete 16-hour online OhioMHAS E-Based Academy courses • Successfully complete a minimum of 40 hours of peer service delivery training; or have completed 3 years of formal peer service delivery • Successfully passed the OhioMHAS Peer Recovery Supporter exam

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

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

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

☐	Participant-directed	☑	Provider managed

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

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

Participant-Direction of Services

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

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

●	The state does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

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

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

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

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

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

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

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

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

8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can select, manage, and dismiss State plan HCBS providers). (*Select one):*

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

b. Participant–Budget Authority (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

○ The state does not offer opportunity for participants to direct a budget.
○ Participants may elect Participant–Budget Authority.
Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. **Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.**

2. **Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.**

3. **Providers meet required qualifications.**

4. **Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).**

5. **The SMA retains authority and responsibility for program operations and oversight.**

6. **The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**

7. **The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.**

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement	Person-Centered Plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.
Discovery	
Discovery Evidence *(Performance Measure)*	**Sub-assurance:** *Person-Centered Plans address all members' assessed needs (including health and safety risk factors) and personal goals, either by the provision of 1915(i) services or through other means.* **1. Number and percent of participants reviewed whose service plans adequately address their assessed needs.** **a. Numerator:** Number of participants whose service plans adequately address their assessed needs, including health and safety risk factors, and personal goals. **b. Denominator:** Total number of participants reviewed

		2. Number and percent of participants reviewed whose person-centered plans have strategies to address and mitigate their health and welfare risk factors. **a. Numerator:** Number of participants whose person-centered plans adequately address their health and welfare risk factors. **b. Denominator:** Total number of participants reviewed **3. Number and percent of service plans reviewed that address individuals' personal goals.** **a. Numerator:** The number of service plans reviewed that address individuals' personal goals. **b. Denominator:** Total number of service plans reviewed **Sub-assurance:** *Person-Centered Plans are updated/revised at least annually or when warranted by changes in the 1915(i) participant's needs.* **4. Number and percent of participants whose person-centered plans were updated at least once in the last twelve months** **a. Numerator:** Number of person-centered plans reviewed that were updated at least annually **b. Denominator:** Total number of participants reviewed **5. Number and percent of 1915(i) participants whose service plans were revised, as needed, to address changing needs.** **a. Numerator:** Number of person-centered plans reviewed that were updated when the participant's needs changed **b. Denominator:** Total number of participants reviewed whose needs changed. **Sub-assurance:** *Services are delivered in accordance with the Person-Centered Plan, including the type, scope, amount, duration, and frequency specified in the Person-Centered Plan.* **6. Number and percent of participants reviewed who received services in the type, scope, amount, duration and frequency specified in the service plan.** **a. Numerator:** Number of participants reviewed who received 1915(i) services in the type, scope, amount, duration and frequency specified in the service plan **b. Denominator:** Total number of participants reviewed **Sub-assurance:** *Participants are afforded choice between/among 1915(i) services and providers.*

		7. Number and percent of participants notified of their rights to choose among 1915(i) services and/or providers. **a. Numerator:** Number of participants notified of their rights to choose among 1915(i) services and/or providers **b. Denominator:** Total number of participants reviewed
	Discovery Activity *(Source of Data & sample size)*	1. Record review based on a representative sample with 95% confidence level and margin of error of +/- 5%. 2. Record review based on a representative sample with 95% confidence level and margin of error of +/- 5%. 3. Record review based on a representative sample with 95% confidence level and margin of error of +/- 5%. 4. IT system(s) or database where service plan data is stored. 100% review. 5. Record review based on a representative sample with 95% confidence level and margin of error of +/- 5%. 6. Record review based on a representative sample with 95% confidence level and margin of error of +/- 5%. 7. Record review based on a representative sample with 95% confidence level and margin of error of +/- 5%.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	1. The state or its designee conducts the review. 2. The state or its designee conducts the review. 3. The state or its designee conducts the review. 4. The state or its designee conducts the review. 5. The state or its designee conducts the review. 6. The state or its designee conducts the review. 7. The state or its designee conducts the review.
	Frequency	1. Semi-annually 2. Semi-annually 3. Semi-annually 4. Semi-annually 5. Semi-annually 6. Semi-annually 7. Semi-annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation*	1. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days. If a corrective action plan is required, the plan must be submitted to the state in accordance

	activities; required timeframes for remediation)	with the process established in the contract. 2. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days. If a corrective action plan is required, the plan must be submitted to the state in accordance with the process established in the contract. 3. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days. If a corrective action plan is required, the plan must be submitted to the state in accordance with the process established in the contract. 4. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days. If a corrective action plan is required, the plan must be submitted to the state in accordance with the process established in the contract. 5. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days. If a corrective action plan is required, the plan must be submitted to the state in accordance with the process established in the contract. 6. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days. If a corrective action plan is required, the plan must be submitted to the state in accordance with the process established in the contract. 7. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days. If a corrective action plan is required, the plan must be submitted to the state in accordance with the process established in the contract.
	Frequency *(of Analysis and Aggregation)*	**1.** Annually **2.** Annually **3.** Annually **4.** Annually **5.** Annually **6.** Annually

		7. Annually

Requirement	The processes and instruments described in the approved Ohio 1915(i) SPA are applied appropriately and according to the approved description to determine for the individual if the needs-based criteria were met.
Discovery	
Discovery Evidence *(Performance Measure)*	***Sub-Assurance:*** *An evaluation for needs-based criteria is provided to all applicants for whom there is reasonable indication that services may be needed in the future.* **8. Number and percent of new enrollees who had an evaluation indicating the individual met LON prior to receipt of services** **a. Numerator:** Number of new enrollees who had an evaluation indicating the individual met LON prior to receipt of services **b. Denominator:** Total number new enrollees ***Sub-Assurance:*** *The processes and instruments described in the approved State Plan are applied appropriately and according to the approved description to determine initial participant LON.* **9. Number and percent of initial LON determinations that were completed using the process required by the approved State Plan.** **a. Numerator:** Number of initial LON determinations reviewed that were completed using the process required by the approved State Plan **b. Denominator:** Total number of initial LON determinations. **10. Number and percent of LON redeterminations for 1915(i) participants that were completed within 365 days of the previous LON determination.** **a. Numerator:** Number of LON redeterminations that were completed within 365 days of the previous LON determination **b. Denominator:** Total number of LON redeterminations for individuals
Discovery Activity *(Source of Data & sample size)*	8. Record review, at the independent entity; 100% review. 9. Record review,100% review. 10. IT system(s) where redetermination records are maintained. Record review,100% review.

Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	8. The state or its designee conducts the review. 9. The state or its designee conducts the review. 10. The state or its designee conducts the review.
Frequency	8. Semi-annually 9. Annually 10. Monthly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	8. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days. If a corrective action plan is required, the plan must be submitted to the state in accordance with the process established in the contract. 9. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days. If a corrective action plan is required, the plan must be submitted to the state in accordance with the process established in the contract. 10. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days. If a corrective action plan is required, the plan must be submitted to the state in accordance with the process established in the contract. ODM will collaborate with other state agencies as necessary to review improvement strategies for maintaining continued contact with program target groups.
Frequency *(of Analysis and Aggregation)*	8. Quarterly 9. Annually 10. Annually

Requirement	Providers meet required qualifications.
Discovery	
Discovery Evidence *(Performance Measure)*	***Sub-Assurance:*** *The State verifies that providers initially and continually meet required participation standards and minimum qualifications and adhere to other standards prior to their furnishing 1915(i) services.* **Sub-assurance:** The State monitors non-licensed/non-certified providers to

assure adherence to waiver requirements.

11. Number and percent of new RMs who meet provider enrollment requirements prior to providing services.
- **a. Numerator:** Number of providers who met enrollment requirements prior to providing authorized services.
- **b. Denominator:** Total number of providers who were enrolled during the review period.

12. Number and percent of RM providers who continue to meet certification requirements.
- **a. Numerator:** Number of providers who met certification requirements one year ago and who continue to meet enrollment requirements at re-enrollment or review.
- **b. Denominator:** Total number of providers who met certification requirements one year ago.

13. Number and percent of new peer recovery supporters who meet provider enrollment requirements prior to providing services
- **a. Numerator:** Number of new providers who met enrollment requirements prior to providing authorized services.
- **b. Denominator:** Total number of new providers who were enrolled during the review period**.**

14. Number and percent of peer recovery supporters who continue to meet enrollment requirements at re-enrollment or review.
- **a. Numerator:** Number of providers who met certification requirements one year ago and who continue to meet enrollment requirements at re-enrollment or review.
- **b. Denominator:** Total number of providers who met certification requirements one year ago.

15. Number and percent of new IPS-SE providers who meet provider enrollment requirements prior to providing services
- **a. Numerator:** Number of new providers who met provider enrollment requirements prior to providing services.
- **b. Denominator:** Total number of new providers who were enrolled during the review period

16. Number and percent of IPS-SE providers who continue to meet enrollment requirements at re-enrollment or review
- **a. Numerator:** Number of providers who met certification requirements one year ago and who continue to meet enrollment requirements at re-enrollment or review
- **b. Denominator:** Total number of providers who met certification

	requirements one year ago.
Discovery Activity *(Source of Data & sample size)*	11. 100% record review. 12. The state or its designee will review provider enrollment information. 100% review. 13. 100% review. 14. The state or its designee will review provider enrollment information. 100% review. 15. The state or its designee will review provider enrollment information. 100% review. 16. The state or its designee will review provider enrollment information. 100% review.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	11. The state or its designee conducts the review. 12. The state or its designee conduct the reviews. 13. The state or its designee conducts the review. 14. The state or its designee conducts the review. 15. The state or its designee conducts the review. 16. The state or its designee collects and generates.
Frequency	11. Semi-annually 12. Semi-annually 13. Semi-annually 14. Semi-annually 15. Semi-annually 16. Semi-annually
Remediation	

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	11. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days. If a corrective action plan is required, the plan must be submitted to the state in accordance with the process established in the contract. 12. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days. If a corrective action plan is required, the plan must be submitted to the state in accordance with the process established in the contract. 13. Ohio MHAS or designee aggregates and analyzes for ODM review 14. Ohio MHAS or designee aggregates and analyzes for ODM review. 15. Ohio MHAS or designee aggregates and analyzes for ODM review 16. Ohio MHAS or designee aggregates and analyzes for ODM review.
Frequency *(of Analysis and Aggregation)*	11. Annually 12. Annually 13. Annually 14. Annually 15. Annually 16. Annually

Requirement	The SMA retains authority and responsibility for program operations and oversight.
Discovery	
Discovery Evidence *(Performance Measure)*	***Sub-Assurance:*** *The SMA assures compliance with authority for program operation and oversight.* **17. Number and percent of chart reviews conducted where the chart was found to be at least 90% compliant with the review standards.** **a. Numerator:** Number of chart audits conducted where the chart was found to be at least 90% compliant with review standards. **b. Denominator:** Total number of chart reviews conducted.
Discovery Activity *(Source of Data & sample size)*	17. The state or its designee will review records. Record review based on a representative sample with 95% confidence level and margin of error of +/- 5%.

Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	17. The state or its designee conducts the review.
Frequency	17. Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	17. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days. If a corrective action plan is required, the plan must be submitted to the state in accordance with the process established in the contract.
Frequency *(of Analysis and Aggregation)*	17. Annually

Requirement	The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
Discovery	
Discovery Evidence *(Performance Measure)*	**Sub-Assurance:** *The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved 1915(i) and only for services rendered.* **18. Number and percent of paid claims for 1915 (i) services that were**

	authorized. **a. Numerator:** Number of paid claims for 1915 (i) services that were for services authorized in the individual's plan of care. **b. Denominator:** Total number of paid claims for 1915(i) services
Discovery Activity *(Source of Data & sample size)*	18. ODM's Medicaid Management Information System (MMIS) claims payment system, MITS. Claims verification audits and provider performance monitoring; 95% confidence level with a margin of error of +/- 5%.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	18. The state or its designee.
Frequency	18. Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	18. The state or its designee
Frequency *(of Analysis and Aggregation)*	18. Annually

Requirement	The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.
Discovery	
Discovery Evidence *(Performance Measure)*	***Sub-Assurance:*** *The State demonstrates on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation, and unexplained death.* **19. Number and percent of Abuse (physical, verbal, emotional, sexual), Neglect, Exploitation, and Misappropriation Incidents (over $500) reported into the ODM approved incident management system(s) within the required timeframe.**

		a. Numerator: Total number of ANEM incidents/cases reported into the ODM approved incident management system within the required timeframe. **b. Denominator:** Total number of ANEM incident/cases. **20. Number and percent of unexplained or suspicious deaths for which an investigation was completed according to rule requirements.** **a. Numerator:** Total number of unexplained or suspicious death investigations completed according to the rule requirements. **b. Denominator:** Total number of unexplained or suspicious deaths. ***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.* **21. Number and percent of Abuse (physical, verbal, emotional, sexual), Neglect, Exploitation, and Misappropriation Incidents (over $500) incident investigations that were completed according to the rule requirements.** **a. Numerator:** Total number of ANEM investigations completed according to the rule requirements. **b. Denominator:** Total number of ANEM investigations. **22. Number and percent of substantiated Ab use (physical, verbal, emotional, sexual), Neglect, Exploitation, and Misappropriation Incidents (over $500) with a prevention plan developed as a result of the incident.** **a. Numerator:** Total number of ANEM prevention plans completed. **b. Denominator:** Total number of ANEM incidents needing a prevention plan. ***Sub-Assurance:*** *The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.* **23. Number and percent of substantiated unauthorized (or unapproved) restraint, seclusion or other restrictive intervention incidents with a prevention plan developed as a result of the incident.** **a. Numerator:** Total number of unauthorized (or unapproved) restraint prevention plans completed. **b. Denominator:** Total number of unauthorized (or unapproved) restraint incidents needing a prevention plan. **24. Number and percent of substantiated Abuse (physical, verbal,**

		emotional, sexual), Neglect, Exploitation, and Misappropriation Incidents (over $500) with a prevention plan developed as a result of the incident. **a. Numerator:** Total number of ANEM prevention plans completed. **b. Denominator:** Total number of ANEM incidents needing a prevention plan. ***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 plan.* **25. Number and percent of incidents investigated for Abuse (physical, verbal, emotional, sexual), Neglect, Exploitation, and all Misappropriation (over $500) incidents investigated that involved paid caregivers.** **a. Numerator:** Total number of ANEM incidents investigated that involved a paid caregiver. **b. Denominator:** Total number of ANEM incidents that involved a paid caregiver.
	Discovery Activity *(Source of Data & sample size)*	19. ODM's Incident Management system. 100 % review. 20. ODM's Incident Management system. 100% review. 21. ODM's Incident Management system. 22. ODM's Incident Management system. 100% review. 23. ODM's Incident Management system. 24. ODM's Incident Management system. 100 % review. 25. ODM's Incident Management system. 100 % review.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	19. The state or its designee conducts the review. 20. The state or its designee conducts the review. 21. The state or its designee conducts the review. 22. The state or its designee conducts the review. 23. The state or its designee conducts the review. 24. The state or its designee conducts the review. 25. The state or its designee conducts the review.

Frequency	19. Quarterly 20. Quarterly 21. Quarterly 22. Quarterly 23. Quarterly 24. Quarterly 25. Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	19. The state or its designee aggregates and analyzes data for review. 20. The state or its designee aggregates and analyzes data for review. 21. The state or its designee aggregates and analyzes data for review. 22. The state or its designee aggregates and analyzes data for review. 23. The state or its designee aggregates and analyzes data for review. 24. The state or its designee aggregates and analyzes data for review 25. The state or its designee aggregates and analyzes data for review
Frequency *(of Analysis and Aggregation)*	19. Annually 20. Annually 21. Annually 22. Annually 23. Annually 24. Annually 25. Annually

Requirement	Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (a)(2).
Discovery	
Discovery Evidence *(Performance Measure)*	**26. Number/percent of HCBS settings meeting appropriate licensure or certification requirements.** **a. Numerator:** Number of 1915(i) participant residences and HCBS provider settings that meet HCBS setting requirements **b. Denominator:** Total number of 1915(i) participant residences and HCBS provider settings

	Discovery Activity *(Source of Data & sample size)*	26. 100% review of individuals through recovery manager.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	26. ODM or its designee conducts the review.
	Frequency	26. Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	26. Independent Entities under contract with the state aggregates and analyzes for the state to review.
	Frequency *(of Analysis and Aggregation)*	26. Annually

System Improvement
(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

Through inter-departmental collaboration, ODM has established a consistent review process and monitoring schedule beginning in SFY 2019 which is now ongoing and will be adhered to as described in this plan.

1. Program performance data book:
   - Track and trend system performance.
   - Analyze discovery.

2. Quality management meetings:
   - Assess system changes.
   - Focus on reporting requirements and refining reports.

3. Reviews include documentation review and interviews.

4. Corrective action plans (CAPs).

Supplemental Outcome Measures- As part of its enhanced quality assurance strategy for Ohio's 1915(i), ODM is working to establish outcome-based performance measures as a means to monitor the effectiveness of the program in key areas. These measures are intended to support ongoing evaluation of key outcomes, including clinical outcomes, in order to inform effective management of contracts with case management entities. These measures include measures to ascertain whether important follow-up occurs after an individual enrolled in the 1915(i) program is admitted to the emergency room or for an inpatient stay, and measures that monitor how frequently individuals enrolled in the 1915(i) program lose Medicaid coverage for more than 30 days due to a failure to comply with a redetermination process.

2. Roles and Responsibilities

1. The independent entities and the state will collect, collate, and review. The State Medicaid agency will review the data and have final direction over corrective action plans.

2. The independent entities and the State will collect, analyze, and report.

3. The independent entities and the State coordinate and conduct reviews.

4. Developed by the provider/contractor, then submitted in accordance with the contract established between provider and ODM. Submitted to the independent entities, MCPs, and ODM or its designee for approval. ODM provides oversight and direction.

3. Frequency

1. Updated and reported semi-annually.
2. Quarterly meetings.
3. Semi-annually.
4. Areas for improvement will be monitored as per CAP and presented quarterly during quality management meetings.

4. Method for Evaluating Effectiveness of System Changes

1. .
   - Set performance benchmarks.
   - Review service trends.
   - Review program implementation.
   - Focus on quality improvement. The Independent Entities and the state will track and trend system performance, analyze the discovery, synthesize the data and with the State Medicaid agency, make corrective action plans regarding quality improvement. This will include reviewing QI recommendations quarterly and building upon those improvements through CQI.

2. .
   - Monitoring contract and 1915(i) HCBS compliance for service delivery.
   - Review of Person-Centered Plan client outcome measures (i.e. personal goals).

3. .
   - Review of clinical operations (utilization management, quality management, care management) as well as fiscal reporting.
   - Compliance issues will require the submission of a corrective action plan to the Independent Entities and the state for approval and ongoing monitoring.

4. .
   - •Analysis of performance data book.
   - • Review findings of program non-compliance follow-up.

Methods and Standards for Establishing Payment Rates

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

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☐	HCBS Habilitation
☐	HCBS Respite Care

For Individuals with Chronic Mental Illness, the following services:

☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Psychosocial Rehabilitation
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)

☑ Other Services (specify below)

Service Name	HCPCS Code	Billing Unit
Recovery management (RM)	T1016	15 Minutes
Peer recovery support (PRS)	H0038	15 Minutes
Individualized placement and support-supported employment (IPS-SE)	H2023	15 Minutes
	H2025	15 Minutes

A. State Plan Reimbursement Methodology

Reimbursements for services are based upon a Medicaid fee schedule established by the State of Ohio.

Payment rates for this 1915(i) program are developed based on payment rates determined for other programs that provide similar services. If payment rates are not available from the other programs that provide similar services, payment rates are determined using modeled rates.

The description below is the State Plan FFS reimbursement methodology for the modeled rates. It is a market-based rate-setting approach developing rates on reasonable projected component assumptions that will be necessary to ensure access to care and adequacy of payment related to delivery of the services. Projected component assumptions exclude any non-Medicaid expenses and activities, as well as non-allowable expenses. The State only includes indirect costs for services and overhead that are compliant with 2 CFR Section 225. The rates will be reviewed every three years to ensure that access to care and adequacy of payments are maintained and re-based as appropriate. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payment are maintained. These rates comply with the requirements of Section 1902(a)(30) of the Social Security Act and 42 CFR 447.200, regarding payments and consistent with economy, efficiency and quality of care. The payment for services is as follows: the lesser of the charge or the Medicaid fee schedule (note: there are no similar Medicare rates). The State shall not claim FFP for room and board and for non-Medicaid services. The rates in the department's service fee schedule as authorized by this state plan amendment shall be set using methods that ensure the rates do not include costs not directly related to the provision of Medicaid services.

All rates are published on the agency's website at https://medicaid.ohio.gov/provider/feescheduleandrates. The Agency's fee schedule rate was set as of August 1, 2021 and is effective for services provided on or after that date. Except as otherwise noted in the Plan, the State-developed fee schedule is the same for both governmental and private individual providers.

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

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

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

B. Standards for Payment

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