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**institutional setting. Individuals with high needs may be served by a waiver with a more limited benefit package because these waiver enrollees do not require as many hours of support in that they frequently participate on a full-time, twelve month basis in day programs offered by county boards. Many of these expensive day program costs are covered by Medicaid as a state plan service cost in Ohio. Ohio is one of a handful of states which covers these services outside of the waiver program on the regular state plan.**

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

- a. \_\_\_\_\_ aged (age 65 and older)
- b. \_\_\_\_\_ disabled
- c. \_\_\_\_\_ aged and disabled
- d.   X   mentally retarded
- e.   X   developmentally disabled
- f. \_\_\_\_\_ mentally retarded and developmentally disabled
- g. \_\_\_\_\_ chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

- a. \_\_\_\_\_ Waiver services are limited to the following age groups (specify):
- b. \_\_\_\_\_ Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):
- c. \_\_\_\_\_ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.





- n. \_\_\_\_\_ Companion services
- o. \_\_\_\_\_ Private duty nursing
- p. \_\_\_\_\_ Family training
- q. \_\_\_\_\_ Attendant care
- r. \_\_\_\_\_ Adult Residential Care
  - \_\_\_\_\_ Adult foster care
  - \_\_\_\_\_ Assisted living
- s. \_\_\_\_\_ Extended State plan services (Check all that apply):
  - \_\_\_\_\_ Physician services
  - \_\_\_\_\_ Home health care services
  - \_\_\_\_\_ Physical therapy services
  - \_\_\_\_\_ Occupational therapy services
  - \_\_\_\_\_ Speech, hearing and language services
  - \_\_\_\_\_ Prescribed drugs
  - \_\_\_\_\_ Other (specify):
- t.  X  \_\_\_\_\_ Other services (specify): Homemaker/Personal Care; Emergency Assistance
- u. \_\_\_\_\_ The following services will be provided to individuals with chronic mental illness:
  - \_\_\_\_\_ Day treatment/Partial hospitalization
  - \_\_\_\_\_ Psychosocial rehabilitation
  - \_\_\_\_\_ Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.

13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and

other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not included in the individual written plan of care.

14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.
15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):
- a.   X   When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility).
  - b.        Meals furnished as part of a program of adult day health services.
  - c.        When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to CMS:
- a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:
    - 1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);

2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and
  3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.
- b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.
  - c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:
    1. Informed of any feasible alternatives under the waiver; and
    2. Given the choice of either institutional or home and community-based services.
  - d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.
  - e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.
  - f. The agency's actual total expenditure for home and community-based and other Medicaid services under the

waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.

- g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.
- h. The agency will provide CMS annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by CMS.
- i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a.   X   Yes            b.            No

- 17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to CMS at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a.            Yes            b.   X   No

- 18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished

are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

19. An effective date of December 1, 2002 is requested.
20. The State contact person for this request is Kim Austin, or Jan Sennett, who can be reached by telephone at 614-466-6742.
21. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by CMS, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature: \_\_\_\_\_

Print Name: Barbara Coulter Edwards

Title: Medicaid Director

Date: \_\_\_\_\_

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it

Level I

displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449. The time required to complete this information collection is estimated to average 160 hours for each new and renewed waiver request and an average of 30 hours for each amendment, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

APPENDIX A - ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

- \_\_\_\_\_ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.
- X   The waiver will be operated by the Ohio Department of Mental Retardation and Developmental Disabilities (ODMR/DD), a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.
- \_\_\_\_\_ The waiver will be operated by \_\_\_\_\_, a separate division within the Single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

Appendix A-1 - Quality Assurance, Compliance Monitoring and Emergency  
Removal

Ohio has a comprehensive, systematic approach for assuring the health and welfare of individuals receiving home and community-based services. The following describes the components of the quality assurance and compliance process.

The Ohio Department of Job and Family Services (ODJFS) provides subrecipient oversight and compliance monitoring of all waiver program and administrative activity.

- In addition to other waiver monitoring activity, ODJFS will conduct targeted reviews of a representative sample of Level 1 recipients.
- ODJFS will conduct look-behind compliance reviews of ODMR/DD

The Ohio Department of Mental Retardation and Developmental Disabilities (ODMR/DD) both directly performs essential functions related to protecting and promoting the health and welfare of individuals and provides subrecipient oversight and compliance monitoring of waiver activities.

Functions directly performed by ODMR/DD to assure health and welfare include:

- Initial certification and recertification of waiver providers,
- Operating an internet-based Incident Tracking System (ITS),
- Administering a statewide mrdd abuse registry,
- Conducting monthly mortality reviews,
- Performing accreditation reviews of county boards of mrdd, and
- Conducting quality assurance reviews as well as providing technical assistance to county boards, providers, individuals and their families.

Functions directly performed by ODMR/DD related to subrecipient oversight and compliance monitoring of health and welfare issues include:

- Assuring that County Boards afford enrollees a free choice of approved providers,
- Assuring that County Boards conduct appropriate application intake procedures and appropriately issue level of care recommendations,
- Reviewing Major Unusual Incident (MUI) data, both on an individual and an aggregate basis, to protect individuals from harm, to determine patterns and trends of activities, to promote systems changes that would reduce MUIs and work with county boards to investigate incidents.

The County Boards of Mental Retardation and Developmental

Level I

Disabilities (CBMR/DD), in their role as Local Medicaid Administrative Authority (LMAA) provide ongoing quality assurance activities through the following activities:

- Implementing an ongoing system of quality assurance oversight with continuous quality improvement activities through individual service plan implementation
- Coordinating the services and monitoring the delivery of those services as specified in the ISP by a Service and Support Administrator
- Identifying patterns and trends of unusual and major unusual incidents, and
- Performing quality assurance reviews of waiver recipients, using the findings to modify and improve the quality of individual plans, and identifying outcomes achieved and the individual's satisfaction with services delivered.

#### Emergency Removal

Current law provides for the emergency removal of individuals from licensed residential facilities where residents are in imminent danger of serious physical or psychological harm.

APPENDIX B - SERVICES AND STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

a. \_\_\_\_\_ Case Management

\_\_\_\_\_ Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1. \_\_\_\_\_ Yes                      2. \_\_\_\_\_ No

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

1. \_\_\_\_\_ Yes                      2. \_\_\_\_\_ No

\_\_\_\_\_ Other Service Definition (Specify):

b. \_\_\_\_\_ Homemaker:

\_\_\_\_\_ Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such

standards of education and training as are established by the State for the provision of these activities.

\_\_\_\_\_ Other Service Definition (Specify):

c. \_\_\_\_\_ Home Health Aide services:

\_\_\_\_\_ Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan.

\_\_\_\_\_ Other Service Definition (Specify):

d. \_\_\_\_\_ Personal care services:

\_\_\_\_\_ Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bedmaking, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

1. Services provided by family members  
(Check one):

\_\_\_\_\_ Payment will not be made for personal care services furnished by a member of the individual's family.

\_\_\_\_\_ Personal care providers may be members of the individual's family. Payment will not be made for services

furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.

Justification attached.  
(Check one):

\_\_\_\_\_ Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

\_\_\_\_\_ Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal care providers will be furnished by (Check all that apply):

\_\_\_\_\_ A registered nurse, licensed to practice nursing in the State.

\_\_\_\_\_ A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

\_\_\_\_\_ Case managers

\_\_\_\_\_ Other (Specify):

3. Frequency or intensity of supervision (Check one):

\_\_\_\_\_ As indicated in the plan of

STATE: Ohio

care

\_\_\_\_\_ Other (Specify):

4. Relationship to State plan services  
(Check one):

\_\_\_\_\_ Personal care services are not provided under the approved State plan.

\_\_\_\_\_ Personal care services are included in the State plan, but with limitations. The waived service will serve as an extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.

\_\_\_\_\_ Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

\_\_\_\_\_ Other service definition (Specify):

e.  X  Respite care:

X  Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

\_\_\_\_\_ Other service definition (Specify):

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following location(s) (Check all that apply):

- X   Individual's home or place of residence
- Foster home
- Medicaid certified Hospital
- Medicaid certified NF
- X   Medicaid certified ICF/MR
- Group home
- Licensed respite care facility
- X   Other community care residential facility approved by the State that is not a private residence (Specify type): Facility licensed by ODMR/DD in accordance with Revised Code 5123.19.
- X   Other ~~service definition~~ **LOCATION** (Specify): **home of a friend or family member of the person or family; sites of community activities.**

The benefit package in the waiver includes a limitation of \$1,000 annually for institutional respite. An enrollee's annual expenditure for institutional respite may exceed \$1,000, subject to prior authorization review either at the time of the ISP process or at a time when needs change, consistent with the preferences of the individual or family. Through the prior authorization process, the additional services will be approved if an assessed need for the additional service exists and if the total expenditures for this service, informal respite, homemaker/personal care, and transportation combined do not exceed \$5,000 annually.

The benefit package in the waiver includes a limitation of \$2,500 annually for informal respite. An enrollee's annual expenditure for informal respite may exceed \$2,500, subject to prior authorization review either at the time of the ISP process or at a time when needs change, consistent with the preferences of the individual or family. Through the prior authorization process, the additional services will be approved if an assessed need for the

**additional service exists and if the total expenditures for this service, institutional respite, homemaker/personal care, and transportation combined do not exceed \$5,000 annually.**

f. \_\_\_\_\_ Adult day health:

\_\_\_\_\_ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. (Check one):

1. \_\_\_\_\_ Yes                      2. \_\_\_\_\_ No

\_\_\_\_\_ Other service definition (Specify):

\_\_\_\_\_ Qualifications of the providers of adult day health services are contained in Appendix B-2.

g.  X  Habilitation:

X  Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

\_\_\_\_\_ Residential habilitation: assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-

institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation which shows that Medicaid payment does not cover these components is attached to Appendix G.

\_\_\_\_\_ Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care. Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

\_\_\_\_\_ Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or

section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs). Prevocational services are available only to individuals who have previously been discharged from a SNF, ICF, NF or ICF/MR.

Check one:

\_\_\_\_\_ Individuals will not be compensated for prevocational services.

\_\_\_\_\_ When compensated, individuals are paid at less than 50 percent of the minimum wage. Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

STATE: Ohio

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DATE: December 1, 2002

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

\_\_\_\_\_ Educational services, which consist of special education and related services as defined in sections (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

  X  

Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons

without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for vocational training that is not directly related to an individual's supported employment program.



assures that each service is cost-effective and necessary to prevent institutionalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

h.   X   Environmental accessibility adaptations:

  X   Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

**The benefit package in the waiver includes a limitation of \$2,000 over the three year period of the waiver for environmental accessibility adaptations. An enrollee's three year expenditure for environmental accessibility adaptations may exceed \$2,000, subject to prior authorization review either at the time of the ISP process or at a time when needs change, consistent with the preferences of the individual or family. Through the prior authorization process, the additional services will be approved if an assessed need for the additional service exists and if the total expenditures for this service, personal emergency response systems, and specialized medical equipment and supplies combined do not exceed \$6,000 over three years.**

\_\_\_\_\_ Other service definition (Specify):

i. \_\_\_\_\_ Skilled nursing:

\_\_\_\_\_ Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

\_\_\_\_\_ Other service definition (Specify):

j.  X  Transportation:

X  Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

**The benefit package in the waiver includes a limitation of \$500 annually for transportation, except for transportation related to habilitation-supported employment which is contained in another benefit. An enrollee's annual expenditure for transportation may exceed \$500, subject to prior authorization review either at the time of the ISP process or at a time when needs change, consistent with the preferences of the individual or family. Through the prior authorization process, the additional services will be approved if an assessed need for the additional service exists and if the total expenditures for this service, institutional respite, informal respite, and homemaker/personal care do not exceed \$5,000 annually.**

\_\_\_\_\_ Other service definition (Specify):

k.  X  Specialized Medical Equipment and Supplies:

X  Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

**The benefit package in the waiver includes a limitation of \$2,000 over the three year period of the waiver for specialized medical equipment and supplies.**

\_\_\_\_\_ Other service definition (Specify):

l. \_\_\_\_\_ Chore services:

\_\_\_\_\_ Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined

prior to any authorization of service.

\_\_\_\_\_ Other service definition (Specify):

m.  X  Personal Emergency Response Systems (PERS)

X  PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

**The benefit package in the waiver includes a limitation of \$2,000 over the three year period of the waiver for PERS.**

\_\_\_\_\_ Other service definition (Specify):

n. \_\_\_\_\_ Adult companion services: \_\_\_\_\_ Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

\_\_\_\_\_ Other service definition (Specify):

o. \_\_\_\_\_ Private duty nursing:

\_\_\_\_\_ Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an

individual at home.

\_\_\_\_\_ Other service definition (Specify):

- p. \_\_\_\_\_ Family training:\_\_\_\_\_ Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care.

\_\_\_\_\_ Other service definition (Specify):

- q. \_\_\_\_\_ Attendant care services:

\_\_\_\_\_ Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

Supervision (Check all that apply):

\_\_\_\_\_ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of care.

\_\_\_\_\_ Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the safety and efficacy of consumer-provided supervision has been certified in writing by a

registered nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the consumer's individual plan of care.

\_\_\_\_\_ Other supervisory arrangements  
(Specify):

\_\_\_\_\_ Other service definition (Specify):

r. \_\_\_\_\_ Adult Residential Care (Check all that apply):

\_\_\_\_\_ Adult foster care: Personal care and services, homemaker, chore, attendant care and companion services medication oversight (to the extent permitted under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. The total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed\_\_\_\_).

Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.

\_\_\_\_\_ Assisted living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision,

safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include  
(Check all that apply):

- \_\_\_\_\_ Home health care
- \_\_\_\_\_ Physical therapy
- \_\_\_\_\_ Occupational therapy
- \_\_\_\_\_ Speech therapy
- \_\_\_\_\_ Medication administration

- \_\_\_\_\_ Intermittent skilled nursing services
- \_\_\_\_\_ Transportation specified in the plan of care
- \_\_\_\_\_ Periodic nursing evaluations
- \_\_\_\_\_ Other (Specify)

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

\_\_\_\_\_ Other service definition (Specify):  
Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

- s.   X   Other waiver services which are cost-effective and necessary to prevent institutionalization (Specify):

**Homemaker/Personal Care: Homemaker/Personal Care means tasks directed at the consumer or the consumer's immediate environment that are necessitated by his or her physical or mental condition (includes emotional and/or behavioral). The level of care is of a supportive or maintenance type, and the tasks encompassed require less skill than some of the duties included in home health care performed by home health aides. This service will help the consumer meet daily living needs, and without this service alone or in combination with other waiver services the individual would require institutionalization.**

**The homemaker/personal care provider should perform such tasks as assisting the consumer with activities of daily living, personal hygiene, dressing, feeding, transfer, ambulatory needs or skills development. Skill development is intervention, specifically**

tailored in its type and frequency to maximize the consumer's capabilities, that focuses on both preventing the loss of skills and enhancing skills that are already present that will lead to greater independence within the residence or the community. The provider may also perform homemaking tasks for the consumer. These tasks may include cooking, cleaning, laundry and shopping, among others. Homemaking and personal care tasks are combined into a single service titled homemaker/personal care because, in actual practice, a single individual provides both services and does so as part of the natural flow of the day. For example, the provider may prepare a dish and place it in the oven to cook (homemaking), assist the consumer in washing up before a meal and assist him/her to the table (personal care), put the prepared meal on the table (homemaking) and assist the consumer in eating (personal care). Segregating these activities into discrete services is impractical.

Services provided include the following:

- Basic personal care and grooming, including bathing, care of the hair and assistance with clothing.
- Assistance with bladder and/or bowel requirements or problems, including helping the consumer to and from the bathroom or assisting the consumer with bed pan routines.
- Assisting the consumer with medications which are ordinarily self-administered when ordered by the consumer's physician.
- Performing household services essential to the consumer's health and comfort in the home (e.g., necessary changing of bed linens or rearranging of furniture to enable the consumer to move about more easily in his/her home).
- Assessing, monitoring and supervising the consumer to ensure the consumer's safety, health and welfare.
- Light cleaning tasks in areas of the home used by the consumer.
- Preparation of a shopping list appropriate to the consumer's dietary needs and financial circumstances, performance of grocery shopping activities as necessary and preparation of meals.
- Personal laundry.
- Incidental neighborhood errands as necessary, including accompanying the consumer to medical and other appropriate appointments and accompanying

consumers for short walks outside the home.

- HPC activities incidental to summer camp participation

Homemaker/personal care providers shall:

- Participate in the consumer's Individual Service Plan (ISP) meetings if and when they are requested by the consumer.
- Perform tasks and duties according to the ISPs.
- Maintain a clean and safe environment.
- Be sensitive to the consumer's and family's needs.
- Recognize changes in the consumer's condition and behavior as well as safety and sanitation hazards, report them to the Service and Support Administrator and record them in the consumer's written record.
- Document all services provided to and on behalf of the consumer.

The benefit package in the waiver includes a limitation of \$1,000 annually for homemaker/personal care. An enrollee's annual expenditure for homemaker/personal care may exceed \$1,000, subject to prior authorization review either at the time of the ISP process or at a time when needs change, consistent with the preferences of the individual or family. Through the prior authorization process, the additional services will be approved if an assessed need for the additional service exists and if the total expenditures for this service, institutional respite, informal respite, and transportation combined do not exceed \$5,000 annually.

Emergency Assistance: Emergency Assistance means increased levels of any waiver service except for Supported Employment and Informal Respite. Emergency Assistance will be provided in one of the following emergency situations:

- Involuntary loss of present residence for any reason, including legal action;
- Loss of present caregiver for any reason, including death of a caregiver or changes in the caregiver's mental or physical status resulting in the caregiver's inability to perform effectively for the individual;
- Abuse, neglect, or exploitation of the individual;
- Health and welfare conditions that pose a serious risk to the individual of immediate harm or death;  
or

- Significant changes in the emotional or physical condition of the individual that necessitate substantial, expanded accommodations that cannot be reasonably provided by the individual's existing caregiver.

Provision of Emergency Assistance will be used for interim services until the emergency situation has been resolved or the individual is transferred to alternative residential supports applicable to the individual's assessed needs including an ICF-MR or applicable supports under an alternative home and community-based services waiver for which the person is eligible and a slot is available.

The benefit package in the waiver includes a limitation of \$8,000 for emergency assistance over the three year period of the waiver.

t. \_\_\_\_\_ Extended State plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached. Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

- \_\_\_\_\_ Physician services
- \_\_\_\_\_ Home health care services
- \_\_\_\_\_ Physical therapy services
- \_\_\_\_\_ Occupational therapy services
- \_\_\_\_\_ Speech, hearing and language services
- \_\_\_\_\_ Prescribed drugs
- \_\_\_\_\_ Other State plan services (Specify):

u. \_\_\_\_\_ Services for individuals with chronic mental illness, consisting of (Check one):

\_\_\_\_\_ Day treatment or other partial  
hospitalization services (Check one):

\_\_\_\_\_ Services that are necessary for  
the diagnosis or treatment of the  
individual's mental illness.  
These services consist of the  
following elements:

- a. individual and group therapy  
with physicians or  
psychologists (or other  
mental health professionals  
to the extent authorized  
under State law),
- b. occupational therapy,  
requiring the skills of a  
qualified occupational  
therapist,
- c. services of social workers,  
trained psychiatric nurses,  
and other staff trained to  
work with individuals with  
psychiatric illness,
- d. drugs and biologicals  
furnished for therapeutic  
purposes,
- e. individual activity therapies  
that are not primarily  
recreational or diversionary,
- f. family counseling (the  
primary purpose of which is  
treatment of the individual's  
condition),
- g. training and education of the  
individual (to the extent  
that training and educational  
activities are closely and  
clearly related to the  
individual's care and  
treatment), and
- h. diagnostic services.

Meals and transportation are  
excluded from reimbursement under  
this service. The purpose of this

STATE: Ohio

service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

\_\_\_\_\_ Other service definition  
(Specify):

\_\_\_\_\_ Psychosocial rehabilitation services (Check one):

\_\_\_\_\_ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

- a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);
- b. social skills training in appropriate use of community services;
- c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and
- d. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

- a. vocational services,
- b. prevocational services,

- c. supported employment services, and
- d. room and board.

\_\_\_\_\_ Other service definition  
(Specify):

\_\_\_\_\_ Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

\_\_\_\_\_ This service is furnished only on the premises of a clinic.

\_\_\_\_\_ Clinic services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations (Specify):

PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

Service	Provider	License	Certification	Other Standard
Respite Care - Institutional-ICF/MR	Facilities Certified as ICFs/MR		Certified according to ORC 3721.022 As ICFs/MR	X See Page 41
Other facilities	Licensed according to ORC 5123.19	Licensed according to ORC 5123.19	See licensure	
Respite Care - Informal	Limited provider		Certification as a waiver provider per ORC 5123.045	X See Page 41
Habilitation-Supported Employment	Agency provider or individual provider		Certification as a waiver provider per ORC 5123.045	X See Page 42
Environmental Accessibility Adaptations	Agency provider or individual provider		Certification as a waiver provider per ORC 5123.045	X See Page 43
Transportation	Agency provider or individual provider		Certification as a waiver provider per ORC 5123.045	X See Page 44
Specialized Medical Adaptive Assistive Equipment & Supplies	Agency provider or individual provider		Certification as a waiver provider per ORC 5123.045	X See Page 45
Personal Emergency Response System	Agency Provider		Certification as a waiver provider per ORC 5123.045	X See Page 46
Homemaker/Personal Care	Agency provider or individual provider	ODMR/DD licensure per ORC 5123.19 (optional)	Certification as a waiver provider per ORC 5123.045	X See Page 46
Emergency Assistance	Agency provider or individual provider, except Supported Employment or Limited Provider			

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

A spouse may not provide services under the waiver to his or her spouse, nor may a parent provide services under the waiver to his or her minor child. "Spouse" means a partner in a marriage that is legally recognized by the state of Ohio. "Parent" means a biological parent, adoptive parent, or step-parent. "Minor child" means a child under the age of 18.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

Attachment to Appendix B-2

CERTIFICATION AND OTHER STANDARDS

1. Respite Care

Institutional Respite

Institutional respite shall be provided in facilities certified as intermediate care facilities for the mentally retarded (ICFs/MR) or other facilities licensed by ODMR/DD under section 5123.19 of the Revised Code. Services shall be provided according to the individual's ISP. ISPs shall be provided to institutional providers of respite services. All individuals who provide services directly to waiver enrollees must meet requirements as listed on Table B.

Providers shall not agree to provide services to any enrollee whose needs the provider cannot meet. Providers shall provide written assurances that the provider and all staff of the provider who provide direct care services have sufficient background and training to protect the health and welfare of the enrollee in the execution of the duties assigned to the provider in the ISP and PAWS authorization for services.

ODJFS and ODMR/DD will sanction for failure to provide authorized services. Sanctions include technical assistance, filing a report of failure of the facility to comply with licensure or certification standards with the appropriate licensing or certifying agency and recoupment of waiver payment for any time claimed and reimbursed as institutional respite when requirements were not met and termination of the waiver provider agreement. Specific sanctions, the compliance monitoring process, and roles of State agencies and their subrecipients, including County Boards of MR/DD and the provider appeal process will be specified in Ohio Administrative Code.

Informal Respite

Informal Respite shall be provided by a limited provider in the following settings: individual's home or place of residence; home of a friend or family member or sites of community activities. "Family member" for this purpose is defined as:

Parent(s), brother(s), sister(s), spouse(s), son(s), daughter(s), grandparent(s), aunt(s), uncle(s), cousin(s), or guardian(s) of the individual who has mental retardation or developmental disabilities. "Family member" also means person(s) acting in a role similar to those specified in this paragraph even though no legal or blood relationship exists if the individual who has mental retardation or developmental disabilities lives with the person(s) and is dependent on him to the extent that if the supports were

withdrawn another living arrangement would have to be found. The person(s) shall verify the relationship by signature.

A limited provider is an individual who is known to the enrollee, is selected by the enrollee or guardian and provides respite only to the enrollee or to multiple enrollees who live in the same family setting. An enrollee eligible for this service must have a family member who is able and willing to accept responsibility for training and monitoring health management activities, behavior support, MUI reporting and other activities required to meet the needs of the individual as identified in the individual's ISP. ODMRDD and ODJFS and any of their designated subrecipients continue to be responsible for ensuring the health and welfare of any individual receiving informal respite provided by a limited provider. If ODJFS or ODMRDD, either directly or through their designated subrecipients determines that the health and welfare of the enrollee cannot be assured in the provision of this service, ODJFS and/or ODMRDD will propose termination of this service. The enrollee will be provided a notice of his right to a Medicaid fair hearing if termination is proposed.

Services shall be provided according to the individual's ISP. ISPs shall be provided to limited providers of informal respite care services.

A limited provider shall be an individual certified pursuant to ORC 5123.045 who meets the following requirements along with those requirements listed in Table B.

- Participation in orientation and any resulting training by the responsible family member about activities required to meet the needs and preferences of the individual(s) including any training stipulated for the individual(s) in his ISP(s);
- Except in the case of several family members enrolled on an hcbs waiver who receive Informal Respite in the same family home, individuals who are Limited Providers, will not concurrently provide Informal Respite to any other individual enrolled on home and community based waivers.

ODJFS and ODMR/DD will sanction for failure to meet and maintain the requirements of Informal Respite. Sanctions include technical assistance, mandatory training, and termination of provider agreement and recoupment of waiver payment for any time claimed and reimbursed as informal respite when requirements were not met. Specific sanctions, the compliance monitoring process, and roles of State agencies and their subrecipients, including County Boards of MR/DD and the provider appeal process will be specified in Ohio Administrative Code.

## 2. Habilitation-Supported Employment Services

Supported Employment services will be provided by an agency or

individual providers certified pursuant to ORC 5123.045.

- All providers are certified pursuant to ORC 5123.045. Staff employed by these agencies who provide supported employment waiver services shall demonstrate at least one year of experience providing supporting employment services or related services or show evidence of at least one formal training in community/supported employment. Agency providers of Waiver Supported Employment shall meet the requirements as listed in Table B.
- Individuals not employed by agencies who are certified to provide Supported Employment services shall demonstrate at least one year of experience providing supporting employment services or related services or show evidence of at least one formal training in community/supported employment. Individuals who provide Waiver Supported Employment shall meet the requirements as listed in Table B.

Providers of supported employment must assure that there is adequate substitute coverage in the event that the provider is not able to provide coverage as specified in the individual's ISP. The provider shall notify the individual when the provider is obtaining another certified provider who can provide substitute coverage.

Providers shall not agree to provide services to any enrollee whose needs the provider cannot meet. Providers shall provide written assurances that the provider and all staff of the provider who provide direct care services have sufficient background and training to protect the health and welfare of the enrollee in the execution of the duties assigned to the provider in the ISP and PAWS authorization for services.

ODJFS and ODMR/DD will sanction for failure to provide authorized services. Sanctions include technical assistance, mandatory training, plans of correction, temporary suspension on providing services to additional waiver enrollees, penalties, fines, termination of provider agreement and recoupment of waiver payment for any time claimed and reimbursed as Supported Employment when requirements were not met. Specific sanctions, the compliance monitoring process, and roles of State agencies and their subrecipients, including County Boards of MR/DD and the provider appeal process will be specified in Ohio Administrative Code.

### 3. Environmental Accessibility Adaptations

Environmental Accessibility Adaptations will be provided by construction companies or individual providers certified pursuant to ORC 5123.045 which provide proof of experience in providing the approved services/products or which provide a resume verifying experience in providing these services/products. All

applicable state and or local regulations that apply to the operation of the business or trade must be met. ODJFS, ODMRDD or their designated subrecipients shall procure covered activities/products by either directly or through subrecipients a RFI Request for Information process to establish initial providers of services. The RFI process shall be repeated no less frequently than once every three years. Waiver enrollees shall select providers of these services/products among those companies, which have either responded to the RFI or have subsequently met the requirements established for the provision of these services.

ODJFS and ODMR/DD will sanction for failure to meet the specifications required for products and/or services as documented in the RFI and a company's response to the RFI or for companies which meet the requirements of the RFI subsequent to the RFI process and request Medicaid waiver provider status. Sanctions include plans of correction, temporary suspension on providing services to additional waiver enrollees, penalties, fines, termination of provider agreement and recoupment of waiver payment for any products or services claimed and reimbursed as Environmental Accessibility Adaptations when specifications were not met. Specific sanctions, the compliance monitoring process, and roles of State agencies and their subrecipients, including County Boards of MR/DD and the provider appeal process will be specified in Ohio Administrative Code.

#### 4. Transportation

(A) Transportation services will be provided by an agency or individual provider certified pursuant to ORC 5123.045. Each provider of private automobile services must show proof of a valid driver's license as well as proof of insurance coverage as specified in Ohio law. Providers of private automobile services must ensure that all individual drivers who provide services must have the requirements listed in Table B.

(B) Any provider of public transportation services such as a bus or taxi company must comply with all applicable state and/or local regulations that apply to the operation of their business. Providers of public bus transportation are not required to have background investigations for bus drivers nor are these bus drivers subject to the MUI requirements of 5123: 2-17-02.

Providers of taxi services must ensure that all individual drivers meet the following requirements:

- o Have background investigations
- o Driver is not an individual on the Abuser Registry

(C) County Boards providers of mr/dd waiver transportation services must demonstrate that drivers who operate vehicles which provide waiver transportation services and who are directly

employed by the board have a valid driver's license, necessary proof of insurance coverage as specified in Ohio law and must meet the requirements listed in Table B.

Private automobile drivers and county board drivers shall be provided any relevant portion of the individual's ISP and shall provide transportation services as described in the relevant portion of the individual's ISP.

Private automobile drivers and county board drivers shall not agree to provide services to any enrollee whose needs the provider cannot meet. Providers shall provide written assurances that the provider has sufficient background and training to protect the health and welfare of the enrollee in the execution of transportation services.

ODJFS and ODMR/DD will sanction for failure to provide adequate health and welfare protections for waiver enrollees and meet and maintain the requirements of Transportation. Sanctions include technical assistance, mandatory training, plans of correction, temporary suspension on providing services to additional waiver enrollees, penalties, fines, termination of provider agreement and recoupment of waiver payment for any time claimed and reimbursed as transportation when requirements were not met. Specific sanctions, the compliance monitoring process, and roles of State agencies and their subrecipients, including County Boards of MR/DD and the provider appeal process will be specified in Ohio Administrative Code.

#### 5. Specialized Medical Adaptive/Assistive Equipment and Supplies

Specialized Medical Adaptive/Assistive Equipment and Supplies will be provided by companies or individual providers certified pursuant to ORC 5123.045 which provide proof of experience in providing the approved services/products or which provide a resume verifying experience in providing these services/products. All applicable state and or local regulations that apply to the operation of the business or trade must be met. ODJFS, ODMRDD or their designated subrecipients shall procure covered activities/products by either directly or through subrecipients a RFI Request for Information process to establish initial providers of services. The RFI process shall be repeated no less frequently than once every three years. Waiver enrollees shall select providers of Specialized Medical Adaptive/Assistive Equipment and Supplies among those companies which have either responded to the RFI or have subsequently met the requirements established for the provision of the services. Waiver enrollees shall select providers of Specialized Medical Adaptive/Assistive Equipment and Supplies among these companies.

ODJFS and ODMR/DD will sanction for failure to meet the specifications required for products and/or services as documented in the RFI and a company's response to the RFI or for companies which meet the requirements of the RFI subsequent to

the RFI process and request Medicaid waiver provider status. Sanctions include a temporary suspension on providing services to additional waiver enrollees, penalties, fines, termination of provider agreement and recoupment of waiver payment for any products or services claimed and reimbursed as Specialized Medical Adaptive/Assistive Equipment and Supplies when specifications were not met. Specific sanctions, the compliance monitoring process, and roles of State agencies and their subrecipients, including County Boards of MR/DD and the provider appeal process will be specified in Ohio Administrative Code.

#### 6. Personal Emergency Response System

Personal Emergency Response Systems will be provided by companies certified pursuant to ORC 5123.045 which provide a 24 hour switch board, provide consumer training on the equipment, ensure that equipment is in operating order and provide quarterly test of equipment to ensure proper operation and have an electronic means to notify emergency personnel such as police, fire, ambulance and psychiatric crisis response entities. Waiver enrollees shall select providers of this service.

Sanctions applicable for failure to meet the specifications required for products and/or services include a temporary suspension on providing services to additional waiver enrollees, penalties, fines, termination of the provider agreement and recoupment of waiver payment for any products or services claimed and reimbursed as Personal Emergency Response Systems when specifications were not met. Specific sanctions, the compliance monitoring process, and roles of State agencies and their subrecipients, including County Boards of MR/DD and the provider appeal process will be specified in Ohio Administrative Code.

#### 7. Homemaker/Personal Care (HPC)

Homemaker/Personal Care will be provided by licensed agencies, non-licensed agencies and individual providers who meet the following requirements:

- Non-licensed agencies and individual providers which provide evidence of certification to provide supported living services according to ORC 5126.431 and ORC 5111.85. An mr/dd board shall not provide HPC services directly. In the event that there is no certified private person or entity which is willing and able to provide services, a mr/dd board may provide such services through an independent contractor who is employed in another capacity by the mr/dd board; such independent contractor shall comply with the requirements of ORC 5126.032, 5126.033 and 5123.64.
- Non-licensed agencies, individual providers and licensed

facilities of Homemaker/Personal Care must ensure that all individuals providing direct service to waiver enrollees meet the requirements listed in Table B.

Non-licensed agencies, individual providers and licensed facilities which provide Homemaker/Personal Care must assure that there is adequate substitute coverage in the event that the provider is not able to provide coverage as specified in the individual's ISP. The provider shall notify the individual when the provider is obtaining substitute coverage.

Providers shall not agree to provide services to any enrollee whose needs the provider cannot meet. Providers shall provide written assurances that the provider and all staff of the provider who provide direct care services have sufficient background and training to protect the health and welfare of the enrollee in the execution of the duties assigned to the provider in the ISP and PAWS authorization for services.

ODJFS and ODMR/DD will sanction for failure to provide authorized services. Sanctions include technical assistance, mandatory training, plans of correction, temporary suspension on providing services to additional waiver enrollees, penalties, fines, termination of provider agreement and recoupment of waiver payment for any time claimed and reimbursed as Homemaker/Personal Care when requirements were not met. Specific sanctions, the compliance monitoring process, and roles of State agencies and their subrecipients, including County Boards of MR/DD and the provider appeal process will be specified in Ohio Administrative Code.

Table B: Summary of Provider Qualifications and Requirements

	Homemaker/Personal Care					Transportation			
	Institutional Respite	Informal Respite	Individual	Agency	Licensed	Supported Employment	Agency/Individual	County Board Bus	Taxi
Background Investigation	5123:2-3-06 5123:2-3-04	5123:2-1-051 except (F)	5123:2-1-051 except (F)	5123:2-1-051	5123:2-3-06	5123:2-1-051	5123:2-1-051	5123:2-1-05	5123:2-1-051
Abuser Registry	5123:2-17-03 (F) (3)	5123:2-17-03 (F) (3)	5123:2-17-03 (F) (3)	5123:2-17-03 (F) (3)	5123:2-17-03 (F) (3)	5123:2-17-03 (F) (3)	5123:2-17-03 (F) (3)	5123:2-17-03 (F) (3)	5123:2-17-03 (F) (3)
Major Unusual Incident (MUI)	5123:2-17-02	5123:2-17-02 except (F) (1), (G) (1), (G) (4), (G) (5), (H) (1), (H) (2) and (K) (1) The provider shall be responsible for taking all reasonable steps necessary to prevent the reoccurrence of major unusual incidents.	5123:2-17-02 except (F) (1), (G) (1), (G) (4), (G) (5), (H) (1) and (H) (2) The provider shall be responsible for taking all reasonable steps necessary to prevent the reoccurrence of major unusual incidents.	5123:2-17-02	5123:2-17-02	5123:2-17-02 except (F) (1), (G) (1), (G) (1), (G) (4), (G) (5), (H) (1) and (H) (2) for individual providers.  The provider shall be responsible for taking all reasonable steps necessary to prevent the reoccurrence of major unusual incidents.	5123:2-17-02 except (F) (1), (G) (1), (G) (4), (G) (5), (H) (1) and (H) (2) for individual providers. The provider shall be responsible for taking all reasonable steps necessary to prevent the reoccurrence of major unusual incidents.	5123:2-17-02	
CPR	5123.19 5123:2-3-07		Provider shall have current certification in CPR	At least one staff person who has current certification in CPR shall be present when receiving services from an agency.	5123.19 5123:2-3-07	For Individual providers: Provider shall have current certification in CPR  For Agency providers: At least one staff person who has current certification in CPR	For Individual providers: Provider shall have current certification in CPR  For Agency providers: At least one staff person who has current certification in CPR shall be present when receiving services from an agency	At least one staff person who has current certification in CPR shall be present when receiving services from an agency.	

	Homemaker/Personal Care					Transportation			
	Institutional Respite	Informal Respite	Individual	Agency	Licensed	Supported Employment	Agency/Individual	County Board Bus	Taxi
						shall be present when receiving services from an agency			
Emergency Backup/Notification			Providers must assure that there is adequate substitute coverage in the event that the provider is not able to provide services as specified in the individual's ISP. The provider shall notify the individual when the provider is obtaining substitute coverage	Providers must assure that there is adequate substitute coverage in the event that the provider is not able to provide services as specified in the individual's ISP. The provider shall notify the individual when the provider is obtaining substitute coverage	Providers must assure that there is adequate substitute coverage in the event that the provider is not able to provide services as specified in the individual's ISP. The provider shall notify the individual when the provider is obtaining substitute coverage	Providers must assure that there is adequate substitute coverage in the event that the provider is not able to provide services as specified in the individual's ISP. The provider shall notify the individual when the provider is obtaining substitute coverage			
Rights	5123.19	5123.64 The county board shall provide training for the provider	5123.64 The county board shall provide training for the provider	5123.64	5123.64	5123.64 The county board shall provide training for the individual provider		5123.64	
Behavior Support	5123.19 5123:2-3-04		Required, see attachment	Required, see attachment	5123.19 5123:2-3-04	Required, see attachment		Required, see attachment	
Medication Administration	Required, see attachment		Required, see attachment	Required, see attachment	Required, see	Required, see			

	Homemaker/Personal Care					Transportation			
	Institutional Respite	Informal Respite	Individual	Agency	Licensed	Supported Employment	Agency/Individual	County Board Bus	Taxi
n					attachment	attachment			
ISP	5123:2-3-17, as described in Attachment to Appendix E		Relevant parts required. Requirements are described in Attachment to Appendix E	Relevant parts required. Requirements are described in Attachment to Appendix E	5123:2-3-17, as described in Attachment to Appendix E	Relevant parts required. Requirements are described in Attachment to Appendix E	Relevant parts required. Requirements are described in Attachment to Appendix E	Relevant parts required. Requirements are described in Attachment to Appendix E	Relevant parts required. Requirements are described in Attachment to Appendix E
Program Management/Habilitation Management	Institutional provider is responsible per 5126.14	Family is responsible per 5126.14	Individual Providers must, by working jointly with assigned SSAs and, where appropriate, family members, ensure the provision of program management services in accordance with 5126.14.	HPC agency is responsible per 5126.14	Licensed facility is responsible per 5126.14	Individual Providers must, by working jointly with assigned SSAs and, where appropriate, family members, ensure the provision of program management services in accordance with 5126.14.			
Other		Except as noted, Limited Providers will not provide informal respite to any other individual enrolled on a waiver.	Supported living certification per 5126:431	Supported living certification per 5126:431		1 year experience or 1 year formal training	Drivers License Proof of insurance	Drivers License Proof of insurance	State and local requirements

Attachment for Behavior Support

- (1) A Provider shall ensure that:
- (a) Restraint and time-out, as defined in paragraph (2) of this rule, are only used with behaviors that are destructive to self or others
  - (b) Behavior support methods are employed with sufficient safeguards and supervision to ensure that the safety, welfare, due process, and civil and human rights of individuals receiving county board services are adequately protected.
  - (c) Aversive behavior support methods are never used for retaliation, for staff convenience, or as a substitute for an active treatment program (interdisciplinary team developed and approved per individual plans).
  - (d) Positive and less aversive teaching and support strategies are demonstrated to be ineffective prior to use of more intrusive procedures.
  - (e) Standing or as needed programs for the control of behavior are prohibited. A "standing or as needed program" refers to the use of a negative consequence or an emergency intervention as the standard response to an individual's behavior without developing a behavior support plan for the individual.
  - (f) Prohibited actions are reported as major unusual incidents in accordance with rule 5123:2-17-02 of the Administrative Code. Prohibited actions shall include the following:
    - (i) Any physical abuse of an individual such as striking, spitting on, scratching, shoving, paddling, spanking, pinching, corporal punishment or any action to inflict pain.
    - (ii) Any sexual abuse of an individual.
    - (iii) Medically or psychologically contraindicated procedures.
    - (iv) Any psychological/verbal abuse such as threatening, ridiculing, or using abusive or demeaning language.
    - (v) Placing the individual in a room with no light.
    - (vi) Subjecting the individual to damaging or painful sound.
    - (vii) Denial of breakfast, lunch or dinner.
    - (viii) Squirting an individual with any substance as a consequence for a behavior.
    - (ix) Time-out in a time-out room exceeding one hour for any one incident and exceeding more than two hours in a twenty-four hour period. Use of a time-out room requires the additional oversight specified in paragraphs (2) of this rule and the following safeguards:
      - (a) A time-out room shall not be key locked, but the door may be held shut by a staff person or by a mechanism that requires constant physical pressure from a staff person to keep the mechanism engaged.
      - (b) The room must be adequately lighted and ventilated, and provide a safe environment for the individual.
      - (c) An individual in a time-out room must be protected from hazardous conditions including, but not limited to, presence of sharp corners and objects, uncovered light fixtures, or unprotected electrical outlets.
      - (d) The individual must be under constant visual supervision by staff at all times.

- (e) A record of time-out activities must be kept.
  - (f) Emergency placement (i.e., without a written plan) of an individual in a time-out room is not allowable.
  - (x) Systematic, planned intervention using manual, mechanical, or chemical restraints, except when necessary to protect health, safety, and property and only when all other conditions required by paragraph (1) of this rule are met.
  - (xi) Medication for behavior control, unless it is prescribed by and under the supervision of a licensed physician who is involved in the interdisciplinary planning process.
- (g) Behavior support policies and procedures adopted by the Agency provider:
- (i) Promote the growth, development and independence of the individual;
  - (ii) Address the extent to which individual choice will be accommodated in daily decision-making, emphasizing self-determination and self-management, to the extent possible;
  - (iii) Specify the individual's conduct to be allowed or not allowed;
  - (iv) Be available to all staff, the individual, parents of minor children and legal guardians;
  - (v) To the extent possible, be formulated with the individual's participation; and
  - (vi) Ensure that an individual must not discipline another individual, except as part of an organized system of self-government.
- (h) *Appropriate conduct* for behavior support is characterized by:
- (i) Interactions and speech that reflect respect, dignity, and a positive regard for the individual;
  - (ii) The absence of group punishment;
  - (iii) The absence of demeaning, belittling or degrading speech or punishment;
  - (iv) Staff speech that is even-toned made in positive and personal terms and without threatening overtones or coercion;
  - (v) Conversations with the individual rather than about the individual while in the individual's presence;
  - (vi) Respect for the individual's privacy by not discussing the individual with someone who has no right to the information;
- (i) Training and experience is required for staff of Agency Providers or for Independent providers who develop behavior support plans and all persons who are responsible for implementing plans are specified and have required training documented.

(2) Requirements for restraint and time-out

- (a) The use of restraint and time-out, because of their possible adverse effects on health and safety, shall require additional oversight by the department. As used in paragraph (J) of this rule, the following definitions shall apply:
  - (i) "Restraint" means any one of the following:

- (a) "Chemical restraint," which means a prescribed medication for the purpose of modifying, diminishing, controlling, or altering a specific behavior. "Chemical restraint" does not include the following:
  - (i) Medications prescribed for the treatment of a diagnosed disorder as found in the current version of the American psychiatric association's "Diagnostic and Statistical Manual" (DSM);
  - (ii) Medications prescribed for treatment of a seizure disorder.
- (b) "Emerging methods and technology," which means new methods of restraint or seclusion that create possible health and safety risks for the individual, including methods or technology that were not developed prior to the effective date of this rule.
- (c) "Manual restraint," which means a hands-on method that is used to control an identified behavior by restricting the movement or function of the individual's head, neck, torso, one or more limbs or entire body, using sufficient force to cause the possibility of injury.
- (d) "Mechanical restraint," which means a device that restricts an individual's movement or function applied for purposes of behavior support, including a device used in any vehicle, except a seat belt of a type found in an ordinary passenger vehicle or an age-appropriate child safety seat.
  - (ii) "Time-out," which means confining an individual in a room and preventing the individual from leaving the room by applying physical force or by closing a door or other barrier, including placement in such a room when a staff person remains in the room with the individual.
- (b) Prior approval from the director must be obtained before using the following methods of restraint:
  - (i) Any emerging methods and technology designated by the director as requiring prior approval; or
  - (ii) Any other extraordinary measures designated by the director as requiring prior approval, including brief application of electric shock to a part of the individual's body following an identified behavior.
- (c) Restraint or time-out shall be discontinued if it results in serious harm or injury to the individual or does not achieve the desired results as defined in the behavior support plan.
- (d) Any use of restraint or time-out in an unapproved manner or without obtaining required consent, approval, or oversight shall be reported as a major unusual incident pursuant to rule 5123:2-17-02 of the Administrative Code.
- (e) Any use of restraint or time-out that results in an injury that meets the definition of a major unusual incident or an unusual incident shall be reported as such pursuant to rule 5123:2-17-02 of the Administrative Code.
- (f) Within five working days after local approval of a behavior support plan using restraint or time-out, the provider shall notify the department by facsimile or other electronic means in a format prescribed by the department. Upon request by the department, the county board or provider shall submit any additional information regarding the use of the restraint or time-out.

Attachment for Medication Administration

Medication Administration Policy

ORC and OAC of the Ohio Board of Nursing and ODMRDD govern the administration of medications and selected health care tasks for individuals with mrdd who receive home and community based waiver services. Requirements are specified for:

- Individuals to self administer medications;
- For individuals to receive assistance in self administering medication;
- To receive medications from an unlicensed worker with appropriate training and supervision;
- When a licensed nurse must administer the medication or perform the health care task.

The requirements are specified by the type and size of facility or program. ORC Chapter 4723 and implementing rules contained in OAC 4723 sections 13, 21 and 22 establish Ohio Board of Nursing requirements. ORC 5123 and 5126 and implementing rules establish companion authority for ODMRDD and county boards.

APPENDIX B-3

KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

Home and community-based services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.



b. X Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

- (1) X A special income level equal to:  
X 300% of the SSI Federal benefit (FBR)  
         % of FBR, which is lower than 300% (42  
CFR 435.236)  
\$          which is lower than 300%
- (2) X Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)
- (3)          Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435.324.)
- (4)          Medically needy without spenddown in 209(b) States.  
(42 CFR 435.330)
- (5)          Aged and disabled who have income at:  
a.          100% of the FPL  
b.          % which is lower than 100%.
- (6)          Other (Include statutory reference only to reflect additional groups included under the State plan.)

7.          Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8.          Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under §435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (§435.217). For individuals whose eligibility is not determined under the spousal rules (§1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR §435.726 and §435.735 just as it does for other individuals found eligible under §435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under §1924.

**REGULAR POST-ELIGIBILITY RULES--§435.726 and §435.735**

- o The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.
- o If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.
- o If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.
- o If other family members are living with the individual, an additional

amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

**SPOUSAL POST-ELIGIBILITY--§1924**

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of §1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The §1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in §1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as \$30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The \$30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the §1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

**REGULAR POST ELIGIBILITY**

1. \_\_\_\_\_ **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

A. **§ 435.726**--States which **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A. \_\_\_\_\_ The following standard included under the State plan (check one):

- (1) \_\_\_\_\_ SSI
- (2) \_\_\_\_\_ Medically needy
- (3) \_\_\_\_\_ The special income level for the institutionalized
- (4) \_\_\_\_\_ The following percent of the Federal poverty level): \_\_\_\_\_ %
- (5) \_\_\_\_\_ Other (specify):  
\_\_\_\_\_

B. \_\_\_\_\_ The following dollar amount:  
\$ \_\_\_\_\_ \*

\* If this amount changes, this item will be revised.

C. \_\_\_\_\_ The following formula is used to determine the needs allowance:

**Note:** If the amount protected for waiver recipients in item 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

- A. \_\_\_\_\_ SSI standard
- B. \_\_\_\_\_ Optional State supplement standard
- C. \_\_\_\_\_ Medically needy income standard
- D. \_\_\_\_\_ The following dollar amount:  
    \$ \_\_\_\_\_ \*

\* If this amount changes, this item will be revised.

- E. \_\_\_\_\_ The following percentage of the following standard that is not greater than the standards above: \_\_\_\_\_ % of \_\_\_\_\_ standard.

- F. \_\_\_\_\_ The amount is determined using the following formula:

- G. \_\_\_\_\_ Not applicable (N/A)

3. Family (check one):

- A. AFDC need standard
- B. \_\_\_\_\_ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

- C. \_\_\_\_\_ The following dollar amount:  
    \$ \_\_\_\_\_ \*

\*If this amount changes, this item will be revised.

D. \_\_\_\_\_ The following percentage of the following  
standard that is not greater than the standards  
above: % \_\_\_\_\_ of \_\_\_\_\_ standard.

E. \_\_\_\_\_ The amount is determined using the following  
formula:

F. \_\_\_\_\_ Other

G. \_\_\_\_\_ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR  
435.726.



**Note:** If the amount protected for waiver recipients in 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under §435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

A. \_\_\_\_\_ The following standard under 42 CFR 435.121:

B. \_\_\_\_\_ The medically needy income  
standard \_\_\_\_\_;

C. \_\_\_\_\_ The following dollar amount:  
\$ \_\_\_\_\_\*

\* If this amount changes, this item will be revised.

D. \_\_\_\_\_ The following percentage of the following  
standard that is not greater than the standards  
above: \_\_\_\_\_% of

E. \_\_\_\_\_ The following formula is used to determine  
the amount:

F. \_\_\_\_\_ Not applicable (N/A)

3. family (check one):

A. \_\_\_\_\_ AFDC need standard

B. \_\_\_\_\_ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C. \_\_\_\_\_ The following dollar amount:  
\$ \_\_\_\_\_\*

\* If this amount changes, this item will be revised.

D. \_\_\_\_\_ The following percentage of the following standard that is not greater than the standards above: \_\_\_\_\_ % of \_\_\_\_\_ standard.

E. \_\_\_\_\_ The following formula is used to determine the amount:

F. X Other: **An amount equal to the need standard for a family of the same size used to determine eligibility under the State's approved 1931 plan.**

G. \_\_\_\_\_ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

**SPOUSAL POST ELIGIBILITY**

2.   X   The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual:  
(check one)

(a)        SSI Standard

(b)        Medically Needy Standard

(c)        The special income level for the  
institutionalized

(d)        The following percent of the Federal  
poverty level:        %

(e)        The following dollar amount  
\$        \*\*

\*\*If this amount changes, this item will be revised.

(f)   X   The following formula is used to determine the needs allowance: **65% of 300% of the SSI payment for an individual.**

(g)        Other (specify):

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.

APPENDIX D

ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

- Discharge planning team
- Physician (M.D. or D.O.)
- Registered Nurse, licensed in the State
- Licensed Social Worker
- Qualified Mental Retardation Professional, as defined in 42 CFR 483.430 (a)  
County Board certified staff performing the Service and Support Administration function, collect assessment information, complete the Level of Care form and make a recommendation to ODMRDD. ODMRDD QMRPs make the final ICF/MR Level of Care determination.
- Other (Specify):

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

- Every 3 months
- Every 6 months
- Every 12 months
- Other (Specify):

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

- The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.
- The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):
  - Physician (M.D. or D.O.)
  - Registered Nurse, licensed in the State
  - Licensed Social Worker
  - Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)
  - Other (Specify):

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

- "Tickler" file
- Edits in computer system
- Component part of case management

X  

Other (Specify): **Integral part of required coordinating activities which are responsibility of the county boards of mr/dd.**

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):

- By the Medicaid agency in its central office
- By the Medicaid agency in district/local offices
- By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program
- By the case managers
- By the persons or agencies designated as responsible for the performance of evaluations and reevaluations
- By service providers
- Other (Specify):

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

- The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

The Level of Care process for evaluating people entering an ICF/MR facility differs from the process used for evaluating applicants for an ICF/MR based waiver. Both processes use the same criteria for an ICF/MR LOC and produce valid and reliable determinations.

\_\_\_\_\_ The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

**APPLICANT INFORMATION: Initial Waiver Application**

Name _____ Date of Birth _____ County _____	
Social Security Number _____ Address _____	
Guardian _____ Address _____	
<b>Residence when enrolled:</b> (check one)	
<input type="checkbox"/> With family	<input type="checkbox"/> Licensed home: facility number _____
<input type="checkbox"/> In own (unlicensed) place	<input type="checkbox"/> Other: _____
<b>Is the applicant currently receiving residential, supported living, or waiver services?</b> Yes No	
<b>Waiver Request</b> (check one) <input type="checkbox"/> Individual Options <input type="checkbox"/> Residential Facility <input type="checkbox"/> Level 1	
<b>Priority status:</b> (check one)	
<input type="checkbox"/> Emergency	<input type="checkbox"/> Caregiver age 60+ <input type="checkbox"/> Deinstitutionalization
<input type="checkbox"/> Supported living refinancing	<input type="checkbox"/> Children with intensive needs <input type="checkbox"/> Regular waiting list
<input type="checkbox"/> Adult services refinancing	<input type="checkbox"/> Adults with intensive needs
<b>Waiver Enrollment (Slot) Number:</b> (check one)	
<input type="checkbox"/> A new slot/enrollment number that has been added, with ODMR/DD written approval.	
<input type="checkbox"/> An existing slot/enrollment number that has never been used.	
<input type="checkbox"/> A slot/enrollment number that has been used, but the occupant is being replaced.	
<input type="checkbox"/> Previous Occupant: _____	
<input type="checkbox"/> Slot/Enrollment Number: _____ Last date of waiver service: _____	

**ICF/MR WAIVER LEVEL OF CARE: Initial Eligibility Determination**

<b>1. The individual meets the minimum criteria for Protective Level of Care</b>		Yes	No
<b>2a. Diagnosed condition(s) that establish(es) the individual's developmental disability (age 6 and above)</b> _____			
<b>2b. Developmental delays assessed for individuals birth through age five</b> _____			
> Attach a medical evaluation and a psychological/psychiatric evaluation that verify this diagnosed condition. <			
<b>3. Was the disability manifested prior to age 22?</b>		Yes	No
<b>4. Is the disability likely to continue indefinitely?</b>		Yes	No
<b>5. Current substantial functional limitations:</b> (Based on functional assessment) Refer to OAC 5101:3-3-07			
<b>i. Self Care (age 6+)</b>		Yes	No
<b>ii. Understanding / Use of Language (age 6+)</b>		Yes	No
<b>iii. Learning (age 6+)</b>		Yes	No
<b>iv. Mobility (age 6+)</b>		Yes	No
<b>v. Self-direction (age 6+)</b>		Yes	No
<b>vi. Capacity for Independent Living (age 6+)</b>		Yes	No
<b>vii. Economic Self-Sufficiency (age 16+ only)</b>		Yes	No
<b>viii. 3 developmental delays (birth to age 5 only)</b>		Yes	No
<b>6-7. Skill Acquisition: The individual could benefit from services and supports to promote the acquisition of skills and to decrease or prevent regression in the performance in areas where delays are indicated and agrees to participate in an individualized plan of services and supports.</b>		Yes	No
<b>8. Level of Care Recommendation:</b>		<b>9. Proposed Date for Waiver Services to Begin (mm/dd/year):</b> _____	
<input type="checkbox"/> ICFMR/DD			
<input type="checkbox"/> Other: _____			
Service Support Administrator: _____		Title/Date: _____	
<b>(ODMRDD USE ONLY)</b>			
ICF/MR Level of Care Approved: _____		Denied: _____ Date services to begin: December 1, 2002	
LOC Effective Date: _____		Date Notice Sent to CBMRDD: _____	
QMRP Signature/Date _____		Waiver Manager Signature/Date _____	

ST

**APPLICANT INFORMATION: Redetermination**

<b>Name</b> _____ <b>County</b> _____		
<b>Date of Birth</b> (mm/dd/year) _____		
<b>Social Security Number</b> _____	<b>Address</b> _____	
<b>Guardian</b> _____	<b>Address</b> _____	
<b>Waiver Enrollment (Slot) Number</b> _____		
<b>Current residence:</b> (check one)		
<input type="checkbox"/> With family	<input type="checkbox"/> Group Home: facility number _____	
<input type="checkbox"/> In own place	<input type="checkbox"/> Other: _____	
<b>Waiver type:</b> (check one)		
<input type="checkbox"/> Individual Options	<input type="checkbox"/> Residential Facility	<input type="checkbox"/> Level 1

**ICF/MR WAIVER LEVEL OF CARE: Redetermination**

<b>Level of Care Effective Date</b> (mm/dd/year): _____
<b>Span date</b> (mm/dd/year): _____
<b>I certify that there has been no substantial change in the individual's condition and that the individual continues to require an ICF/MRDD Level of Care.</b>
<b>Service Support Administrator:</b> _____ <b>Title/Date:</b> _____
<b>(ODMRDD USE ONLY)</b>
ICF/MR Level of Care Approved: _____ Denied: _____ Date services to begin: _____
LOC Effective Date: _____ Date Notice Sent to CBMRDD: _____
_____ QMRP Signature/Date

**APPLICANT INFORMATION: Redetermination**

Name _____ County _____	
Date of Birth (mm/dd/year) _____	
Social Security Number _____	Address _____
Guardian _____	Address _____
Waiver Enrollment (Slot) Number _____	
Current residence: (check one)	
<input type="checkbox"/> With family	<input type="checkbox"/> Group Home: facility number _____
<input type="checkbox"/> In own place	<input type="checkbox"/> Other: _____
Waiver type: (check one)	
<input type="checkbox"/> Individual Options	<input type="checkbox"/> Residential Facility <input type="checkbox"/> Level I

**ICF/MR WAIVER LEVEL OF CARE: Redetermination**

1. The individual meets the minimum criteria for Protective Level of Care, as found in section (C) (2) of OAC 5101:3-3-08			Yes	No
2. Diagnosed condition(s) that establish(es) the individual's developmental disability _____				
> Attach a medical evaluation and a psychological/psychiatric evaluation that verify this diagnosed condition. <				
3. Was the disability manifested prior to age 22?			Yes	No
4. Is the disability likely to continue indefinitely?			Yes	No
5. Current substantial functional limitations: (Based on functional assessment) Refer to OAC 5101:3-3-07				
i. Self Care			Yes	No
ii. Understanding / Use of Language			Yes	No
iii. Learning			Yes	No
iv. Mobility			Yes	No
v. Self-direction			Yes	No
vi. Capacity for Independent Living			Yes	No
vii. Economic Self-Sufficiency (age 16+ only)			Yes	No
viii. 3 developmental delays (0-5 yrs only)			Yes	No
6-7. Skill Acquisition: The individual could benefit from services and supports to promote the acquisition of skills and to decrease or prevent regression in the performance of those areas where delays are indicated and agrees to participate in an individualized plan of services and supports.			Yes	No
8. Level of Care Recommendation:				
<input type="checkbox"/> ICFMR/DD				
<input type="checkbox"/> Other: _____				
Level of Care Effective Date (mm/dd/year): _____				
Span date (mm/dd/year): _____				
Service Support Administrator: _____			Title/Date: _____	
<b>(ODMRDD USE ONLY)</b>				
ICF/MR Level of Care Approved: _____ Denied: _____ Date services to begin: _____				
LOC Effective Date: _____ Date Notice Sent to CBMRDD: _____				
QMRP Signature/Date _____			Waiver Manager Signature/Date _____	

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:
  - a. informed of any feasible alternatives under the waiver; and
  - b. given the choice of either institutional or home and community-based services.
2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.

**Enrollees disenrolled from other mr/dd waivers shall be afforded the opportunity to apply for enrollment on this waiver if their health and welfare can be assured within the benefit package limitations of this waiver.**

**Individuals participating in the waiver will not lose their eligibility for the waiver due to an increase in the need for a covered service that causes the total need for the relevant service(s) to exceed the maximum permitted amounts established by the state unless the state has evaluated the individual and determined that the individual's health and welfare cannot be assured by any one or any combination of the following:**

- (A) Adding more available natural supports; and
- (B) Prior authorizing additional services or levels of service subject to the limitations of the approved waiver; and
- (C) Accessing services available under the Emergency Assistance service covered by the waiver; and
- (D) Accessing available non-waiver services, other than natural supports; and
- (E) Accessing funds previously placed in a local risk fund or state risk fund in accordance with Ohio Administrative Code 5123:1-5-02.

**To the extent that the above efforts are unsuccessful, and the state finds that the absence of sufficient service(s) prevents the state from being able to assure the individual's health and welfare, the following will apply:**

- (A) Individuals will be given the opportunity to apply for an alternate HCBS waiver for which the individual is eligible that may more adequately respond to the services needs of the individual, to the extent that such waiver openings exist. Individuals in emergency

situations are statutorily permitted to access services on a priority basis before other individuals on the waiting list.

(B) Individuals will be offered an opportunity for placement in an ICFMR including a state operated developmental center.

(C) Individuals will be informed and given the opportunity to request a fair hearing if the state proposes to terminate the individual's waiver eligibility, consistent with the requirements under 42 CFR 431.210, .211, .221; and 430 subpart D. Waiver services will be continued during the pendency of a timely requested hearing including the provision of emergency services, even if the services exceed the benefit package limitation.

3. The following are attached to this Appendix:

- a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;
- b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;

**At the time the person requests HCB waiver services, the county board of mr/dd in which the person resides is responsible for explaining the services available under the waiver. The individual will be informed of the amount, scope and duration of services and benefit package limitations available in this waiver, including a full explanation of how the various benefit package limitations interface.**

- c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services;

**The County Board or the ODMR/DD will use the attached form to document 3a and 3b. When the "Freedom of Choice" form is signed by the individual, the County Board or ODMR/DD will also provide a copy of the ODHS 8007 or 4074 (copies enclosed). In situations where the licensed provider is not separate from the county board, the ODMR/DD shall explain the services available under the HCBS waiver.**

- d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

**At the time individuals or their authorized representatives apply for any type of Medical assistance in Ohio they are given a pamphlet: "You Have a Right to a Hearing" (ODHS 8007) as well as "Explanation of State Hearing Procedures"**

(ODHS 4059). Both of these notifications are provided to the applicant by the county department of job and family services (CDJFS) at the time the Medicaid application is filed and both are required by Ohio Administrative Code (OAC 5101:6-2-01).

b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained: **County board of mr/dd where person was enrolled in waiver.**

FREEDOM OF CHOICE DOCUMENTATION

Name (Last, First, Middle Initial)	County

**A. Selection of HCBS Waiver (check one)**

I understand that enrollment on a Medicaid Home & Community Based Services (HCBS) Waiver is strictly voluntary. I also understand that if enrolled I will be receiving Waiver services instead of services in an Intermediate Care Facility for the Mentally Retarded.

- I have chosen HCBS Waiver Services
- I have not chosen HCBS Waiver Services

**B. Applicant's Responsibilities**

- ❖  I understand the HCBS Waiver must keep the cost of my services below a certain dollar amount for me to be on the Waiver. I understand that I may be required to pay a patient liability to one of my service providers if that is part of my financial eligibility to stay on the Waiver.
- ❖  I understand the HCBS Waiver will deliver services according to my Individual Service Plan (ISP). I will cooperate in a reassessment when my ISP is about to expire.
- ❖  I understand that my ISP will be monitored and reviewed by my Service Support Administrator and that I can contact my Service Support Administrator at any time I have questions about my ISP or the services that I receive.
- ❖  I understand that I have the right to choose the provider for each of my HCBS Waiver services.  
(An approved provider is one who meets ODMRDD Provider Certification.)

Applicant's Signature/Date
Authorized Representative Signature/Date
Legal Guardian Signature/Date
Service Support Administrator Signature/Date

Form Distribution

- Original to official file of applicant at the County Board of MRDD
- Copy to the Consumer, Guardian (if applicable), COG (if applicable)
- Copy to ODMR/DD with Level of Care packet

STATE: Ohio

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DATE: December 1, 2002

**STATE HEARING FORMS**

ODHS 4000  
ODHS 4022  
ODHS 4059  
ODHS 4065  
ODHS 4074  
ODHS 7334

APPENDIX E - PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

\_\_\_\_\_ Registered nurse, licensed to practice in the State

\_\_\_\_\_ Licensed practical or vocational nurse, acting within the scope of practice under State law

\_\_\_\_\_ Physician (M.D. or D.O.) licensed to practice in the State

\_\_\_\_\_ Social Worker (qualifications attached to this Appendix)

  X   Case Manager **(In Ohio, called Service and Support Administrator.)**

\_\_\_\_\_ Other (specify):

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

\_\_\_\_\_ At the Medicaid agency central office

\_\_\_\_\_ At the Medicaid agency county/regional offices

\_\_\_\_\_ By case managers

\_\_\_\_\_ By the agency specified in Appendix A

\_\_\_\_\_ By consumers

  X   Other (specify): **At the county board of mr/dd.**

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

\_\_\_\_\_ Every 3 months  
\_\_\_\_\_ Every 6 months  
  X   Every 12 months  
\_\_\_\_\_ Other (specify):

a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:

**The Medicaid agency conducts periodic on-site audits of service plans. A random sample of recipient plans of care (in Ohio, called Individual Service Plans or ISPs) will be selected. The audit will include a face-to-face assessment of the recipient.**

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.
2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

**Individual plans of care are regulated in accordance with Ohio Administrative Code 5123:2-3-17 for individuals in licensed homes and Appendix E-2 Attachment for individuals who live in their own homes or with their families. A specific plan of care form is not required; however, the plan of care form used must include all of the data elements required in b.1. above. Ohio does require that payment authorization for waiver services be done through a statewide form and that is attached to this appendix.**

The Level One waiver planning requirements are the following:

Individual Service Plans (ISPs), or plans of care, shall be developed for each individual and shall:

- Be written;
- Be developed by qualified persons with input from each recipient under the waiver;
- Describe, regardless of funding source, medical and other services identified through the assessment process to be furnished to the recipient, the service frequency, the service duration, the type of contractor who will furnish each service, and the completion and approval date(s) of the ISP;
- Be subject to the approval of the Medicaid agency;
- Identify the county board representative responsible for service coordination;
- Maximize the use of natural supports and generic resources; and
- Be maintained for a minimum period of seven years from the ISP effective date or for six years after any initiated audit is completed and adjudicated, whichever is longer;
- Include the designation of a person who is the individual's personal representative.

In addition, to recommend approval of the ISP, the county board is required to do all of the following:

- Ensure that the ISP reflects the services needed for health and safety and to prevent institutionalization
- Ensure that the ISP contains, at a minimum, the type of services to be furnished, the frequency and duration of each service, and the type of contractor to furnish each service.
- Ensure that habilitation services are addressed and include skill development and/or intervention(s) directed at the prevention of further loss of skills.

For licensed facilities, ISPs shall be developed for each individual pursuant to OAC 5123:2-3-17.

APPENDIX F - AUDIT TRAIL

a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.
2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.

3. Method of payments (check one):

- X   Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).
- Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.
- Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.
- Other (Describe in detail):

b. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:
  - a. When the individual was eligible for Medicaid waiver payment on the date of service;
  - b. When the service was included in the approved plan of care;
  - c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

    X     Yes

           No. These services are not included in this waiver.

The Service and Support Administrator in the County Board of Mental Retardation and Developmental Disabilities is responsible for referring an individual requesting supported employment assistance under the waiver to the Bureau of Vocational Rehabilitation for assessment and determination of whether the individual would qualify for assistance. A denial issued by BVR shall be received before supported employment is added to the Payment Authorization for Waiver Services (PAWS). The denial is retained in the individual's service records. The Department of MR/DD's Division of Audits shall audit waiver payment records to assure that the denial is on file when supported employment is an authorized service.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

    X     All claims are processed through an approved MMIS.

           MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the

STATE: Ohio

Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

- The Medicaid agency will make payments directly to providers of waiver services.
- The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.
- The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.
- Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):

**The Ohio Department of MR/DD-the agency designated in Appendix A as responsible for administration of this waiver.**

Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

**Claims are submitted directly to the single state agency as do all Medicaid state plan providers.**

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

b. Billing Process and Records Retention

1a. Process to determine individual was eligible for Medicaid waiver payment on the date of service.

MMIS will reimburse claims for waiver services only for individuals who are shown to be eligible for Medicaid payment and are determined eligible for the waiver on the date of service. This is accomplished by causing an interface to occur between MMIS and Ohio's CRIS-E Eligibility Data System. MMIS only approves claims for individuals who are Medicaid and HCBS waiver eligible.

1b. Process to determine that the service was included in the approved plan of care.

Prior to adjudication by MMIS, a provider's claim for payment of HCBS waiver services must first clear an ODMR/DD data system. The ODMR/DD data system rejects any provider claim for payment of service unless all of the following elements exist:

- The recipient was authorized to receive the service claimed for payment;
- The date of such service was on or after the effective date of the individual's enrollment; and
- The provider was approved on or prior to the effective date of the service to provide such service for the individual.

Provider claims for waiver services will be rejected by the ODMR/DD data system once the total number of units approved for the individual is reached. The claim will not be forwarded and adjudication by MMIS and payment for waiver services in excess of what is authorized from the approved plan of care will not be made.

APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G - 1

COMPOSITE OVERVIEW  
COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver.

If there is more than one level (e.g. hospital and nursing facility), complete an Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

Level of Care: ICF/MR

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1 (FY-03)	\$ 7,421	\$ 18,364	\$ 69,217	\$ 12,330
2 (FY-04)	\$ 7,671	\$ 18,639	\$ 69,909	\$ 12,515
3 (FY-05)	\$ 7,831	\$ 18,919	\$ 70,608	\$ 12,702



METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor D as:

"The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following page.

**"D" VALUE PROJECTION  
FACTOR D**

**APPENDIX G-2**

LOC: ICF-MR

**DEMONSTRATION OF FACTOR D ESTIMATES FOR WAIVER YEAR #1 WHICH INCLUDES 01-DEC-02 THROUGH 30-NOV-03**

Column A	Column B	Column C	Column C-1	Column D	Column E
WAIVER SERVICES	# UNDUP RECIPIENTS USING SRVC	AVERAGE ANNUAL UNITS/USER	UNIT TYPE	AVERAGE COST/UNIT	TOTAL ( B x C x D)
RESPITE CARE – INSTITUTIONAL	3000	4	DAY	\$ 250.00	\$ 3,000,000
RESPITE CARE - NON-INSTITUTIONAL	3000	200	HOUR	\$ 12.00	\$ 7,200,000
HOMEMAKER/PERSONAL CARE	3000	45	HOUR	\$ 22.00	\$ 2,970,000
TRANSPORTATION	3000	720	MILE	\$ 0.45	\$ 972,000
SERVICES WITHIN THE INDIVIDUAL \$5,000 COST CAP SUBTOTAL					\$ 14,142,000
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS RECEIVING SERVICES WITHIN THE INDIVIDUAL \$5,000 COST CAP					3000
AVERAGE COST PER RECIPIENT FOR SERVICES WITHIN THE INDIVIDUAL \$5,000 COST CAP					\$ 4,714
Column A	Column B	Column C	Column C-1	Column D	Column E
WAIVER SERVICES	# UNDUP RECIPIENTS USING SRVC	AVERAGE ANNUAL UNITS/USER	UNIT TYPE	AVERAGE COST/UNIT	TOTAL ( B x C x D)
EMERGENCY ASSISTANCE	150	360	HOUR	\$ 22.00	\$ 1,188,000
EMERGENCY ASSISTANCE SUBTOTAL					\$ 1,188,000
ESTIMATED UNDUPLICATED RECIPIENTS RECEIVING EMERGENCY ASSISTANCE SERVICES					150
AVERAGE COST PER RECIPIENT FOR EMERGENCY ASSISTANCE SERVICES					\$ 7,920
Column A	Column B	Column C	Column C-1	Column D	Column E
WAIVER SERVICES	# UNDUP RECIPIENTS USING SRVC	AVERAGE ANNUAL UNITS/USER	UNIT TYPE	AVERAGE COST/UNIT	TOTAL ( B x C x D)
ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS	1000	1	ITEM	\$ 2000.00	\$ 2,000,000
SPECIALIZED MEDICAL EQUIPMENT & SUPPLIES	2500	3	ITEM	\$ 500.00	\$ 3,700,000
PERSONAL EMERGENCY RESPONSE SYSTEMS	750	6	MONTH	\$ 35.00	\$ 150,000
SUPPLIES, EQUIPMENT & ADAPTATIONS SUBTOTAL					\$ 5,907,000
ESTIMATED UNDUPLICATED RECIPIENTS RECEIVING SUPPLIES, EQUIPMENT & ADAPTATIONS					3000
AVERAGE COST PER RECIPIENT FOR SERVICES WITHIN THE INDIVIDUAL \$5,000 COST CAP					\$ 1,969
Column A	Column B	Column C	Column C-1	Column D	Column E
WAIVER SERVICES	# UNDUP RECIPIENTS USING SRVC	AVERAGE ANNUAL UNITS/USER	UNIT TYPE	AVERAGE COST/UNIT	TOTAL ( B x C x D)
SUPPORTED EMPLOYMENT SERVICES	300	90	DAY	\$ 60.00	\$ 1,620,000

STATE: Ohio

DATE: December 1, 2002

TRANSPORTATION SUPPORTED EMPLOYMENT	240	180	TRIP	\$ 12.00	\$ 518,400
SUPPORTED EMPLOYMENT SUBTOTAL					\$ 2,138,400
ESTIMATED UNDUPLICATED RECIPIENTS RECEIVING SUPPORTED EMPLOYMENT SERVICES					300
AVERAGE COST PER RECIPIENT FOR SUPPORTED EMPLOYMENT SERVICES					\$ 7,128
GRAND TOTAL:					\$ 23,375,900
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS (FACTOR C):					3150
FACTOR D (Divide Grand Total By The Estimated Number Of Unduplicated Recipients)					\$ 7,421
AVERAGE LENGTH OF STAY (in days): 181					

**"D" VALUE PROJECTION**

**APPENDIX G-2**

**FACTOR D**

LOC: ICF-MR

**DEMONSTRATION OF FACTOR D ESTIMATES FOR WAIVER YEAR #2 WHICH INCLUDES 01-DEC-03 THROUGH 30-NOV-04**

Column A	Column B	Column C	Column C-1	Column D	Column E
WAIVER SERVICES	# UNDUP RECIPIENTS USING SRVC	AVERAGE ANNUAL UNITS/USER	UNIT TYPE	AVERAGE COST/UNIT	TOTAL ( B x C x D )
RESPITE CARE - INSTITUTIONAL	5000	4	DAY	\$ 250.00	\$ 5,000,000
RESPITE CARE - NON-INSTITUTIONAL	5000	200	HOUR	\$ 12.00	\$ 12,000,000
HOMEMAKER/PERSONAL CARE	5000	45	HOUR	\$ 22.00	\$ 4,950,000
TRANSPORTATION	5000	1000	MILE	\$ 0.45	\$ 2,250,000
<b>SERVICES WITHIN THE INDIVIDUAL \$5,000 COST CAP SUBTOTAL</b>					<b>\$ 24,200,000</b>
<b>TOTAL ESTIMATED UNDUPLICATED RECIPIENTS RECEIVING SERVICES WITHIN THE INDIVIDUAL \$5,000 COST CAP</b>					<b>5000</b>
<b>AVERAGE COST PER RECIPIENT FOR SERVICES WITHIN THE INDIVIDUAL \$5,000 COST CAP</b>					<b>\$ 4,840</b>
Column A	Column B	Column C	Column C-1	Column D	Column E
WAIVER SERVICES	# UNDUP RECIPIENTS USING SRVC	AVERAGE ANNUAL UNITS/USER	UNIT TYPE	AVERAGE COST/UNIT	TOTAL ( B x C x D )
EMERGENCY ASSISTANCE	250	360	HOUR	\$ 22.00	\$ 1,980,000
<b>EMERGENCY ASSISTANCE SUBTOTAL</b>					<b>\$ 1,980,000</b>
<b>ESTIMATED UNDUPLICATED RECIPIENTS RECEIVING EMERGENCY ASSISTANCE SERVICES</b>					<b>250</b>
<b>AVERAGE COST PER RECIPIENT FOR EMERGENCY ASSISTANCE SERVICES</b>					<b>\$ 7,920</b>
Column A	Column B	Column C	Column C-1	Column D	Column E
WAIVER SERVICES	# UNDUP RECIPIENTS USING SRVC	AVERAGE ANNUAL UNITS/USER	UNIT TYPE	AVERAGE COST/UNIT	TOTAL ( B x C x D )
ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS	1650	1	ITEM	\$ 2000.00	\$ 3,300,000
SPECIALIZED MEDICAL EQUIPMENT & SUPPLIES	4100	3	ITEM	\$ 500.00	\$ 6,150,000
PERSONAL EMERGENCY RESPONSE SYSTEMS	1250	9	MONTH	\$ 35.00	\$ 393,750
<b>SUPPLIES, EQUIPMENT &amp; ADAPTATIONS SUBTOTAL</b>					<b>\$ 9,843,750</b>
<b>ESTIMATED UNDUPLICATED RECIPIENTS RECEIVING SUPPLIES, EQUIPMENT &amp; ADAPTATIONS</b>					<b>5000</b>
<b>AVERAGE COST PER RECIPIENT FOR SERVICES WITHIN THE INDIVIDUAL \$5,000 COST CAP</b>					<b>\$ 1,969</b>
Column A	Column B	Column C	Column C-1	Column D	Column E
WAIVER SERVICES	# UNDUP RECIPIENTS USING SRVC	AVERAGE ANNUAL UNITS/USER	UNIT TYPE	AVERAGE COST/UNIT	TOTAL ( B x C x D )

STATE: Ohio

DATE: December 1, 2002

SUPPORTED EMPLOYMENT SERVICES	500	100	DAY	\$ 65.00	\$ 3,250,000
TRANSPORTATION SUPPORTED EMPLOYMENT	400	200	TRIP	\$ 12.50	\$ 1,000,000
SUPPORTED EMPLOYMENT SUBTOTAL					\$ 4,250,000
ESTIMATED UNDUPLICATED RECIPIENTS RECEIVING SUPPORTED EMPLOYMENT SERVICES					500
AVERAGE COST PER RECIPIENT FOR SUPPORTED EMPLOYMENT SERVICES					\$ 8,500
GRAND TOTAL:					\$ 40,273,750
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS (FACTOR C):					5250
FACTOR D (Divide Grand Total By The Estimated Number Of Unduplicated Recipients)					\$ 7,671

AVERAGE LENGTH OF STAY (in days): 281

**"D" VALUE PROJECTION**

**APPENDIX G-2**

**FACTOR D**

**LOC:** ICF-MR

**DEMONSTRATION OF FACTOR D ESTIMATES FOR WAIVER YEAR #3 WHICH INCLUDES 01-DEC-04 THROUGH 30-NOV-05**

Column A	Column B	Column C	Column C-1	Column D	Column E
WAIVER SERVICES	# UNDUP RECIPIENTS USING SRVC	AVERAGE ANNUAL UNITS/USER	UNIT TYPE	AVERAGE COST/UNIT	TOTAL (B x C x D)
RESPITE CARE - INSTITUTIONAL	6000	4	DAY	\$ 250.00	\$ 6,000,000
RESPITE CARE - NON-INSTITUTIONAL	6000	200	HOURL	\$ 12.00	\$ 14,400,000
HOMEMAKER/PERSONAL CARE	6000	45	HOURL	\$ 22.00	\$ 5,940,000
TRANSPORTATION	6000	1000	MILE	\$ 0.45	\$ 2,700,000
<b>SERVICES WITHIN THE INDIVIDUAL \$5,000 COST CAP SUBTOTAL</b>					<b>\$ 29,040,000</b>
<b>TOTAL ESTIMATED UNDUPLICATED RECIPIENTS RECEIVING SERVICES WITHIN THE INDIVIDUAL \$5,000 COST CAP</b>					<b>6000</b>
<b>AVERAGE COST PER RECIPIENT FOR SERVICES WITHIN THE INDIVIDUAL \$5,000 COST CAP</b>					<b>\$ 4,840</b>
Column A	Column B	Column C	Column C-1	Column D	Column E
WAIVER SERVICES	# UNDUP RECIPIENTS USING SRVC	AVERAGE ANNUAL UNITS/USER	UNIT TYPE	AVERAGE COST/UNIT	TOTAL (B x C x D)
EMERGENCY ASSISTANCE	300	360	HOURL	\$ 22.00	\$ 2,376,000
<b>EMERGENCY ASSISTANCE SUBTOTAL</b>					<b>\$ 2,376,000</b>
<b>ESTIMATED UNDUPLICATED RECIPIENTS RECEIVING EMERGENCY ASSISTANCE SERVICES</b>					<b>300</b>
<b>AVERAGE COST PER RECIPIENT FOR EMERGENCY ASSISTANCE SERVICES</b>					<b>\$ 7,920</b>
Column A	Column B	Column C	Column C-1	Column D	Column E
WAIVER SERVICES	# UNDUP RECIPIENTS USING SRVC	AVERAGE ANNUAL UNITS/USER	UNIT TYPE	AVERAGE COST/UNIT	TOTAL (B x C x D)
ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS	2000	1	ITEM	\$ 2000.00	\$ 4,000,000
SPECIALIZED MEDICAL EQUIPMENT & SUPPLIES	4900	3	ITEM	\$ 500.00	\$ 7,350,000
PERSONAL EMERGENCY RESPONSE SYSTEMS	1500	11	MONTH	\$ 35.00	\$ 577,500
<b>SUPPLIES, EQUIPMENT &amp; ADAPTATIONS SUBTOTAL</b>					<b>\$ 11,927,500</b>
<b>ESTIMATED UNDUPLICATED RECIPIENTS RECEIVING SUPPLIES, EQUIPMENT &amp; ADAPTATIONS</b>					<b>6000</b>
<b>AVERAGE COST PER RECIPIENT FOR SERVICES WITHIN THE INDIVIDUAL \$5,000 COST CAP</b>					<b>\$ 1,988</b>
Column A	Column B	Column C	Column C-1	Column D	Column E
WAIVER SERVICES	# UNDUP RECIPIENTS	AVERAGE ANNUAL	UNIT TYPE	AVERAGE COST/UNIT	TOTAL

STATE: Ohio

DATE: December 1, 2002

	USING SRVC	UNITS/USER			( B x C x D)
SUPPORTED EMPLOYMENT SERVICES	600	110	DAY	\$ 70.00	\$ 4,620,000
TRANSPORTATION SUPPORTED EMPLOYMENT	480	220	TRIP	\$ 13.00	\$ 1,372,800
SUPPORTED EMPLOYMENT SUBTOTAL					\$ 5,992,800
ESTIMATED UNDUPLICATED RECIPIENTS RECEIVING SUPPORTED EMPLOYMENT SERVICES					600
AVERAGE COST PER RECIPIENT FOR SUPPORTED EMPLOYMENT SERVICES					\$ 9,988

GRAND TOTAL:	\$ 49,336,300
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS (FACTOR C):	6300
FACTOR D (Divide Grand Total By The Estimated Number Of Unduplicated Recipients)	\$ 7,831

AVERAGE LENGTH OF STAY (in days): 320

APPENDIX G - 3

METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

- A. The following service(s), other than respite care, are furnished in residential settings other than the natural home of the individual (e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

**All services approved in the waiver are provided to individuals who live in licensed facilities, other than ICFs/MR or NFs, or in homes they themselves either own or rent. Room and board is paid by the individual with their personal resources and income. Incomes/personal resources may be subsidized with 100% State (Supported Living) funds or local funds and are paid separately.**

\*(NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

The following service(s) are furnished in the home of a paid caregiver. (Specify):

- B. NONE

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

APPENDIX G - 4

**METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER**

Check one:

  X   The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

       The State will reimburse for the additional costs of rent and food attributable to an unrelated live in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services ) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

APPENDIX G - 5

**FACTOR D'**

**LOC:** ICF/MR

NOTICE: On July 25, 1994, CMS published regulations which changed the definition of Factor D'. The new definitions is:

"The estimated annual average per capita Medicaid cost for all other services provided to individual in the waiver program"

Included in Factor D' the following:

The cost of all State plan services (including home health, personal care and adult day health furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.

The cost of short term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D' :

If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.

Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

Factor D' is computed as follows (check one) :

Based on CMS Form 2082 (relevant pages attached)

Based on CMS Form 372 (Initial report) for years 7/00 - 6/01 of waiver # 0231.01, which serves as a similar population.

Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

Other (specify) :

STATE: Ohio

100

DATE: December 1, 2002

**FACTOR D' EXPLANATION OF ADJUSTMENTS**

Appendix G-5

Projected Annual Average Per Capita Medicaid Cost for All Other Services Provided to Individuals in the Waiver Program ( D' ) using item IV.B.1.b and VIII.B.1 from HCFA-372 (initial report), dated 6/04/2002 for reporting period 07/01/00 through 06/30/01 for waiver # 0231.01.

FY96	FY97	FY98	FY99	FY00	FY01	FY02
	1.50%	1.50%	1.50%	1.50%	1.50%	1.50%
\$ 16,721	\$ 16,972	\$ 17,226	\$ 17,485	\$ 17,747	\$ 17,825	\$ 18,092

FY03 (Waiver Year 1)	FY04 (Waiver Year 2)	FY05 (Waiver Year 3)
1.50%	1.50%	1.50%
\$ 18,364	\$ 18,639	\$ 18,919

The Projected Average Per Capita Medicaid Cost for All Other Services Provided to Individuals in the Waiver Program is calculated as the cost of previous year multiplied by the inflation rate (1.5%).

APPENDIX G - 6

**FACTOR G**

**LOC:** ICF/MR

The July 25, 1994 final regulation defines Factor G as:

"The estimated annual average per capita Medicaid cost for hospitals, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data only for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

  X   Based on institutional cost trends shown by CMS Form 2082. Attached is an explanation of any adjustments made to these numbers.

       Based on trends shown by CMS Form 372 for years \_\_\_\_\_ of waiver # \_\_\_\_\_, which reflect costs for an institutionalized population at this LOC. Attached is an explanation of any adjustments made to these numbers.

       Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.

       Based on State DRGs for the disease(s) or condition(s) indicated on item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.

       Other (specify):

**FACTOR G - EXPLANATION OF ADJUSTMENTS MADE TO CMS-2082**

APPENDIX G - 6

The CMS-2082's for FFY-98, FFY-99 and FFY-00 were used to establish the inflation rate for Factor G values.

The CMS-2082 total cost for ICF/MR's is divided by the total number of ICF/MR recipients to determine the average cost per recipient.

FFY-98 :		FFY-99:		FFY-00 :	
Total cost for ICF/MR's =	\$537,681,556	Total cost for ICF/MR's =	\$541,975,258	Total cost for ICF/MR's =	\$556,327,978
# of ICF/MR recipients =	8162	# of ICF/MR recipients =	8268	# of ICF/MR recipients =	8281
Total Cost / #recipients =	<u>\$ 65,876</u>	Total Cost / # recipients =	<u>\$65,551</u>	Total Cost / #recipients =	<u>\$ 67,181</u>

FY-00	FY-01	FY-02	FY-03 (Waiver Year 1)	FY-04 (Waiver Year 2)	FY-05 (Waiver Year 3)
	1.00%	1.00%	1.00%	1.00%	1.00%
\$ 67,181	\$ 67,853	\$ 68,532	\$ 69,217	\$ 69,909	\$ 70,608

The population served in ICF/MR facilities are of the same needs as those persons receiving services from the HCBS Waiver for persons with MR/DD.

APPENDIX G - 7

**FACTOR G'**

**LOC:** ICF/MR

The July 25, 1994 final regulation defines Factor G' as:

"The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted."

Include in Factor G' the following:

The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.

The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

Factor G' is computed as follows (check one) :

\_\_\_\_\_ Based on CMS Form 2082 (relevant pages attached)

  X   Based on CMS Form 372 (initial report) for years 7/00- 6/01 of waiver # 0231.01, which serves as a similar population.

\_\_\_\_\_ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

\_\_\_\_\_ Other (specify) :

STATE: Ohio

DATE: December 1, 2002

**FACTOR G' - EXPLANATION OF ADJUSTMENTS**

APPENDIX G - 7

Projected Annual Average Per Capita Medicaid Costs for All Other Services Provided to Individuals Served in the Waiver, were the Waiver not granted ( G' ) using item IV.B.1.a from the CMS-372 (initial report), dated 6/04/02 for reporting period 07/01/00 through 06/30/01 for waiver # 0231.01.

FY96	FY97	FY98	FY99	FY00	FY01	FY02
	1.50%	1.50%	1.50%	1.50%	1.50%	1.50%
\$ 11,124	\$ 11,291	\$ 11,460	\$ 11,632	\$ 11,807	\$ 11,968	\$ 12,148

FY03 (Waiver Year 1)	FY04 (Waiver Year 2)	FY05 (Waiver Year 3)
1.50%	1.50%	1.50%
\$ 12,330	\$ 12,515	\$ 12,702

Projected Annual Average Per Capita Medicaid Costs for All Other Services Provided to Individuals Served in the Waiver is calculated as the cost of previous year multiplied by the inflation rate (1.5%).

APPENDIX G - 8

**DEMONSTRATION OF COST NEUTRALITY**

**LOC:** ICF/MR

YEAR 1

FACTOR D:	<u>\$ 7,421</u>		FACTOR G:	<u>\$ 69,217</u>
FACTOR D':	<u>\$ 18,364</u>		FACTOR G':	<u>\$ 12,330</u>
TOTAL:	<u>\$ 25,785</u>	≤	TOTAL:	<u>\$ 81,547</u>

YEAR 2

FACTOR D:	<u>\$ 7,671</u>		FACTOR G:	<u>\$ 69,909</u>
FACTOR D':	<u>\$ 18,639</u>		FACTOR G':	<u>\$ 12,515</u>
TOTAL:	<u>\$ 26,310</u>	≤	TOTAL:	<u>\$ 82,424</u>

YEAR 3

FACTOR D:	<u>\$ 7,831</u>		FACTOR G:	<u>\$ 70,608</u>
FACTOR D':	<u>\$ 18,919</u>		FACTOR G':	<u>\$ 12,702</u>
TOTAL:	<u>\$ 26,750</u>	≤	TOTAL:	<u>\$ 83,311</u>