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State/Territory Name: Ohio

Technical Correction to State Plan Amendment (SPA) #: 17-017

This file contains the following documents in the order listed:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

September 20, 2017

Barbara R. Sears, Director
Ohio Department of Medicaid
P.O. Box 182709
50 West Town Street, Suite 400
Columbus, Ohio 43218

RE: Technical Correction to Ohio State Plan Amendment (SPA) TN 17-017

Dear Ms. Sears:

This is a technical correction to Ohio SPA 17-017 which was approved on August 23, 2017. Effective July 1, 2017, this SPA added individuals who are diagnosed with certain chronic conditions as a new target group population to Ohio's 1915(i) home and community-based state plan program. A pagination error was discovered after this SPA was approved. Per the state's request, we are issuing this technical correction to change "page 30" that was approved in this SPA to "page 30-a."

If you have any questions, please contact Christine Davidson, of my staff, at (312) 886-3642 or christine.davidson@cms.hhs.gov if you have any questions.

Sincerely,

/s/

Ruth A. Hughes
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Sarah Curtin, ODM
Carolyn Humphrey, ODM
Greg Niehoff, ODM
Rebecca Jackson, ODM

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

August 24, 2017

Barbara R. Sears, Director
Ohio Department of Medicaid
P.O. Box 182709
50 West Town Street, Suite 400
Columbus, Ohio 43218

RE: State Plan Amendment Transmittal Number 17-017

Dear Ms. Sears:

Enclosed for your records is an approved copy of the following State Plan Amendment:

Transmittal #17-017
- Coverage & Limitations: 1915(i) Home & Community Based State Plan Option – New Population
- Effective Date: July 1, 2017
- Approval Date: August 23, 2017

If you have any questions regarding this State Plan Amendment, please have a member of your staff contact Christine Davidson at (312) 886-3642 or by email at christine.davidson@cms.hhs.gov.

Sincerely,

/s/
Ruth A. Hughes
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Sarah Curtin, ODM
Carolyn Humphrey, ODM
Becky Jackson, ODM
Greg Niehoff, ODM

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER: **17-017**	2. STATE **OHIO**
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **July 1, 2017**	

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION: Section 1915(i) of the Social Security Act 42 CFR 441.710	7. FEDERAL BUDGET IMPACT: a. FFY 17 $ 4,800 thousands b. FFY 18 $ 93,100 thousands
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-I, pages 6 through 30-a *cd*	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 3.1-I, pages 6 through ~~30~~ 29 (TN 15-014) *cd*

10. SUBJECT OF AMENDMENT: Coverage and Limitations: 1915(i) Home and Community-Based Services option: New Population

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

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

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO: **Carolyn Humphrey** **Ohio Department of Medicaid** **P.O. BOX 182709** **Columbus, Ohio 43218**
13. TYPED NAME: **BARBARA R. SEARS**	
14. TITLE: **STATE MEDICAID DIRECTOR**	
15. DATE SUBMITTED: June 13, 2017	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: June 13, 2017	18. DATE APPROVED: August 23, 2017
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2017	20. SIGNATURE OF REGIONAL OFFICIAL: /s/
21. TYPED NAME: Ruth A. Hughes	22. TITLE: Associate Regional Administrator

23. REMARKS:

Instructions on Back

FORM CMS-179 (07-92)

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually.
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	08/01/2016	07/31/2017	8,980
Year 2	08/01/2017	07/31/2018	9,225
Year 3	08/01/2018	07/31/2019	9,470
Year 4	08/01/2019	07/31/2020	9,715
Year 5	08/01/2020	07/31/2021	9,960

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

Financial Eligibility

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

2. ☑Income Limits.

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

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

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

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

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

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

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

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

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

(*Select one*):
☐ Specify the 1915(c) waiver/waivers CMS base control number/numbers for which the individual would be eligible: ___

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

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

●	The State does not provide State plan HCBS to the medically needy.
○	The State provides State plan HCBS to the medically needy *(select one):*
	○ The State elects to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a State makes this election, medically needy individuals only receive 1915(i) services.

	○	The State does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And either

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

Or

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

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

Qualifying Adult Needs and Strengths Assessment (ANSA) Criteria

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

The ANSA tool consists of items that are rated as:
'0' no evidence or no need for action
'1' need for watchful waiting to see whether action is needed

'2' need for action
'3' need for either immediate or intensive action due to a serious or disabling need

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

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

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

The user's manual for the ANSA may be found on-line at: Adult Needs and Strengths Assessment (ANSA)

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

Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	**NF (& NF LOC waivers)**	**ICF/MR (& ICF/MR LOC waivers)**	**Applicable Hospital LOC (& Hospital LOC waivers)**
Persons scoring a 2 or above on at least one of the items in the 'mental health needs' or 'risk behaviors' sections of the ANSA or persons scoring a 3	For 21 years and older Need for a minimum of one of the following: • Assistance with the completion of a minimum of 2 ADLs including:	For individuals age 10 and older, the criteria for a developmental disability level of care is met when: (a) The individual has been diagnosed with a severe, chronic disability that:	Admission criteria for an inpatient psychiatric stay: Ohio has let a contract with a vendor to pre-certify inpatient psychiatric

on at least one of the items in the 'life domain functioning' section of the ANSA may be eligible for 1915(i) service(s). The ANSA tool consists of items that are rated as: '0' no evidence or no need for action '1' need for watchful waiting to see whether action is needed '2' need for action '3' need for either immediate or intensive action due to a serious or disabling need. The mental health needs domains includes scoring on psychosis, impulse control, depression, anxiety, interpersonal problems, antisocial behavior, adjustment to trauma, anger control, substance use, and eating disturbance. The risk behaviors domain includes scoring on suicide risk, self-injurious behavior, other self-harm, gambling,	○ **Bathing** (The adult needs assistance with applying cleansing agent and/or rinsing and/or drying.) ○ **Dressing** (The adult needs assistance with putting on and taking off an item of clothing/prosthesis and/or fastening and unfastening an item of clothing/prosthesis.) ○ **Eating** (The adult needs assistance with getting food into his or her mouth and/or chewing and/or swallowing.) ○ **Grooming** (The adult needs assistance with oral hygiene and hair care (either washing or brushing/combing hair) and nail care (either cutting fingernails or toenails.)) ○ **Mobility** (The adult needs assistance with bed mobility and/or locomotion and/or transfers inside the house.) ○ **Toileting** (The adult needs assistance with using a toilet/urinal/bedpan and/or changing incontinence supplies/feminine hygiene products and/or cleansing him- or herself.) **OR** • Assistance with the completion of 1 ADL as listed above and with	i. Is attributable to a mental or physical impairment or combination of mental and physical impairments, other than an impairment caused solely by mental illness; ii. Is manifested before the individual is age 22; and iii. Is likely to continue indefinitely. (b) The condition is substantial functional limitations in at least three of the following major life activities, as determined through use of the developmental disabilities level of care assessment: i. Self-care; ii. Receptive and expressive communication; iii. Learning; iv. Mobility; v. Self-direction; vi. Capacity for independent living; and vii. Economic self-sufficiency. (c) The condition reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services,	stays. The vendor uses nationally-recognized proprietary care management guidelines for this process. Inpatient psychiatric admission criteria include the need for inpatient treatment because of imminent danger to self or others (as evidenced by imminent risk of additional attempt of suicide/homicide or to seriously harm self or others, current plan for suicide/homicide or serious harm to self or others, command auditory hallucinations for suicide/homicide or serious harm to self or others, etc.); or a behavioral health disorder characterized by severe psychiatric or behavioral symptoms (including hallucinations or delusions that are very bothersome to the patient or are associated with severe pressure to respond or act, severely disorganized speech, severe mania, depression, anxiety or comorbid substance use disorder, etc.)

exploitation, danger to others, sexual aggression, and criminal behavior. Life functioning domain includes scoring on Physical/Medical; Family Functioning; Employment; Social Functioning; Recreational; Intellectual; Sexuality; Living Skills; Residential Stability; Legal; Sleep; Self Care; Decision Making; Involvement in Recovery; Transportation; and Medication Involvement.	medication self-administration. OR • A minimum of 1 skilled nursing service or skilled rehabilitation service. OR • 24 Hour support, in order to prevent harm, due to a cognitive impairment, as diagnosed by a physician or other licensed health professional and as determined by the BCAT. *When an adult's long term services and supports needs meet the criteria above, and the adult has a diagnosis of a developmental disability, but not an intellectual disability, and the adult is expected to require lifelong assistance with ADLs due to a physical limitation, the criteria for intermediate level of care is met.	individualized supports, or other forms of assistance of lifelong or extended duration that are individually planned and coordinated.	accompanied by severe dysfunction in daily living (as evidenced by complete neglect of self-care, complete withdrawal from all social interactions, complete inability to maintain any appropriate aspect of personal responsibility in any adult roles, etc.); or because the patient will not participate in treatment voluntarily and requires involuntary commitment, needs physical restraint, seclusion or other involuntary control, is significantly delirious, or has a behavioral health disorder and requires around-the-clock medical or nursing care for somatic treatment.

*Long Term Care/Chronic Care Hospital

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

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

ICD-10 CODE	DIAGNOSIS CATEGORY DESCRIPTION
B20-B97.35	HIV/Aids
C15.3-C26.9	Malignancy

C33-C43.9	Malignancy
C45-C45.9	Malignancy
C50.011-C68.9	Malignancy
C70.0-C96.Z	Malignancy
D00.08-D04.0	Malignancy
D05.00-D09.19	Malignancy
D09-.3-D09.9	Malignancy
D37.5-D49.9	Malignancy
D56.4-D58.2	Sickle Cell Anemia
D65-D68.9	Hemophilia
D83.0-D83.2	Immune Deficiency
E84.0-E84.9	Cystic Fibrosis
F06.0	Psychotic disorders with hallucinations or delusions
F06.2	Psychotic disorder with delusions
F06.30-F06.34	Mood disorders
F06.4	Anxiety disorder
F07.0	Personality change
F20.0-F29	Schizophrenia
F30.10-F30.9	Manic episodes
F31.0-F31.9	Bipolar disorder
F32.0-F39	Major depressive and mood disorders
F40.00-F40.11	Phobic and other anxiety disorders
F40.240	Claustrophobia
F40.241	Acrophobia
F40.8	Other phobic anxiety disorders
F41.0	Panic disorder without agoraphobia
F41.1	Generalized anxiety disorder
F42.2-F42.9	Obsessive-compulsive disorder
F43.10-F43.12	Post-traumatic stress disorder
F43.20-F43.25	Adjustment disorders
F44.0	Dissociative amnesia
F44.1	Dissociative fugue
F44.4-F44.9	Dissociative and conversion disorders
F45.0-F45.9	Somatoform disorders
F48.1, F48.3	Other nonpsychotic mental disorders
F50.00-F50.9	Eating disorders
F53	Postpartum depression
F60.3	Borderline personality disorder
F63.3-F63.9	Impulse disorders
F64.1-F68.8	Gender identity disorders
F65.0-F66	Paraphilias and other sexual disorders
F68.10-F68.8	Disorders of adult personality and behavior
F90.0-F90.9	Attention-deficit hyperactivity disorders
F91.0-F91.9	Conduct Disorders
F93.0-F93.9	Emotional disorders with onset specific to childhood
F94.0-F94.04	Disorders of social functioning with onset specific to childhood and adolescence
N18.6	End Stage Renal Disease (ESRD)

Q85.00-85.09	Malignancy
Z21	HIV/AIDS
Z48.21-Z95.4	Previous Transplant
Z51.11	Malignancy

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

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

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

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

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

All 1915(i) services are provided to individuals who reside in home and community-based settings meeting HCBS characteristics in 42 CFR 441.301(c)(4)(i)-(v). These individuals must also receive their 1915(i) services in their home or the community.

Prior to any enrollment into the 1915(i), the Recovery Manager will review the HCBS living and provider settings of all individuals receiving State Plan 1915(i) services to ensure that all individuals live and receive services in settings that meet the standards outlined in 42 CFR 441.710 (a)(1)(i) through (a)(1)(v). The recovery manager's scope of responsibilities include on-going monitoring of the settings for compliance with HCBS regulations. The independent entity will review and validate compliance with setting requirements. ODM, or its designee, will ensure HCBS compliance through its regulatory oversight activities of the contracted independent entities and will enforce compliance actions as necessary.
In settings that are provider-owned and -controlled, the Recovery Manager's responsibility is to ensure the settings demonstrate the home and community-based qualities outlined in 42 CFR 441.710 (a)(1)(vi). Please note: the certified residential settings are intended to be homes where the individual lives. The majority of services and behavioral healthcare is provided in other locations outside of the residence, such as in the community at large or in a

clinic setting. The 1915(i) services are designed to be delivered in community settings including, but not exclusively, in the individual's home.

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

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

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

The independent entity reviews the information documented by the HCBS verification checklist. If that review indicates that the setting is not compliant with HCBS requirements, the independent entity will submit the proposed denial of enrollment to the state level review process. In order to assure state-wide consistency in the determination process, ODM is instituting a state-level review process which includes the independent entities and other subject matter experts for any individual who may be denied enrollment based on a non-complaint setting. If a setting is ultimately determined not to be an HCBS setting, the individual is denied enrollment and afforded due process.

Most persons eligible for the 1915(i) services live in their own home or with families or friends that are either owned or leased by the individuals their family or friend in the same manner as any adult who does not have a mental illness or diagnosed chronic condition. There are some persons seeking these services who do not have family or friends with whom they can live or are not functioning at a level where their health and safety can be supported in a totally independent setting. Depending upon the person's level of need and functioning, he or she may choose to live in a licensed Adult Care Facility which is a provider-owned or

controlled setting that furnishes the level of support and supervision the individual needs in order to live in the community.

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

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

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

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

Person-Centered Planning & Service Delivery

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

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

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

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

3. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the

independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. *(Specify qualifications):*

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

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

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

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

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

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

The Person-Centered Plan is developed through a collaborative process that includes input from the applicant/individual, identified community supports (family/nonprofessional caregivers), the Recovery Manager, primary care/specialists, and managed care plan staff involved in assessing and/or providing care for the applicant/individual. The Person-

Centered Plan is a comprehensive plan that integrates all components and aspects of care that are deemed medically necessary, needs based, are clinically indicated, and are provided in the most appropriate setting to achieve the individual's goals.

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

The Person-Centered Plan is developed by:

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

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

- The short and long term goals as defined by the individual.
- The strengths, needs, and preferences as identified by the individual
- The identified Medicaid and non-Medicaid services
- The nature, amount and scope of the identified 1915(i) services.
- The nature of the non-Medicaid services and supports
- The Person-Centered Plan reflects that the setting in which the individual resides is chosen by the individual and is an HCB setting. The setting chosen by the individual is integrated in, and supports full access of, individuals receiving 1915(i) services to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving 1915(i) services.
- The Person-Centered Plan reflects the individual's strengths and weaknesses.
- The Person-Centered Plan reflects the clinical and support needs as identified through an assessment of functional need.
- The Person-Centered Plan includes individually identified goals and desired outcomes.
- The Person-Centered Plan reflects the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports.

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

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

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

The Person-Centered Plan must reflect the individual's desires and choices. The individual's signature demonstrates his or her participation in the development and ongoing review of their Person-Centered Plan. Records must be maintained and are subject to State and/or Federal audit. The individual must attest to participation in the development of the Person-Centered Plan. On occasion, an individual may refuse to sign the Person-Centered Plan for reasons associated with the individual's behavioral health diagnosis. If an individual refuses to sign the Person-Centered Plan, the Recovery Manager is required to document on the Person-Centered Plan that the individual was present at the

development of the plan and agreed to the plan but refused to sign. The Recovery Manager must also document in the Person-Centered Plan record that a planning meeting with the individual did occur and that the Person-Centered Plan reflects the individual's choice of services and agreement to participate in the services identified in the Person-Centered Plan. The Person-Centered Plan record must contain an explanation of why the individual refused to sign the plan and how this will be addressed in the future.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Services

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

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

Service Definition (Scope):

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

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

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

- Initiates Person-Centered Plan or trans-disciplinary team discussions and meetings when services are not achieving desired outcomes;
- Advocates for continuity of services, system flexibility and integration, proper utilization of facilities and resources, accessibility, and individual rights; and
- Participates in any activities related to quality oversight and provides reporting as required.

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

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

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

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

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

☒ Categorically needy *(specify limits):*

The following activities are excluded from recovery management as a billable 1915(i) service:

- Travel time incurred by the Recovery Manager may not be billed as a discrete unit of service;
- Services that constitute the administration of another program such as child welfare or child protective services, parole and probation functions, legal services, public guardianship, special education, and foster care;
- Representative payee functions; and
- Other activities identified by ODM

☐ Medically needy *(specify limits):*

NA

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

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

			or one year post-degree experience working with individuals with diagnosed chronic conditions. • Be trained in administering the ANSA, eligibility evaluation and assessment tools used by the State • Be trained in person-centered planning. • Be trained in incident management, including incident reporting, prevention planning, and risk mitigation. • Be trained in evaluating HCBS living arrangements. • Be trained in health insurance portability and accountability act (HIPAA) privacy requirements, 42 CFR part 2 confidentiality of alcohol and drug abuse patient records. Supervisor will have supervisory experience related to the scope of work and will have a Bachelor's degree or be an RN plus 5 years of experience.

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

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

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

☐	Participant-directed	X	Provider managed

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

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

Service Definition (Scope)*:*

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

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

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

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

1. Facilitation of natural supports;
2. Transportation; or,

3. Peer services. IPS-SE: Individualized Placement and Support- Supported Employment (IPS-SE): Providers who chose to offer IPS-SE employment service shall meet the following requirements to be OhioMHAS qualified providers: 1. IPS-SE is an evidence based practice which is integrated and coordinated with mental health treatment and rehabilitation designed to provide individualized placement and support to assist individuals with a severe and persistent mental illness obtain, maintain, and advance within competitive community integrated employment positions. 2. In order to be an IPS-SE qualified provider, the provider must: (a) Provide the evidence-based practice of IPS-SE after completion of training/certification on the model; (b) Have current fidelity reviews completed by an OhioMHAS approved fidelity reviewer as required by the developer of the practice; and, (c) Achieve the minimum fidelity score necessary to maintain fidelity, as defined by the developer of the practice.
Additional needs-based criteria for receiving the service, if applicable *(specify):*
N/A
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*
☑ Categorically needy *(specify limits):*