

Ohio Department of Medicaid

Recovery Management Guide

*A Guide for Overseeing Recovery
Management Services
For the Specialized Recovery
Services (SRS) program*

Effective July 1, 2016

Table of Contents

Purpose and Introduction

- Purpose
- Introduction

Program Eligibility and Enrollment

- Individual Screening and Assessment
- Eligibility and Enrollment

Assessments

- Initial Assessment
- Annual Assessment
- Event-Based Assessment for a Significant Change of Condition
- Ongoing Assessment

Recovery Management

- Recovery Management Practice Standards
- Recovery Management Process Requirements
 - Acuity Level 2
 - Individual-to-Recovery Manager Ratios
 - Other Recovery Management Process Requirements
 - Recovery Management Contractor Supervision of Recovery Managers

Person-Centered Care Planning and Care Coordination

- Plan Development
 - Person-Centered Care Plan Contents
 - Disaster Planning
 - Recovery Management Services
 - Person-Centered Care Plan Process Requirements
 - Changes to the Person-Centered Care Plan
 - Review Expectations
 - Anticipated Increased Services
 - Provider Selection
 - Recovery Management Agency Choice
 - Recovery Manager Choice

Ensuring Individual's Health and Welfare

- Acknowledgement of Responsibility
- Behavioral Interventions: Restraint, Seclusion or Restrictive Interventions
- Service Monitoring
- Incident Discovery, Reporting and Prevention Planning

Individual's Due Process Rights

- Requesting an Assistant Attorney General for a Hearing
- Hearings Process

Complaint Process

Access to ODM Information Management Systems

Terminating a User's Access

Appendix A: Code Sheet **A**

Appendix B: Ohio Administrative Code Rules **B**

Appendix C: SRS Care Coordination Process Flow **C**

Appendix D: HCBS Setting Verification Checklist (Draft) **D**

Attachments

Purpose and Introduction

Purpose

As the single-state Medicaid agency, the Ohio Department of Medicaid (ODM) has oversight responsibility for all Home and Community-Based Services (HCBS) programs that use Medicaid as their primary funding source. ODM is responsible for the administration and oversight of all HCBS programs. Through the Department of Administrative Services (DAS), ODM contracts with Recovery Management Agencies to assist with the implementation and management of ODM-administered HCBS programs throughout the state of Ohio. The Recovery Management Agencies perform both Independent Entity and Recovery Manager functions within the Specialized Recovery Services (SRS) program. It also contracts with a Provider Oversight Contractor to assist with provider compliance and operate a system for investigating and tracking incidents. The Recovery Management Contractor (or “Contractor”) and Provider Oversight Contractor must work closely and cooperatively with each other.

The federal government requires HCBS programs to ensure the health and welfare of each individual; it is also the fundamental goal of the relationship between ODM, the Recovery Management Contractors, and the Provider Oversight Contractor. This Recovery Management Guide details ODM’s standards and expectations related to the daily operations to achieve that goal. As issues and/or potential inefficiencies are identified, ODM may modify the Recovery Management Guide, through a contract amendment during the term of the contract in order to clarify expectations, improve performance and to better meet the needs of individuals on the HCBS programs. In the event there is a conflict between the terms and conditions of the contract and this guide, the contract is controlling.

Introduction

In order to better meet the needs of individuals with severe and persistent mental illness (SPMI) Ohio has used options available through its Medicaid program to create the Specialized Recovery Services (SRS) program. This program offers an array of home and community-based services (HCBS) that are person-centered, recovery-oriented, and aimed at supporting individuals in the community. The SRS program modernizes and improves the delivery of behavioral health services to better meet the recovery needs of those currently eligible, but also builds a foundation to ensure a robust continuum of supports and evidence-based options will be available in the future.

The SRS program is not a one size fits all program and is customized to each individual’s needs and goals. Individuals in the SRS program direct and plan service delivery, with support from individuals they choose to be involved. Person-centered services are delivered pursuant to a written Person-Centered Care Plan that is developed through a process led by the individual, including people he or she has chosen to participate. SRS program services can be offered in community-based settings (e.g., individual’s own home), as well as residential, employment, and day settings to help individuals live in the most integrated setting possible. All residential services must have home-like characteristics and may not be institutional in nature.

Program Eligibility and Enrollment

Individual Screening and Assessment Process

The Recovery Management Contractor assesses an applicant for enrollment into an Ohio Department of Medicaid-HCBS program, and the steps that follow the determination. Individuals interested in making application to the Specialized Recovery Services (SRS) program will be referred to the Single Entry Point (SEP) Agency in their area.

1. The SEP will complete a Long-Term Care Questionnaire to determine if an individual has indications of severe and persistent mental illness.
2. If indications are present, the SEP will complete the SRS program pre-screening questions in order to determine if a referral should be made for the SRS program.
3. The SEP will determine if the individual is currently receiving Medicaid or if he or she needs assistance completing a Medicaid application.
4. If the SEP determines that the individual should be referred to the SRS program, an e-mail is sent to the BLTCSS mailbox with subject line "SRS program referral" along with the individual's name, address, phone number, e-mail address and Medicaid number (if available).
5. Upon receipt of the referral, the Ohio Department of Medicaid (ODM) will randomly assign an Independent Entity (IE) within the region where the individual resides. Upon receipt of the referral, the IE will assign a Recovery Manager. The Recovery Manager shall conduct the initial assessment with the applicant and his/her authorized representative, legal guardian, or appropriate power of attorney, if applicable.
6. When appropriate, the Recovery Management Contractor refers and/or assists the applicant to access other community resources in obtaining necessary services. This may include linking them to and/or making a referral to the County Department of Job and Family Services, the County Board of Developmental Disabilities, PASSPORT Administrative Agency, Adult Protective Services, Community Behavioral Health Center, and/or any other community resources that may be able to meet the applicant's immediate needs.
7. If the applicant is residing in an institution, the Recovery Management Contractor must discuss the HOME Choice program with the applicant. The HOME Choice program assists with transitioning individuals from the nursing facility to a home setting by providing goods and services. If the applicant is interested in HOME Choice, the Recovery Management Contractor must complete an Ohio Department of Medicaid 02361 form "*HOME Choice Application.*" Information about the HOME Choice program can be found at <http://medicaid.ohio.gov/FOROHIOANS/Programs/HomeChoice.aspx> .
8. At any time during the eligibility determination process, the Recovery Management Contractor may deny enrollment in the SRS program if the Recovery Management Contractor has not made contact with the applicant after at least three attempts to contact the applicant at varying times, and on at least three different days. The Recovery Management Contractor must maintain documentation of all attempts to reach the

applicant. If the Recovery Management Contractor has knowledge of an individual's behavioral health provider it is expected that attempts to engage the provider to help contact the individual will be made prior to denying enrollment in the SRS program.

9. If the applicant does not meet program eligibility criteria for an Ohio Department of Medicaid HCBS program, the Recovery Management Contractor must, with the applicant's permission, refer the applicant to other appropriate resources. The Recovery Management Contractor must provide the applicant with the contact information for the appropriate local agency.
10. Within three business days of the completion of the eligibility determination, the Recovery Management Contractor must enter the HCBS application status into the Ohio Department of Medicaid-approved financial eligibility system.

Eligibility and Enrollment

Prior to enrollment in the Specialized Recovery Services (SRS) program, the Recovery Manager will determine if the individual meets targeting and functional needs criteria for SRS using criteria described in OAC rule 5160-43-02. The individual conducting eligibility assessments and developing a Person-Centered Care Plan cannot be a provider of other SRS.

Information that may be used to determine eligibility for enrollment includes, but is not limited to:

- Assessment data;
- Reports from other professionals and team members;
- Ongoing monitoring; and
- Other information requested by or received from members of the individual's team.

The applicant or authorized representative must agree to participate in the Ohio Department of Medicaid-administered HCBS program assessment and enrollment processes. This agreement is formally documented with the individual's signature on the *Individual SRS Program Agreement and Responsibilities* form and shall be obtained upon enrollment, but no later than, the Person-Centered Care Plan development date.

The Recovery Manager will provide to the individual, upon enrollment and as appropriate, the phone numbers of the Recovery Management Contractor, Recovery Manager, and the Medicaid Hotline. The Recovery Manager must also educate the individual enrolled in an HCBS program about his or her right to contact any of these entities for assistance or to notify them of concerns and will issue the individual an SRS Program Handbook.

At the conclusion of the assessment process, the Recovery Manager must make a recommendation to the IE whether the applicant should be enrolled in or maintain enrollment in the program. The Recovery Manager must maintain documentation of each assessment and evidence gathered to make the determination. If, at any time during the assessment process or while enrolled in the SRS program, the applicant or individual fails to meet any of the eligibility or enrollment criteria, the Recovery Manager must recommend to the IE denial or disenrollment of the individual and inform him or her of hearing rights.

Assessments

The assessment process is designed to identify an applicant's needs, strengths and need for Specialized Recovery Services (SRS). Assessments are completed for SRS program applicants and enrolled individuals at least once per year, in addition to ongoing, as-needed assessments performed as a part of the Recovery Management Contractor's day-to-day operations.

The assessment process collects data, evaluates for service need, and provides linkage to programs and services for applicants or individuals seeking access to SRS. This section outlines expectations and standards for conducting:

1. **Initial assessments** when an applicant requests enrollment in the SRS program.
2. **Annual assessments** for an individual's redetermination for SRS program eligibility.
3. **Event-based assessments** for an individual enrolled in the SRS program when he or she experiences a significant change in condition.
4. **Ongoing assessments** for an individual enrolled in the SRS program when he or she experiences any other changes.

The following principles guide the assessment process:

- All assessments are conducted face-to-face with the SRS program applicant or individual enrolled in SRS program.
- The Recovery Manager will complete the assessment using the information gathered from the applicant and, to the extent possible, the applicant's informal caregivers and/or representative.
- With the applicant's permission, the assessment will also include information from his or her current service providers and any other sources identified by the applicant as having information that will be useful in determining his or her need for services.
- The assessment process must include evaluating the individual's current or intended community residence to verify the residence meets the home and community-based setting requirements outlined in OAC rule 5160-44-01.
- At the applicant or individual's request, the assessment may be terminated at any time and can be rescheduled at a later date and time, within prescribed timelines.
- Assessment components will be completed using information gathered from the applicant or individual enrolled in SRS program and, to the extent possible, his or her informal caregivers and/or representative, as well as the applicant or individual's professional support team (physician, specialists, providers, etc.). Additionally, the assessment will include review of the applicant or individual's care needs, goals, strengths and preferences.

- The assessment is focused on the applicant or individual's current mental health and functional needs.
- The assessment data is documented on the Ohio Department of Medicaid-approved assessment tool.
- The Recovery Manager provides the applicant or individual with linkage to needed services identified during the assessment process through program enrollment, referral to other support systems, and/or enrollment in other service programs.
- If, at any time during the assessment process, the applicant or individual enrolled in the SRS program fails to meet any of the eligibility or enrollment criteria, the Recovery Manager will recommend the applicant or individual for denial or disenrollment and inform him or her of hearing rights.

Initial Assessment

Initial assessments are completed via the approved Recovery Management system to determine SRS program eligibility and the need for SRS.

This assessment is used to determine the applicant's level of functioning, as well as identify the applicant's potential service needs for the SRS program. It also serves as the supporting documentation if the applicant is determined not to meet the eligibility requirements of the SRS program.

The Recovery Manager must complete all assessment activities and have a care plan in place 45 days from the date the individual is assigned to the Independent Entity.

Annual Assessment

Once enrolled in the SRS program, each individual is required to have an annual face-to-face assessment to determine his or her continued eligibility for the program. Annual assessments follow the same process as previously outlined for initial assessments.

The Recovery Manager must contact the individual to schedule the annual assessment at least 30 calendar days prior to the due date of the next assessment. At that time, the Recovery Manager will also contact all individual-identified team members to invite them to participate in the annual assessment. Annual face-to-face assessments are conducted and an eligibility determination made no more than 365 calendar days after the previous eligibility determination.

Event-Based Assessments for a Significant Change of Condition

The Ohio Department of Medicaid requires the Recovery Management Contractor conduct a face-to-face assessment for any reported actual or potential significant change of condition, or at the request of the individual. The Recovery Manager must make contact with the individual within 24 hours of the Recovery Manager's knowledge of an actual or potential significant change of condition. The Recovery Manager must complete a visit and an event based assessment to determine if there has been a significant change (if applicable) within **three calendar days** of the

Recovery Management Contractor's knowledge of the event. If the significant change would require a new assessment, then it shall be completed by the Recovery Manager. Please note if this is done, then this will change the annual reassessment date.

A significant change in condition may include, but is not limited to:

- An acute medical condition that results in institutionalization and/or the significant changes or deterioration of the individual's condition;
- Change of residence;
- Three reported incidents within 90 days; and
- Failure to use SRS for 30 days.

Ongoing Assessment

The Recovery Manager must assess the individual's changing care needs on an ongoing basis and address needs as they arise. The Recovery Manager is not required to complete the entire Ohio Department of Medicaid-approved eligibility assessment tool when conducting an ongoing assessment. However, the Recovery Manager may include communication with the individual, authorized representative, providers, and other members of the team in order to promptly and appropriately address the individual's personal circumstances.

Recovery Management

All individuals enrolled in the Specialized Recovery Services (SRS) program receive Recovery Management (RM) services. RM assists individuals with linkage and authorization for services and supports necessary to carry out the individualized Person-Centered Services Plan. RM is individual-focused and promotes and supports the individual's preferences, values and right to self-determination. The Recovery Manager is also essential to ensure the individual's health and welfare.

Recovery Managers assist individuals in gaining access to approved SRS, Medicaid State Plan and community services, as well as medical, social, educational and other appropriate services, regardless of the funding source. RM includes, but is not limited to, the following core functions:

- Monitoring the individual's health and welfare;
- Periodically assessing the individual's needs, service goals and objectives;
- Annually assessing the individual's program eligibility;
- Scheduling, coordinating and facilitating meetings with the individual and his or her trans-disciplinary team;
- Authorizing services in the amount, scope, and duration to meet the individual's needs;
- Linking and referring the individual to needed service providers;
- Developing and reviewing the Person-Centered Services Plan for SRS;
- Monitoring the delivery of all services identified in the individual's Person-Centered Care Plan;
- Transition planning for significant changes, including those changes that occur prior to enrollment on the SRS program and at significant life milestones such as entering or exiting school, work, etc.;
- Identifying and reporting incidents, as well as prevention planning to reduce the risk of reoccurrence.

Recovery Management Practice Standards

1. The maximum average staffing level for Recovery Management (RM) must be maintained in accordance with the contract.
2. The Recovery Manager must be an RN or possess a Bachelor's Degree in social work, counseling, psychology, or similar field and have a minimum of 3 years post degree experience working with individuals diagnosed with SPMI.

3. The Recovery Manager maintains the minimum contact and visit schedules with the individual enrolled in the SRS program in accordance with the specifications outlined in this section and in the contract.
4. The Recovery Manager maintains the confidentiality of the individual's data in accordance with the Health Insurance Portability and Accountability Act regulations (HIPAA).
5. The Recovery Manager reports and documents incidents in accordance with OAC rule 5160-43-06 and the requirements of this Recovery Management Guide.
6. The Recovery Manager informs individuals of service alternatives and choice of qualified providers and assists individuals with linkage to providers and/or with the provider selection process, as needed.
7. The person-centered care planning process continually addresses the individual's services and supports needs and the Recovery Manager revises or updates the individual's Person-Centered Care Plan as the individual's needs and resources change. The Recovery Manager must complete plan updates within 10 calendar days of a request or identified need or within 48 hours if verbal authorization is given.
8. The Recovery Manager must inform individuals of their rights and responsibilities while enrolled in the Specialized Recovery Services program.

Recovery Management Process Requirements

The following principles and responsibilities underline Recovery Management (RM) services for individuals enrolled in the Specialized Recovery Services (SRS) program.

1. The Recovery Manager must explain the role and responsibilities of RM to the individual and, if applicable, his or her authorized representative both verbally and in writing. This must include an explanation of the Recovery Management Contractor's role related to the Ohio Department of Medicaid in the operations of this HCBS program.
2. The Recovery Manager must provide current contact information to the individual. The Recovery Manager must also ensure the individual has the Recovery Management Contractor's information accessible to family members and emergency personnel.
3. The Recovery Manager must obtain permission in writing from the individual prior to contact with any members of the individual's team to request information about care and treatment plans in effect, and to request notification of any changes in plans of care and treatment to reduce duplication of services. At the time permission is obtained, the individual must be informed of the right to revoke permission to any person at any time within the rules and requirements of the SRS program. Permission must be renewed annually. The Recovery Manager must provide his or her contact information to all members of the individual's team.
4. For all service additions and changes, the Recovery Manager must contact the individual within 24 hours after the service addition or change was to be initiated to confirm that it is in place and that the individual is satisfied with the service addition or change and document the intervention in the clinical record.

5. The Recovery Manager must contact service providers to verify delivery of services in the amount, scope, and duration as identified on the individual’s Person-Centered Care Plan no later than **three business days** after the scheduled service start date and document intervention in the clinical record.
6. The Recovery Manager must maintain ongoing communication with the individual and members of the team, including all service providers listed on the Person-Centered Care Plan. The purpose of this requirement is to identify any problems in service delivery, validate the current Person-Centered Care Plan to ensure assistance and consistency are being provided in accordance with the Person-Centered Care Plan, and to request notification of any changes in the individual’s condition or needs. The contact will also identify any potential risks and/or monitor any known risks to the individual’s health and welfare.
7. The Recovery Manager must monitor the quality of the service delivery and care provided by all authorized HCBS providers. This includes review of service delivery records, incident reports, and other documentation of service delivery.
8. All individuals enrolled on the SRS program will be an acuity level 2. The Recovery Management Contractor will conduct visits and contacts according to the acuity level 2 contact schedule described below. More frequent monitoring and contacts may occur depending on the individuals’ situation. Recovery Manager contact is defined as a face-to-face visits, phone conversation, email exchange or other electronic communication with the individual that ensure the exchange of information between the Recovery Manager and the individual. Electronic communications without response are not considered as a Recovery Manager contact with the individual.

Acuity Level 2

Level 2 Recovery Management will be provided to all individuals enrolled in the SRS program.

Frequency of Individual Contact	Timing of In-Person Visit
Maximum of 30 calendar days between contacts	Minimum of three visits in six months, Maximum of 60 calendar days between visits

Individual-to-Recovery Manager Ratios

The **new enrollee-to-Recovery Manager ratio** must not exceed one Full-Time Equivalent (FTE) Recovery Manager per sixty individuals.

Other Recovery Management Process Requirements

The Recovery Management Contractor must:

- Monitor the individual’s progress with respect to the identified comprehensive goals, objectives and outcomes;

- Re-evaluate the individual's goals, objectives, services, and all program eligibility requirements when applicable and at least once every 12 months;
- Complete the HCBS Settings Verification Checklist annually and with each change in residence to verify the residence meets the home and community-based setting requirements outline in OAC rule 5160-44-01;
- Maintain documentation in accordance with Ohio Department of Medicaid rules, regulations, policies and procedures;
- Provide the individual, upon enrollment and as appropriate, with a copy of the Ohio Department of Medicaid-approved Individual's Bill of Rights. If, at any time, the individual is no longer eligible for the Specialized Recovery Services program, the Recovery Management Contractor shall recommend him or her for disenrollment, advise the individual of this determination, and inform him or her of state hearing rights.

Recovery Management Contractor Supervision of Recovery Managers

The Recovery Management Contractor must maintain a Recovery Manager-to-supervisor ratio of not more than 12:1. Supervisors must meet with each Recovery Manager at least once per month to review caseloads, current case assignments, critical issues, etc. Supervisors must also hold monthly team meetings with their Recovery Managers for peer review, reviewing practice standards, etc.

Person-Centered Service Planning and Care Coordination

The assessment provides information for the initial steps of person-centered service planning. The care planning process is intended to:

1. Identify the strengths and needs of the individual including risk areas to be addressed to ensure the individual's health and welfare;
2. Develop goals to address needs;
3. Set desired outcomes for each need;
4. Identify available supports and determine the type of informal support and provider(s) to address unmet needs; and
5. Set a pattern of delivery for each provider.

The Person-Centered Service Plan should:

- Reflect the individual's strengths and preferences;
- Reflect clinical and support needs as identified through an assessment of functional need;
- Include individually identified goals and desired outcomes;
- Reflect the services and supports (paid or unpaid) that will assist the individual to achieve goals and providers of those services and supports, including natural supports;
- Reflect the setting in which the individual resides was chosen by the individual from among setting options which included non-disability specific settings and the option for a private unit in a residential setting;
- Be understandable to the individual receiving services and supports. The written plan must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient;
- Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all persons and providers responsible for its implementation;
- Be distributed to the individual and other people involved in the plan; and
- Prevent the provision of unnecessary or inappropriate services and supports.

The Recovery Management Contractor will use these components, as well as other information outlined below, to inform and develop a comprehensive Person-Centered Care Plan for the individual that addresses his or her needs.

Plan Development

Person-centered service planning and care coordination address the individual's changing circumstances and needs over time. It must be revised as often as necessary to meet the individual's needs.

The Person-Centered Service Plan is a written outline of the individual's SRS. The Person-Centered Care Plan identifies goals, objectives and outcomes related to their SRS.

The Recovery Management Contractor develops the Person-Centered Care Plan, as outline in OAC 5160-44-02, and in collaboration with a team. The team members, at a minimum, include the individual, informal caregiver(s), authorized representative, mental health providers, and the Recovery Manager. The Recovery Manager documents communication records and/or team meeting minutes in the planning process.

The Recovery Manager authorizes, arranges and initiates services. This includes communicating, collaborating and negotiating with the individual, mental health provider, SRS providers and informal caregivers.

The Recovery Manager contacts all providers and agencies that are, or will, participate in meeting the individual's needs, scheduling meetings, disseminating information, planning updates, maintaining documentation, as well as mediating disagreements among team members. The Recovery Manager must tell the individual that he or she has the right to request a state hearing regarding any decisions made about his or her HCBS or Medicaid benefits.

Person-Centered Service Plan Contents

The Person-Centered Service Plan must include, but is not limited, to:

- The name, phone number and service responsibilities of all paid SRS providers;
- The total number of approved units of each service and the total projected monthly cost for SRS for 12 months beginning with the enrollment and/or annual date;
- The start and stop dates of service delivery; and
- Any modifications to the additional conditions required for provider owned or controlled residential settings outline in OAC 5160-44-01 paragraph (C). The plan must include all of the required elements outlined in OAC 5160-44-02 paragraph (B).

Disaster Planning

The Recovery Management Contractor must ensure every individual has a disaster plan in place and that it is documented in the Person-Centered Service Plan. This plan must address a fire, tornado, electrical outage and other potential risks that would prevent an individual from receiving services in his or her residence.

Recovery Management Services

Recovery Management services must be outlined in the Person-Centered Service Plan. The Person-Centered Service Plan must indicate acuity level 2 and contact schedule, as well as specify that the Recovery Management services include monitoring of services, specific monitoring and interventions that occur for an individual's needs.

Person-Centered Service Plan Process Requirements

The Person-Centered Care Plan is updated at the individual's annual assessment, at other times the Recovery Management Contractor determines necessary or when events dictate the reassessment of the individual's needs and re-evaluation of the Person-Centered Care Plan.

Changes to the Person-Centered Service Plan

The Recovery Manager must respond to requests for changes to the Person-Centered Service Plan in writing and within 10 calendar days of a request from the individual. Approvals must be updated in the Person-Centered Service Plan. All responses must include notice of the right to a state hearing.

- The Recovery Manager must review and/or modify the Person-Centered Service Plan within 24 hours of receipt of a notification of a significant change in the individual's physical or mental condition.
- The Recovery Manager must notify the individual and the individual's providers of all changes in the Person-Centered Service Plan.
 - The Recovery Manager must provide written documentation prior to the expected date of service change or verbal notification prior to the expected date of delivery of the service change if written documentation is not possible prior to the expected date of service delivery.
 - The Recovery Manager must provide an updated Person-Centered Service Plan no later than 48 hours after the date of service change if verbal notification was given.
- The Person-Centered Service Plan is not complete until it is signed by the individual, or the individual's authorized representative or legal guardian.
- The Recovery Manager must contact the individual no later than 24 hours after the initiation of, or change to, services to assess the individual's satisfaction with the services and/or change.
- The RM must document all contacts or visits with the individual, authorized representative, providers, or other team members in the case record within one business day of the contact and/or visit.

Review Expectations

Upon completion of the care plan the Recovery Manager will forward the draft plan and the results of the HCBS Settings Verification Checklist to its Independent Entity contact for final review and approval. The plan must be approved within 10 days of the request.

Provider Selection

Free Choice of Provider: Individuals enrolled in an HCBS program have the right to select an eligible provider of his or her choice for any Medicaid service, within the authorized service. The Recovery Management Contractor is responsible for ensuring that individuals are afforded this right to select the provider of his or her choice and assist, to the extent needed, in the selection process.

Provider search options include:

- Ohio Department of Medicaid consumer website (<http://medicaid.ohio.gov>)
- Ohio Department of Medicaid-approved system
- Medicaid Consumer Hotline (1-800-324-8680).

The Recovery Management Contractor is responsible for ensuring that the individual has selected an adequate number of providers to ensure full coverage of services authorized in the Person-Centered Care Plan. This includes, but is not limited to, assisting individuals with identifying potential providers, contacting the providers to determine interest, and linking individuals to interested providers.

Recovery Management Agency Choice

Individuals have the right to choose and change their Recovery Management Agency annually, or on a case-by-case basis as determined by the Ohio Department of Medicaid.

Recovery Manager Choice

The individual will be able to change their Recovery Manager within the Recovery Management Agency every quarter.

Ensuring Individual's Health and Welfare

“Health and welfare” is an assurance required by the Centers for Medicare and Medicaid Services (CMS) whereby the Ohio Department of Medicaid (ODM) must ensure that safeguards are taken to protect the health and welfare of individuals enrolled in an ODM-administered HCBS program. CMS will not grant an ODM-administered HCBS program, and may terminate an existing ODM-administered HCBS program, if ODM fails to ensure compliance with this requirement. ODM meets this requirement, at a minimum, by implementing policies and procedures regarding the following:

- Individual risk and safety planning and evaluations
- Individual critical incident management
- Housing and environmental safety evaluations
- Individual behavioral interventions (see below)
- Natural disaster and public emergency response planning.

ODM requires the Recovery Management Contractor to assess, identify, and care plan for risk and/or safety factors that may impact the individual's health and welfare. When the Recovery Management Contractor identifies risk factors it must work with the individual's team to put services and supports in place to mitigate the risk. An emergency response plan should be activated for, but not limited to, severe weather alerts issued by the National Weather Service or County Sheriff Department, Snow Emergency Level 2 or 3 assignments, flooding, severe winds/tornadoes, power outages, fires, drinking water advisory, etc. Risks can be identified through formal and ongoing assessment, incident reports, reports from providers, documentation reviews, and other means.

Person-Centered Care Plans must address health and welfare concerns when risk factors exist. Services and supports must be put in place to address the risk.

Acknowledgment of Responsibility

When the individual poses or continues to pose a risk to his or her health and welfare, the Recovery Management Contractor must develop and implement an Acknowledgment of Responsibility. The Acknowledgement of Responsibility is created between the Recovery Management Contractor and the individual and/or the legal guardian, as applicable, identifying the risks and setting forth interventions recommended by the Recovery Management Contractor to remedy risks to the individual's health and welfare.

How to develop an effective Acknowledgement of Responsibility Plan:

- Identify the goal – what needs to change in order to reduce the risk of health and safety to the individual;

- Identify the potential risk to the individual's health and welfare and what behaviors or concerns are putting the individual at risk;
- Develop objectives to reduce the identified behavior or concern that is impacting health and safety;
- Develop objectives that are specific, achievable, measurable, realistic and timely; and
- Develop action steps (interventions) to mitigate against the risks and the individual's agreement to implement the action steps with assistance from the Recovery Manager.

The individual and/or the legal guardian, as applicable, must sign the Acknowledgement of Responsibility. If she or he does not, the Recovery Management Contractor must document the refusal to sign.

The Acknowledgement of Responsibility must be identified in the Person-Centered Care Plan, and it must be monitored monthly to ensure the individual is adhering to the proposed interventions, as well as for follow up on recommendations for service linkage, etc. The documentation must address how the individual is progressing with the agreed-upon interventions, progress toward goals (positive and negative), if interventions would need to be changed, etc. If the individual has followed the plan and is no longer considered a risk, then the plan can be discontinued. This must be documented in the clinical record.

The Acknowledgement of Responsibility must:

- Be in writing and uploaded into the individual's record in the Recovery Management system;
- Be documented in the Person-Centered Service Plan;
- Be reviewed with the individual monthly and as needed; and
- Be monitored during visits, team meetings, and plan updates to determine progress toward achieving the desired outcomes. Monitoring must be documented in the communication notes in the Recovery Management system.

Action must be taken if the identified risks continue and/or cannot be mitigated. The Recovery Management Contractor must document all monitoring, and interventions that prove successful, as well as action steps that do not mitigate identified risks. Such documentation must be included in the communication records and in any updated Acknowledgement of Responsibility agreements.

If the individual does not adhere to the agreed-upon interventions, the Recovery Management Contractor must submit a recommendation to the Bureau of Long-Term Care Services and Support to disenroll the individual from the program due to the inability to ensure his or her health and welfare. This must be done as soon as a continued risk is identified or after intervention attempts have failed. The clinical record must show how the individual failed to adhere to the prevention plan and what the Recovery Manager has done to get the individual to follow the prevention plan.

Behavioral Interventions: Restraint, Seclusion or Restrictive Interventions

Restraint and seclusion are used for behaviors that pose a serious risk of harm to the individual or to others. They include aggression to others, objects, or self.

If such behaviors occur, the Recovery Management Contractor must identify and engage an authorizing entity. The use of restraint or restrictive intervention is permitted only if authorized by a physician, County Board of Developmental Disabilities, a licensed psychologist, or other behavioral health professional. Only physicians can authorize chemical restraints. Only a County Board of Developmental Disabilities can authorize the use of seclusion.

The following are *not* considered restraints:

- Any device that an individual can remove or is used for positioning and/or alignment;
- Physical guidance or assistance to complete Activities of Daily Living or medical procedures, or for safety, such as holding hands when crossing the street if not age-appropriate; or
- Medication ordered to be used in preparation for a medically necessary medical procedure.

The following are prohibited:

- Use of seclusion that is not a part of a plan authorized and overseen by a County Board of Developmental Disabilities
- Use of prone (face-down) restraint if prohibited by an authorizing entity.

The Recovery Management Contractor must identify and develop a plan that addresses behaviors that include the use of restraint, seclusion and restrictive interventions. Recovery Managers must ensure the following are addressed for the use of restraint, seclusion, or restrictive interventions:

- Ensuring agreement from the team that the use of use of restraint, seclusion, or restrictive intervention is appropriate.
- Obtaining consent from the individual enrolled in the program or authorized representative for the plan and the interventions.
- Building safety and well-being measures into the Person-Centered Care Plan as well as measures to mitigate or prevent risk
- Obtaining written verification of authorization of the use of restraint, seclusion, or restrictive intervention by the authorizing entity.
- Identifying an oversight entity for ongoing monitoring the use of the restraint, seclusion, or restrictive intervention. The person implementing the restraint, seclusion, or restrictive intervention cannot be person responsible for monitoring the use of the restraint, seclusion, or restrictive intervention.

- Identifying and directing the party responsible to train staff that implement the restraint, seclusion, or restrictive intervention.
- Documenting the planned use of restraint, seclusion, restrictive interventions in the Person-Centered Care Plan, and communication record.

Individuals with developmental disabilities that are served by a County Board of Developmental Disabilities are eligible to access support with behavior plan development. This includes the County Board of Developmental Disabilities oversight committees and processes. Recovery Managers must collaborate with local County Boards of Developmental Disabilities staff to access this service on behalf of the individual.

Reporting expectations: Any use of an approved restraint, seclusion or restrictive intervention must be documented by the provider and reviewed by the Recovery Manager during routine visits and team meetings. Any use of a restraint, seclusion, or restrictive intervention that is not approved or is implemented contrary to the plan must be reported as an incident via the ODM-approved system. Additionally, the use of any prohibited restraint or seclusion or any unauthorized use of a restrictive intervention must be reported as an incident. The Recovery Management Contractor must review reporting requirements with all persons authorizing or implementing a restraint, seclusion, or restrictive intervention.

The Recovery Management Contractor must develop and send an annual report to the physician who certified the restraint, seclusion plan or restrictive intervention plan. The report must include identification of the restraint, seclusion or restrictive intervention used frequency of use per month, and information on the outcome or response to the use of the restraint, seclusion, or restrictive intervention. The Recovery Management Contractor must ensure the physician evaluates the need for, and re-authorizes if necessary, the use of the restraint, seclusion, or restrictive intervention at least annually.

Review: The Recovery Management Contractor must review and discuss the use of restraint, seclusion, or restrictive intervention with the team at least every 90 days. Additionally, the Recovery Management Contractor must review all incident reports related to the use of restraint, seclusion, or restrictive intervention. The Recovery Management Contractor is required to review the use of restrictive interventions to ensure the use was appropriate and within prescribed guidelines.

Service Monitoring

The Recovery Management Contractor must monitor service delivery continuously. Monitoring services is not a compliance review process, but rather a quality check to ensure the health and welfare of the individual, as well as to ensure all needs are being met. At any time, if there are concerns about the individual's well-being, including incident identification, or about the performance of the provider, the Recovery Management Contractor must file incident reports.

Monitoring services includes:

- Confirming the start of services within one business day of a new service or a new provider being added to a Person-Centered Services Plan.
- Monitoring provider service delivery by reviewing notes, and other documentation. Any changes that were made to the Person-Centered Services Plan that were not previously

reported to the Recovery Management Contractor must be addressed with an event-based assessment or incident report.

Incident Discovery, Reporting and Prevention Planning

Incidents are described in Ohio Administrative Code rule 5160-43-06. The Recovery Management Contractor must comply with that rule and follow the protocol below when an incident occurs:

Take Immediate Action: Upon discovery of an incident or allegation, the Recovery Management Contractor must take immediate action(s) to ensure the health and welfare of the individual. In the event of a death of an individual, the Recovery Management Contractor must notify and provide relevant details to the local county coroner when the Recovery Management Contractor is aware that the:

- Individual's disability was a result of an accident, injury, or trauma;
- Individual's death is potentially accidental, suicidal or homicidal;
- Individual has a history of drug or alcohol abuse and/or misuse of medications including controlled substances;
- Individual has been a victim, or has a history, of alleged abuse, neglect, or exploitation; or
- Individual's death is questionable, potentially suspicious, and/or under unknown circumstances.

In addition, in the event of a death, the Recovery Management Contractor must contact the individual's natural supports and offer linkage and make a referral to local grief and counseling services.

Report to Protective Agencies: Immediately after securing the individual's safety, the Recovery Management Contractor must notify law enforcement, county children services, adult protective services, County Board of Developmental Disabilities or other entity, as appropriate. The Ohio Department of Medicaid also requires the Recovery Management Contractor to cooperate with these entities, as needed, in an investigation.

Report Incident to Provider Oversight Contractor: The Recovery Management Contractor must report incidents in the ODM-approved system within 24 hours of the Recovery Management Contractor discovery, as directed by ODM. Refer to OAC rule 5160-43-06 for SRS program incident management system information.

Incidents Alerts: Incident alerts are incidents (see below) that must be reported to ODM within 24 hours of discovery due to the severity and/or impact of the incident on the individual or the need for ODM involvement. ODM monitors each incident alert to ensure that the investigation, remediation, and prevention planning are timely and effective. The Recovery Management Contractor must report incident alerts within 24 hours of discovering the incident to both the Provider Oversight Contractor and ODM.

The notification must include the following information in the subject line: INCIDENT ALERT, alert type as identified below, incident number assigned by the incident database. ODM does not close the incident alert until after the health and safety of the individual has been ensured. Prior to closing the incident alert, ODM reviews all pertinent information, including investigation

outcomes, recommendations, final reports, approved prevention plans and verification of implementation of the approved prevention plans.

When the individual is a MyCare Ohio member, OAC rule 5160-43-06 is not applicable. Refer to OAC rule 5160-58-05.3 for incident management responsibilities.

The following incidents are cause for an alert:

1. A suspicious death that could not reasonably have been expected, and in which at least one of the following circumstances exists:
 - The circumstances and/or the cause of death are not related to any known medical condition of the individual; or
 - Someone's action or inaction may have caused or contributed to the individual's death, including inadequate oversight of medication or misuse of medication.
2. Abuse or neglect that required the individual's removal from his or her place of residence;
3. Hospitalization or emergency department visit (including observation) as a result of:
 - Abuse or neglect;
 - Accident, injury or fall when someone's action or inaction may have caused or contributed to the occurrence, including inadequate oversight of medication or misuse of medication;
 - Injury or illness of an unknown cause or origin; and
 - Reoccurrence within seven calendar days of the individual's discharge from a hospital.
4. Harm to multiple people as a result of an incident;
5. Injury resulting from the authorized or unauthorized use of a restraint, seclusion or restrictive intervention;
6. Incidents involving an employee of the recovery management contractor or provider oversight contractor;
7. Misappropriation that is valued at five hundred dollars or more;
8. Incidents generated from correspondence received from the Ohio Attorney General, Office of the Governor, the Centers for Medicare and Medicaid Services or the Federal Office of Civil Rights; and
9. Incidents identified by a public media source.

At its discretion, ODM may request further review of any incident under investigation, and/or conduct a separate, independent review or investigation of any incident.

ODM shall ensure the health and welfare of individuals enrolled in the program. ODM and providers are responsible for ensuring individuals in the specialized recovery services program are protected from abuse, neglect, exploitation and other threats to their health, safety and well-being. Upon entering into a Medicaid provider agreement, and annually thereafter, all providers, including all employees who have direct contact with individuals enrolled in the program, must acknowledge in writing they have reviewed this rule and related procedures.

Incidents include, but are not limited to, all of the following:

1. Abuse: the injury, confinement, control, intimidation or punishment of an individual by another person that has resulted in, or could reasonably be expected to result in physical harm, pain, fear or mental anguish. Abuse includes, but is not limited to physical, emotional, verbal and/or sexual abuse and use of restraint, seclusion or restrictive intervention that results in, or could reasonably be expected to result in, physical harm, pain, fear or mental anguish to the individual.
2. Neglect: when there is a duty to do so, the failure to provide goods, services and/or treatment necessary to assure the health and welfare of an individual.
3. Exploitation: the unlawful or improper act of using an individual or an individual's resources for monetary or personal benefit, profit or gain.
4. Misappropriation: depriving, defrauding or otherwise obtaining the money or real or personal property (including medication) of an individual by any means prohibited by law.
5. Death of an individual that meets the criteria for a suspicious death as described in paragraph (J)(2)(a) of OAC rule 5160-43-06.
6. Death of an individual that is not defined in paragraph (F)(5) of OAC rule 5160-43-06.
7. Hospitalization or emergency department visit (including observation) as a result of:
 - Accident, injury or fall when someone's action or inaction may have caused or contributed to the occurrence, including inadequate oversight of medication or misuse of medication;
 - Injury or illness of an unknown cause or origin; and
 - Reoccurrence of an illness or medical condition within seven calendar days of the individual's discharge from a hospital.
8. Unauthorized use of restraint, seclusion and/or restrictive intervention that does not result in, or cannot reasonably be expected to result in, injury to the individual.
9. An unexpected crisis in the individual's family or environment that results in an inability to assure the individual's health and welfare in his or her primary place of residence.
10. Inappropriate service delivery including, but not limited to:
 - A provider's violation of the requirements set forth in OAC rule 5160-43-04 of the and/or any other Administrative Code rules referenced therein that results in an

inability to assure the individual's health and welfare, or could reasonably be expected to place the individual's health and welfare in jeopardy;

- Services provided to the individual that are beyond the provider's scope of practice; and
- (c) Medication administration errors involving the individual.

10. Actions on the part of the individual that place the health and welfare of the individual or others at risk including, but not limited to:

- Activities that involve law enforcement;
- Misuse of medications;
- Use of illegal substances; and
- The individual cannot be located.

Suspicious Death: If an incident meets the criteria for a suspicious death, the Recovery Management Contractor must notify ODM within one business day of the Recovery Management Contractor's date of discovery. The term "suspicious death" is defined in OAC rule 5160-43-06, and refers to a death in which:

- There is no reasonable explanation for the death because the circumstances or the cause of the death are not related to any known medical condition; or
- There is indication that someone's action or inaction may have caused or contributed to the death.

Potential Recovery Management Contractor Involvement/Conflict of Interest: If, at any time, during the discovery or investigation stages, information surfaces that indicates that a Recovery Management Contractor employee is directly or indirectly responsible for the death, abuse or neglect of an individual, the Recovery Management Contractor must immediately notify ODM, which will assume the investigation. When the ODM is conducting an investigation and requires interviews with the Recovery Managers, Recovery Management supervisors may be present, but not interfere, during the interview.

Incident Prevention Planning: After the investigation concludes, the Recovery Management Contractor must create a prevention plan to prevent the same or similar incident from reoccurring and submit it to the Provider Oversight Contractor. Prevention planning must include an evaluation to determine how to mitigate the effects of the occurrence, how to eliminate the risk to the individual from the cause(s) and contributing factors, and/or how to eradicate those cause(s) and contributing factors that pose a continued risk to the individual and others.

The prevention plan must:

- Be objective, measurable, attainable, reasonable (include timelines), realistic, enforceable, verifiable, and sustainable;
- Consider and address all cause(s) and contributing factors and effects of the occurrence; and

- Be comprehensive and meet appropriate, legal, ethical, industry and professional standards, and be an acceptable practice.

The Recovery Manager or supervisor will have three business days to complete the prevention plan and submit to the Provider Oversight Contractor for approval. If the prevention plan is not completed timely, the Provider Oversight Contractor will escalate to the clinical manager. The clinical manager will then have two days to complete the prevention plan and submit it to the Provider Oversight Contractor for approval. If the prevention plan is not submitted within these two days, then the Provider Oversight Contractor will escalate to the ODM contract manager.

Some prevention plan elements may require multiple actions including, but not limited, to:

- Training for other provider and agency staff members;
- Revising Person-Centered Care Plans;
- Employee Discipline; or
- Taking administrative actions (i.e., changing policy or procedures, reassigning staff, increasing staff ratios).

Individual's Due Process Rights

The Recovery Management Contractor must issue hearing rights for all changes to Person-Centered Care Plans that result in a reduction, denial, or suspension of Medicaid and/or Specialized Recovery Services (SRS). The Recovery Management Contractor must notify applicants who are denied enrollment in the SRS program or denied the provider of their choice, the reason for the denial or termination and of their appeal rights. The Recovery Management Contractor must review and evaluate all information to make a determination about requested services and be prepared to defend the action in a state hearing, if the individual requests one. More information on the state hearings process can be found in Chapter 5101:6 of the Ohio Administrative Code. All actions must include an explanation of the decision, as well as rule citations and language to support the action.

The Independent Entity (IE) Contractor will lead all hearings in which it recommended the service denial or modification to requested services and the Ohio Department of Medicaid (ODM) concurred with the Recovery Management Contractor's recommendation. In addition, the IE contractor will lead all program denial hearings and ODM will lead all proposed disenrollment hearings.

The Recovery Management Contractor must produce and provide copies of an appeal summary to the hearing officer and to the individual and his or her authorized representative(s) at least three business days prior to the hearing date.

Requesting an Assistant Attorney General for a Hearing

When the Recovery Management Contractor is notified that the individual will have legal representation, the Recovery Management Contractor must request an Assistant Attorney General to represent the Recovery Management Contractor at the hearing. However, the Attorney

General's office will provide an Assistant Attorney General *only* if the Recovery Management Contractor can confirm that the appellant has legal representation.

- All requests for Attorney General representation must be made as directed by ODM. If the request is received fewer than 24 hours before the hearing is scheduled, but at least 30 minutes before the hearing, the Recovery Management Contractor can e-mail a request for an Assistant Attorney General to attend the hearing. An Assistant Attorney General cannot be requested with a phone call.
- The Recovery Management Contractor will be notified of the name of the Assistant Attorney General assigned to the hearing.
- If the Assistant Attorney General is requested fewer than 30 minutes prior to the start of a hearing, or if the request for an Assistant Attorney General is denied or otherwise cannot be fulfilled, the Recovery Management Contractor must proceed without Assistant Attorney General Representation.

Hearings Process

- If an Assistant Attorney General is attending the hearing, ODM or the Recovery Management Contractor, depending upon who is leading the hearing, must forward all documents pertaining to the hearing to the assigned Assistant Attorney General. If a hearing has been canceled, ODM or the Recovery Management Contractor, as appropriate, must notify the Attorney General's office by e-mail as soon as it learns of the cancellation.
- If an appellant appears at the hearing with legal representation without advance notice and their legal representation admits new written information or presents testimony not previously seen or heard by ODM, the Recovery Management Contractor or the Assistant Attorney General, and the preceding parties need time to review and consider the new information, they can request that the hearing be reconvened or the record left open for the submission of additional documentation. State hearing officers will make the final ruling on whether the hearing will be reconvened or the record left open.
- If an appellant has no legal representation and submits new evidence or documentation not previously reviewed or considered, ODM or the Recovery Management Contractor may request that the hearing officer reconvene the hearing or leave the record open to allow them to review and respond to the new evidence or documentation.
- If an appellant has requested a state hearing within 15 days of the Recovery Management Contractor having issued an adverse notice containing hearing rights, the Recovery Management Contractor must continue the appellant's services at his or her current level until the outcome of the state hearing. When the hearing decision is rendered, the Recovery Management Contractor must follow the decision as directed and submit a compliance form to the Bureau of State Hearings validating compliance.
- When ODM receives a hearing decision, the decision will be forwarded to the Recovery Management Contractor. The Recovery Management Contractor is responsible for reading the hearing decision and adhering to the compliance ordered in the decision. The Recovery Management Contractor must complete the State Hearing Compliance Form #4068 and provide a complete description of the compliance action, including the exact dates the action occurred. The Recovery Management Contractor must submit the completed State

Hearing Compliance Form to the ODM designee. All compliance, in accordance with rule 5101:6-7-03 of the Ohio Administrative Code, must be achieved within 15 calendar days of the decision and no later than 90 days from the date of the hearing request. ODM will review the compliance and, if accepted, forward it to the Bureau of State Hearings. If not accepted, the compliance will be returned to the Recovery Management Contractor for further action.

- If the appellant disagrees with the state hearing decision, he or she may make a written request for an administrative appeal to the Ohio Department of Job and Family Services, Bureau of State Hearings, PO Box 182825, Columbus OH 43218-2825 or fax (614) 728-0874. Their written request must be received by the Bureau of State Hearings within 15 calendar days of the date the hearing decision was issued.
- During the administrative appeal process, the Recovery Management Contractor must proceed with enacting the state hearing decision *unless* instructed by the Bureau of State Hearings to do otherwise.

Complaint Process

The Specialized Recovery Services (SRS) program enrolled individuals, service providers, family members, individual advocates, or others involved in the care of the individual have the right to make complaints to, or about, the Recovery Management Contractor. Complaints can be made to the Recovery Management Contractor, Provider Oversight Contractor, or to the Ohio Department of Medicaid (ODM) and they can originate from a face-to-face conversation, phone call, fax, e-mail, ODM constituent inquiry, or regular mail.

The Recovery Management Contractor must maintain records of all complaints. If the Recovery Management Contractor receives a complaint about a provider, the complaint must be forwarded to the Provider Oversight Contractor. The Recovery Management Contractor must use the following protocol for complaints:

1. Categorize complaints, reference a department, and determine a resolution type.
2. Send a complaint acknowledgment letter to the complainant within one business day of the complaint. A copy of this letter must be sent to the ODM contract manager.
3. Investigate all complaints within three business days of the date of receiving the complaint and maintain a record of all investigatory notes.
4. Submit an action plan to the ODM contract manager via e-mail within seven days of receiving the complaint.
5. Address and attempt to resolve all complaints within 15 calendar days and record the resolution.
6. The Recovery Management Contractor must send a follow-up letter to each complainant to confirm that resolution has taken place. A copy of this letter must be sent to the ODM contract manager.

7. If a complainant indicates to ODM that a satisfactory resolution was not obtained, and ODM agrees, the complaint will be re-opened and returned to the Recovery Management Contractor for further investigation (Step 3) and to proceed through the complaint process again.

Access to ODM Information Management Systems

In order to fulfill Recovery Management functions, the Recovery Management Contractor must have access to state data systems, which requires it to implement a secure **virtual private network connection**. This must be done in cooperation with Ohio Department of Medicaid (ODM).

ODM will provide the Recovery Management Contractor access to three ODM data systems:

1. Medicaid Information Technology System (MITS), which is the Ohio Department of Medicaid database that contains Medicaid information.
2. Client Registry Information System - Enhanced (CRIS-E) or Ohio Benefits, which is the statewide eligibility system Emergency Response Plan used by Ohio Department of Medicaid and county departments of job and family services
3. The Ohio Department of Medicaid approved Recovery Management system.

The Recovery Management Contractor must request individual Recovery Management Contractor staff access through ODM by submitting the appropriate access request documentation. The request is made by completing a *Code of Responsibility Form* (Ohio Department of Medicaid #07078), which can be requested by e-mail to BHCP@medicaid.ohio.gov with a copy sent to the ODM contract manager(s). Completed forms must be submitted to the same e-mail address.

Terminating a User's Access

The Recovery Management Contractor must request termination of the Ohio Department of Medicaid system access within **one** business day of the last date of employment for any user with access to any Ohio Department of Medicaid system. Requests for terminations may be made in advance. E-mail termination requests to BHCP@medicaid.ohio.gov.

Appendix A: Code Sheet

Specialized Recovery Services (SRS) program Denial and Disenrollment Codes and Descriptions

11500 - Over Resources
11600 - Over Income
13600 - Customer Option - Declining SPMI Program Eligibility
13700 - Failed SPMI Program Age Criteria
13800 - Does not meet SPMI Clinical Needs and Assessment

Appendix B: Ohio Administrative Code Rules

- 5160-43-01 "Specialized Recovery Services Program Definitions."
- 5160-43-02 "Specialized Recovery Services Program Individual Eligibility and Program Enrollment."
- 5160-43-03 "Specialized Recovery Services Program Individual Rights and Responsibilities."
- 5160-43-04 "Specialized Recovery Services Program Covered Services and Provider Requirements."
- 5160-43-05 "Specialized Recovery Services Program Provider Conditions of Participation."
- 5160-43-06 "Specialized Recovery Services Program Incident Management System."
- 5160-43-07 "Specialized Recovery Services Program Compliance: Provider Monitoring, Oversight, Structural Reviews and Investigations."
- 5160-43-08 "Specialized Recovery Services Program Billing Procedures and Payment Rates for Recovery Management."
- 5160-43-09 "Specialized Recovery Services Program Criminal Records Checks for Providers."
- 5160-44-01 "Nursing facility-based level of care home and community-based services programs: home and community-based settings."
- 5160-44-02 "Nursing facility-based level of care home and community-based services programs: person-centered planning."
- 5160-58-05.3 "MyCare Ohio waiver and 1915(i) Specialized Recovery Services Program members: incident management system."

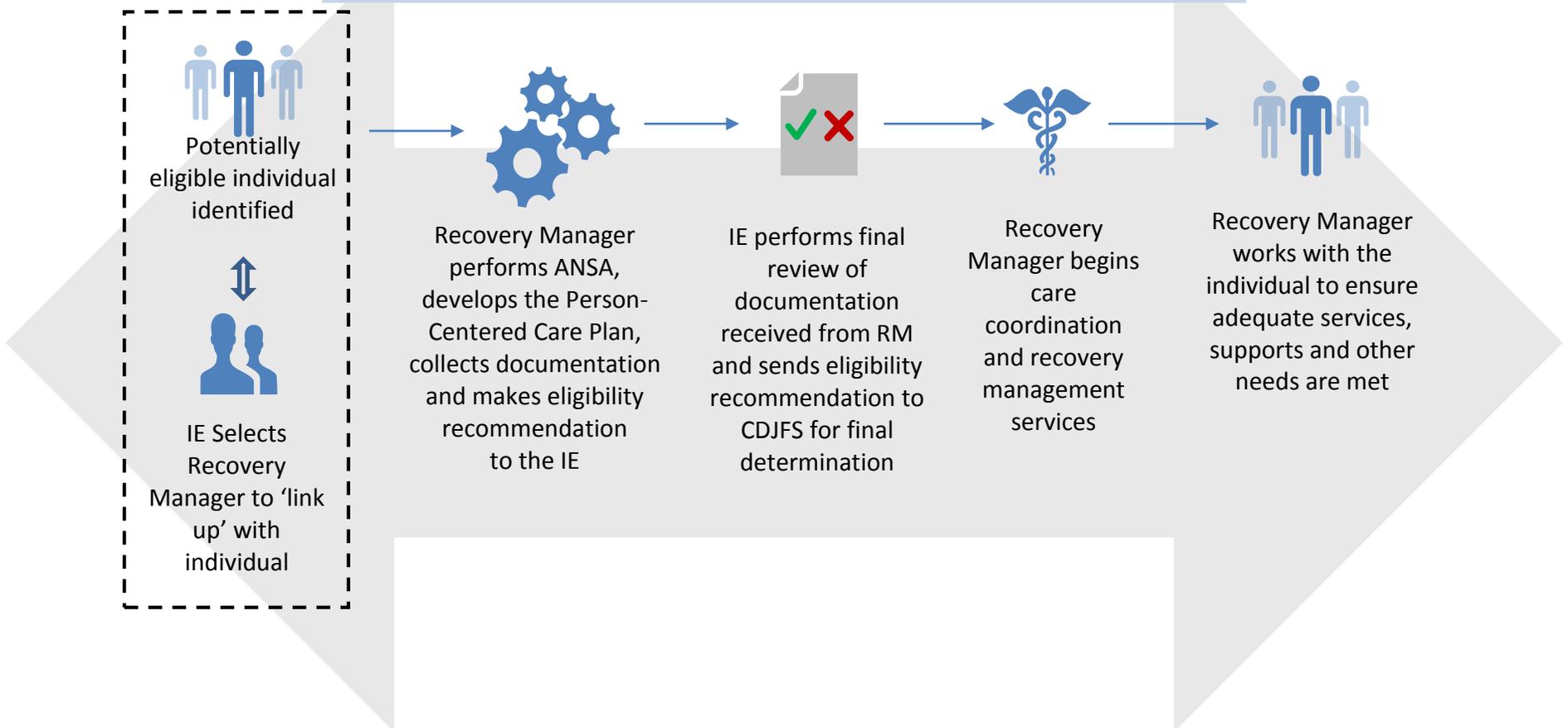
TN: 15-014
Supersedes:
TN: New

Approved: _____

Effective: 07/01/2016

Appendix C: Care Coordination Flow

♥ Ongoing Behavioral and Physical Health Care Coordination ♥



Ohio Department of Medicaid

TN: 15-014
 Supersedes:
 TN: New

Approved: _____

Effective: 07/01/2016

Home and Community-Based Services (HCBS) Setting Verification Checklist

Section I: Qualities Required for All Home and Community-Based Settings

Complete this section for each individual, regardless of his or her current living arrangement.

The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community.		
<p>1. Does the individual reside in a setting that he or she owns or leases or is owned or leased by a member of the individual's family? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, do not complete Section II.</p>	<p>2. Does the individual reside in a setting that is owned or leased by the same party that furnishes HCBS services in the setting? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, complete Section II.</p>	<p>3. Is the individual able to describe how he or she accesses the community, including who assists in facilitating the activity and where he or she goes? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting.		
<p>4. Was the individual given a choice of available options regarding where to live/receive services? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
The setting ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.		
<p>5. Does the individual have access to telephones or other electronic devices to use for personal communication in private and at any time? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>6. Does the individual know how to file a complaint about his or her level of involvement with the greater community? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>7. Does the individual report the use of interventions/restrictions like those that might be used in an institutional setting (seclusion, physical or chemical restraints, locked doors)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
The setting optimizes opportunities for individuals to make choices and control his or her own schedules regarding daily activities, physical environment, and with whom to interact.		
<p>8. Does the individual have opportunities to make informed choices about when tasks, services and activities are furnished? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
The setting facilitates choice regarding services and supports and who provides them.		
<p>9. Does the individual make informed choices about who provides services to him or her? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		

Section II: Additional Conditions Required for Provider Owned or Controlled Residential Settings

Complete this section only when the individual resides in a setting that is owned or leased by the same party that furnishes HCBS services in that setting.

The individual has a legally enforceable agreement specifying responsibilities and protections from eviction.			
10. Does the individual have a legally enforceable agreement such as a lease or resident agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No	11. Does the agreement specify the responsibilities of the individual and the provider with respect to the setting? <input type="checkbox"/> Yes <input type="checkbox"/> No	12. Does the agreement specify the circumstances under which the individual's residency may be terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No	13. Does the agreement address the steps an individual can follow to request a review or appeal the termination of residency? <input type="checkbox"/> Yes <input type="checkbox"/> No
The individual has privacy in his or her sleeping/living unit.			
14. Is the individual's living unit configured so that the individual's privacy is protected including when assistance is provided to the individual? <input type="checkbox"/> Yes <input type="checkbox"/> No			
The setting provides living unit doors that are lockable by the individual with only appropriate staff having keys.			
15. Can the individual lock his or her door to the unit? <input type="checkbox"/> Yes <input type="checkbox"/> No	16. Does the individual have a key to his or her own living unit? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Individuals sharing units have a choice of roommates in the setting.			
17. If the individual does not have his or her own bedroom, does the individual share a bedroom with a roommate of his or her choice? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Individuals have the freedom and support to furnish and decorate their sleeping or living units within the lease or other agreement			
18. Can the individual furnish and decorate his or her unit as they please within the terms spelled out in in the legally enforceable? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Individuals' freedom to control schedules and activities and have access to food at any time.			
19. Does the individual control his or her daily schedule without being required to adhere to a set schedule for	20. Does the individual have access to typical home areas such as cooking and dining areas, laundry, living and entertainment areas? <input type="checkbox"/> Yes <input type="checkbox"/> No	21. Does the individual have access to food between and after regularly scheduled meal times? <input type="checkbox"/> Yes <input type="checkbox"/> No	

TN: 15-014

Supersedes:

TN: New

Approved: _____

Effective: 07/01/2016

waking, bathing, eating, exercising, or activities? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Individuals are able to have visitors of his or her choosing at any time.		
22. Are visiting hours or the number of visitors allowed at one time determined by the individual? <input type="checkbox"/> Yes <input type="checkbox"/> No	23. If visiting hours are addressed in the legally enforced agreement, are individuals made aware of limitations before moving into the residential setting? <input type="checkbox"/> Yes <input type="checkbox"/> No	
The setting is physically accessible for each individual.		
24. Are supports to facilitate mobility provided where needed, e.g., home modifications, grab bars, shower seats, or hand rails, etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No	25. Are there gates, locked doors, or other barriers preventing access/exit from areas in the setting? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Results (Select one result from the options listed below)

HCBS Setting

- The individual resides in a private residence and experiences community integration, privacy, choice, and control. (“Yes” response to question 1, and “Yes” responses to questions 3 through 8 in section 1). OR
- The individual resides in a provider-owned/controlled setting and experiences community integration, privacy, choice and control (“Yes” response for questions 2 through 8 in section 1 and “Yes” responses to questions 10 through 25 in Section 2)

Non-HCBS Setting

- The individual resides in a private residence and does not experience community integration, privacy, choice, and control in the setting. (“Yes” response to question 1 and one or more “No” response to questions 3 through 8 in section 1) OR
- The individual resides in a provider-owned/controlled setting and does not experience community integration, privacy, choice, and control in the setting. (“Yes” response to question 2 in Section 1 and one or more “No” responses to questions 10 through 25 in Section 2.

Date Completed _____

Name of Individual Interviewed _____

Signature of the Person Completing the Form _____

ATTACHMENT C
THE OHIO DEPARTMENT OF MEDICAID
THE BUREAU OF LONG-TERM CARE SERVICES & SUPPORT
QUALITY MANAGEMENT PLAN
REQUIREMENTS FOR THE
RECOVERY MANAGEMENT CONTRACTOR

(C) Contractor Requirements for HCBS Program Assurance II

(1) The Contractor is expected to monitor to ensure newly enrolled individuals are receiving HCBS program services timely requirements outlined in this contract. At least quarterly, the Ohio Department of Medicaid will evaluate the Contractor based on the performance measure listed below.

The number and percentage of approved individuals receiving HCBS program services timely from the eligibility determination date **(Standard is 95%)**.

(2) The Contractor is expected to monitor its performance to ensure adherence to the contact and visit requirements outlined in this contract. At least quarterly, the Ohio Department of Medicaid will evaluate the Contractor based on the performance measures listed below. The compliance standard for all measures is 95%:

- (a) Per the outlined acuity level standards in this contract, the number and percentage of contacts with individuals that are completed timely, including:
 - (i) Individuals with Level Two acuity enrolled for more than six months.
- (b) Per the outlined acuity level standards in this contract, the number and percentage of visits with individuals that are completed timely, including:
 - (i) Individuals with Level Two acuity enrolled for more than six months.
- (c)
 - (i) The individual's eligibility determination for the program.

(3) The Contractor is expected to monitor its performance to ensure that individuals enrolled in the program are receiving safe, effective, and adequate care. At least annually, the Ohio Department of Medicaid will evaluate the Contractor based on the performance measures listed below. The compliance standard for these measures is 95%.

- (a) The number and percentage of approved individuals receiving HCBS program services safely;
- (b) The number and percentage of approved individuals receiving HCBS program services effectively; and
- (c) The number and percentage of approved individuals receiving HCBS program services adequately.

(4) The Contractor is expected to monitor its performance to ensure all of the HCBS program individuals' needs are identified in their individual Person-Centered Care Plan. At least annually, the Ohio Department of Medicaid will evaluate the Contractor based on the performance measure listed below. The number and percentage of approved Person-Centered Care Plans that address all needs of the individual enrolled in the program **(Standard is 100%)**.

(5) The Contractor is expected to monitor its performance to ensure HCBS program individuals' Person-Centered Care Plans are reviewed at least during each visit and revised as appropriate per the standards of this contract, as well as fully revised annually. At least annually, the Ohio Department of Medicaid will evaluate the Contractor based on the performance measures listed below. The compliance standard for these measures is outlined below.

- (a) The number and percentage of approved Person-Centered Care Plans that are reviewed during each visit **(Standard is 95%)**;
- (b) The number and percentage of approved Person-Centered Care Plans that are revised when appropriate per the standards of this contract **(Standard is 100%)**; and
- (c) The number and percentage of approved Person-Centered Care Plans that are revised annually **(Standard is 100%)**.

(6) The Contractor is expected to monitor its performance to ensure that HCBS program individuals are receiving services in the type, amount, frequency, and duration as specified in their Person-Centered Care Plan. At least annually, the Ohio Department of Medicaid will evaluate the Contractor based on the performance measures listed below. The compliance standard for these measures is outlined below.

- (a) The number and percentage of individuals receiving services in the type as specified in the Person-Centered Care Plan **(Standard is 100%)**;
- (b) The number and percentage of individuals receiving services in the amount as specified in the Person-Centered Care Plan **(Standard is 95%)**;
- (c) The number and percentage of individuals receiving services in the scope as specified in the Person-Centered Care Plan **(Standard is 100%)**;
- (d) The number and percentage of individuals receiving services in the duration as specified in the Person-Centered Care Plan **(Standard is 95%)**;

(7) The Contractor is expected to monitor its performance to ensure that HCBS program individuals are made aware that they can choose their providers. At least annually, the Ohio Department of Medicaid will evaluate the Contractor based on the performance measure listed below. The compliance standard for this measure is outlined below. The number and percentage of individuals enrolled in the program for

whom there is evidence that the Contractor provided information to make the individual aware that he/she can choose his/her providers **(Standard is 100%)**.

(8) The Contractor is expected to monitor its performance to ensure that HCBS program individuals have input regarding the services they are receiving. At least annually, the Ohio Department of Medicaid will evaluate the Contractor based on the performance measure listed below. The compliance standard for this measure is outlined below. The number and percentage of individuals enrolled in the program for whom there is evidence that the individuals had input regarding the services they are receiving **(Standard is 100%)**.

(9) The Contractor must develop and monitor service delivery to ensure implementation of due process policies, procedures and activities in accordance with the Ohio Administrative Code. At least quarterly, the Ohio Department of Medicaid will evaluate the Contractor based on the performance measures listed below. The compliance standards for these measures are outlined below.

- (a) The number and percentage of HCBS program individuals who were informed of the right to a state hearing, including evaluation of the appealable event;
- (b) The number and percentage of HCBS program individuals who requested a state hearing;
- (c) The number and percentage of HCBS program individuals who had a hearing held;
- (d) The number and percentage of hearings where the individual's appeal was overruled **(Standard is 95%)**; and
- (e) The number of hearings where the individual's appeal was sustained **(Standard for sustained hearings is less than 5%)**.

NOTE: As part of the State's ongoing monitoring of the HCBS program and the Contractor, the State will periodically review the Contractor's compliance with the above requirements.

(D) Contractor Requirements for HCBS Program Assurance III

(1) With guidance from the Ohio Department of Medicaid, the Contractor shall monitor provider availability and report the results of the monitoring to the Ohio Department of Medicaid. The monitoring shall be by region and by HCBS program and include, at a minimum, potential provider availability issues due to location, potential provider availability issues related to the multi-lingual needs of a particular community, and potential provider availability issues related to the need for a particular specialty in a community.

Monthly Reporting Requirement: The Contractor shall report its monitoring of potential provider availability issues to the Ohio Department of Medicaid, or immediately if the situation merits immediate action.

(E) Contractor Requirements for HCBS Program Assurance IV

(1) The Contractor shall monitor to ensure proper identification of instances of any incident involving HCBS program individuals, as well as address and seek to prevent instances of abuse, neglect and exploitation of HCBS program individuals. At least monthly, the Ohio Department of Medicaid will evaluate the Contractor based on the performance measures and standards listed below.

TN: 15-014

Supersedes:

TN: New

Approved: _____

Effective: 07/01/2016

- (a) The number and percentage of incidents reported timely (**Standard is 100%**);
- (b) The number and percentage of incident alerts reported timely (**Standard is 100%**);
- (c) The number and percentage of incident prevention plans developed timely (**Standard is 95%**); and
- (d) The number and percentage of incident prevention plans integrated into the Person-Centered CarePlan timely (**Standard is 95%**).

(2) The Contractor must review each implemented “Acknowledgement of Responsibility” on an ongoing basis.

Quarterly Reporting Requirement: - Contractor will report all “Acknowledgement of Responsibility” agreements that have been initiated and are in place each quarter. All active “Acknowledgement of Responsibility” agreements must be categorized as to the issues that were addressed with individuals and listed in the report, as well as revisions to the plans based on success or lack of success with the outlined action steps.

(3) The Contractor is expected to monitor to ensure that all incidents of unauthorized use of restraints and/or seclusion and restrictive interventions with HCBS program individuals are reported and addressed. At least quarterly, the Ohio Department of Medicaid will monitor the following:

- (a) Number of reported incidents of unauthorized use of restraints and/or seclusion.
- (b) Number of reported incidents of unauthorized use of restrictive interventions.
- (c) Number of individuals with approved Person-Centered Care Plans using restraint, seclusion, or restrictive interventions;
- (d) Of those individuals with approved Person-Centered Care Plans using restraint, seclusion, or restrictive interventions, the number with approved restraints (mechanical, chemical, and physical), the number with approved seclusion, and the number with approved restrictive interventions.

(4) The Contractor must submit and receive approval by the Ohio Department of Medicaid for updates on its detailed Emergency Response Plan for natural disasters and other public emergencies (e.g., floods, extreme heat, extreme cold, etc.) on a quarterly basis. Coordination with other appropriate systems is recommended (e.g., American Red Cross, Area Agencies on Aging, etc.).

Quarterly Reporting Requirement: The Contractor must report when and where the Emergency Response Plan was activated, whether the plan was effective, and if not, what improvement activities are needed. The Ohio Department of Medicaid will monitor adherence to the approved Emergency Response Plan on an ongoing basis.

Quarterly Reporting Requirement: The Contractor must summarize the data above in the quarterly management report, noting any patterns and/or trends and any actions taken to prevent future noncompliance.

(F) Contractor requirements for HCBS Program Assurance V

TN: 15-014

Supersedes:

TN: New

Approved: _____

Effective: 07/01/2016

(1) The State must demonstrate to the Centers for Medicare and Medicaid Services that it retains administrative authority over the HCBS program and that its administration of the HCBS program is consistent with its approved HCBS state plan amendment. In furtherance of this assurance, the Contractor must complete semi-annual clinical practice reviews of individuals' charts according to the following schedule: 100% of the charts of new Recovery Manager's during their first six months of employment; 100% of the charts of each Recovery Manager who has been identified as having performance issues; for all other Recovery Managers, a sample of the total census as identified and recorded within Ohio Department of Medicaid-approved Recovery Management system. The expected requirement for standard met is 90%

The reviews of the charts must include at a minimum the following:

- (a) Verification that the documentation supports program eligibility.
- (b) If there was a guardianship, evidence that the guardianship was verified and documented. The guardianship may be verified either by the Recovery Manager indicating the guardianship papers were viewed, or by a copy of the guardianship papers in the chart, or a notation that guardianship was verified with the probate court, either by phone or online.
- (c) Verification that the charts contained the form signed by the individual indicating the individual's choice to receive community-based long-term care instead of facility-based long-term care.
- (d) Verification that the assessment tool was complete.
- (e) Verification that the correct billing procedure codes were identified on the Person-Centered Care Plan.
- (f) If the individual needs assistance with medication administration, verification that the name of the person responsible for providing the assistance is identified on the assessment tool and in the Person-Centered Care Plan.
- (g) Documentation that individual was informed of right to free choice of eligible providers.
- (h) Verification that all paid and unpaid supports are identified on the Person-Centered Care Plan.
- (i) Verification of documentation in the chart of inter-disciplinary team meetings.
- (j) Verification that the Person-Centered Care Plan is complete, including identification of goals, objectives and methods to achieve the goals
- (k) Verification that the Person-Centered Care Plan goals, objectives, and methods are clearly supported by clinical documentation.
- (l) Verification that all needs identified in the assessment are addressed in the Person-Centered Care Plan or documented elsewhere as appropriate.
- (m) Verification that the services are being delivered according to the individual's goals and objectives as described in the Person-Centered Care Plan.
- (n) Verification that the Recovery Manager is applying sound clinical judgment in the performance of the Recovery Management duties.
- (o) Verification that any known or perceived risks and/or safety considerations that could impact individual's health and welfare are identified and addressed in the Person-Centered Care Plan and/or other clinical documentation.
- (p) Verification that the Recovery Manager made changes to the Person-Centered Care Plan as individual's needs change.
- (q) Verification that any follow up on identified issues and/or concerns is documented.
- (r) Verification that clinical documentation is complete and follows general practice standards.
- (s) Verification that all incidents have been reported as required.

Semi-Annual Reporting Requirement: Results of these reviews must be reported at the following quarterly briefings.

(2) The Contractor must develop and ensure implementation of a process pursuant to the directions in the Recovery Management Guide for the resolution of complaints by individuals, providers and stakeholders. At least quarterly, the Ohio Department of Medicaid will evaluate the Contractor based on the performance measures listed below. The compliance standards for these measures are outlined below.

- (a) The number of complaints received in each complaint category.
- (b) The number of complaints for which the investigations were not started within three business days, and provide the reason for noncompliance (**Standard is 100%**).
- (c) The number of complaints that were not resolved within 15 calendar days, and provide the reason for noncompliance (**Standard is 95%**).

(3) The Contractor must send its current staff roster and supervisory assignments, by region, to the Ohio Department of Medicaid contract manager on the first business day of the month.

(4) The Contractor must demonstrate that it conducts regularly scheduled meetings with individuals, individual supports, and other stakeholders. The meetings shall address, if appropriate, the following:

- (a) Quality committees, which include individuals, individuals' supports and other stakeholders.

Quarterly Reporting Requirement: A description of the meetings must be contained in the Quarterly Management Report.

(G) Contractor requirements for HCBS Program Assurance VI

(1) The Contractor must demonstrate that it has designed and implemented an adequate system for assuring financial accountability of the HCBS program.

- (a) The Contractor must promptly and accurately enter individual information into the eligibility and service payment systems.
- (b) The Contractor must cooperate with the Ohio Department of Medicaid program integrity activities (e.g., Unit of Service Verification reviews, financial services and the Ohio Attorney General's Medicaid Fraud Control Unit).
- (c) The Contractor shall collaborate with the Ohio Department of Medicaid's efforts to manage cost growth in the HCBS programs. The Contractor shall analyze data from the Ohio Department of Medicaid's quarterly individual-specific and provider reports of incurred costs of program services and use it to manage cost growth in the HCBS programs.

Quarterly Reporting Requirement: The Contractor must describe how it is managing cost growth in the HCBS programs.

(H) Monitoring of the Recovery Management Contractor:

(1) Ongoing Program Review – The Ohio Department of Medicaid conducts an ongoing review process that relies on a universal survey instrument that can be applied to all home and community-based services Medicaid programs. These reviews are intended to generate performance data related to the six core HCBS program assurances, as well as data related to individual free choice of provider and individual satisfaction.

The Ohio Department of Medicaid intends to conduct annual reviews of each HCBS program, which will include face-to-face interviews with individuals and record reviews, with approximately 150 randomly selected individuals on each HCBS program. Samples of this size will produce findings that can be reported with a 95% confidence level within a margin of error of +/-8%.

Data compiled from these reviews will be discussed with the Contractor at a semi-annual quality briefing.

(2) Targeted Reviews – The Ohio Department of Medicaid may at any time conduct specific targeted reviews of the Contractor for any purpose, including without limitation for the purpose of assuring health and welfare and/or reviews of individual deaths, and the Contractor will cooperate with any request made by the Ohio Department of Medicaid.

(3) Notice of Adverse Outcomes – If the ongoing or targeted review by the Ohio Department of Medicaid identifies Contractor deficiencies, the Ohio Department of Medicaid staff will follow the Office's adverse outcome protocol. As part of the protocol, the Ohio Department of Medicaid will communicate any adverse findings to the Contractor and require immediate action and/or a plan of correction. The Contractor shall submit a plan of correction within the required timeframes. If the Ohio Department of Medicaid approves the plan of correction, the Contractor shall implement the plan of correction immediately see Attachment Ten – Recovery Management Guide

(4) Monitoring of Alerts Process – The Ohio Department of Medicaid monitors incidents as part of the alerts process to ensure that investigation and remediation are timely and effective. Incidents requiring an alert are defined in Attachment Ten – Recovery Management Guide.

(5) Review of Monthly and Quarterly Reports – After the Ohio Department of Medicaid reviews reports, the Ohio Department of Medicaid will follow-up with the Contractor as needed.

(6) Semi-Annual Quality Briefings – The Contractor must participate with the Ohio Department of Medicaid in semi-annual quality briefings. These briefings serve as the forum for the Ohio Department of Medicaid and the Contractor to share and review performance data which has been collected by either party. This performance data may include performance metrics, results of any reviews, information on any compliance or performance issues or concerns, along with actions taken to remedy those issues or concerns, and whether those actions were effective.

(7) Quarterly Multi-Agency Quality Forums – The Contractor shall participate in the Quarterly Multi-Agency Quality Forums convened by the Ohio Department of Medicaid. The forum is attended by multiple agencies and contractors involved in home and community-based services programs and the group is referred to as the Quality Steering Committee (QSC). The committee collects, compiles, and reports aggregate HCBS program-specific performance data. The committee uses this data, and conducts additional analysis, as a means to assess and

TN: 15-014

Supersedes:

TN: New

Approved: _____

Effective: 07/01/2016

compare performance across Ohio’s Medicaid HCBS program systems, to identify cross-program structural weaknesses, to support collaborative efforts to improve HCBS program systems, and to help move Ohio toward a more unified quality management system. The Ohio Department of Medicaid uses this forum to monitor and oversee the Contractor.

(8) Annual Contractor Review – The Ohio Department of Medicaid will conduct an annual review of the Contractor in order to ensure compliance with all contract terms. The annual review includes desk reviews and an on-site visit.

The Ohio Department of Medicaid will issue an annual review report and the Contractor will be required to develop and submit a plan of correction related to all identified deficiencies. The Ohio Department of Medicaid will continue to monitor the Contractor’s compliance with that plan of correction.

(9) Notice of Noncompliance and Plans of Correction – Pursuant to Rule 5160-43-07 of the Ohio Administrative Code, the Ohio Department of Medicaid will identify operational deficiencies and will issue all notices of noncompliance in writing to the Contractor. The notice of noncompliance will require the Contractor to develop and submit a Plan of Correction. In addition to the requirement of a Plan of Correction from the Contractor, actual and liquidated damages will be assessed, and other remedial actions permitted under the Contract may be taken, when appropriate as determined by the Ohio Department of Medicaid, in coordination with the Department of Administrative Services.

(I) Ohio Department of Medicaid Initiated Plan of Corrections

A Plan of Correction (POC) is a structured activity, process or quality improvement initiative implemented by the Contractor to improve identified operational and clinical quality deficiencies, or to otherwise address identified areas of noncompliance with this Contract, with program rules and/or with HCBS program requirements. It is the expectation that POCs are to be implemented immediately after the Ohio Department of Medicaid has reviewed and approved the plan.

Below is the State’s quality improvement strategy:

Discovery Activities					Remediation	
Requirement	Discovery Evidence <i>(Performance Measures)</i>	Discovery Activity <i>(Source of Data & sample size)</i>	Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	Frequency	Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	Frequency of Analysis and Aggregation
Person-Centered Plans address assessed needs of SRS program participants, are updated annually, and document choice of services and providers.	<p>Sub-assurance: <i>Person-Centered Plans address all members' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.</i></p> <p>1. Number and percent of participants reviewed whose service plans adequately address their assessed needs. Numerator: Number of participants whose service plans adequately address their assessed needs, including health and safety risk factors, and personal goals. Denominator: Total number of participants reviewed</p>	1. Record review based on a representative sample with 95% confidence level and margin of error of +/- 5%.	1. The state or its designee conducts the review.	1. Quarterly	1. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.	1. Annually Field Reviewers
		2. Record review	2. The state or its	2. Quarterly		

TN: 15-014
 Supersedes:
 TN: New

Approved: _____

Effective: 07/01/2016

	<p>participants reviewed whose service plans have strategies to address and mitigate their health and welfare risk factors.</p> <p>a. Numerator: Number of participants whose service plans adequately address their health and welfare risk factors.</p> <p>b. Denominator: Total number of participants reviewed</p> <p>3. Number and percent of service plans reviewed that address individuals' personal goals.</p> <p>a. Numerator: The number of service plans reviewed that address individuals' personal goals.</p> <p>b. Denominator: Total number of service plans reviewed</p> <p>Sub-assurance: <i>Person-Centered Plans are updated/ revised at least annually or when warranted by changes in the SRS program participant's needs.</i></p> <p>4. Number and percent of participants whose service plans were</p>	<p>based on a representative sample with 95% confidence level and margin of error of +/- 5%.</p> <p>3. Record review based on a representative sample with 95% confidence level and margin of error of +/- 5%.</p> <p>4. IT system(s) or database where service plan data</p>	<p>designee conducts the review.</p> <p>3. The state or its designee conducts the review.</p> <p>4. The state or its designee conducts the</p>	<p>3. Quarterly</p> <p>4. Quarterly</p>	<p>designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p> <p>3. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p> <p>4. The state or its designee aggregates the data and produces</p>	<p>Field Reviewers</p> <p>3. Annually Field Reviewers</p> <p>4. Annually</p>
--	--	---	--	---	--	--

	<p>updated at least once in the last twelve months</p> <p>a. Numerator: Number of service plans reviewed that were updated at least annually</p> <p>b. Denominator: Total number of participants reviewed</p> <p>5. Number and percent of sampled SRS program participants whose service plans were revised, as needed, to address changing needs.</p> <p>a. Numerator: Number of service plans reviewed that were updated when the participant's needs changed</p> <p>b. Denominator: Total number of participants reviewed whose needs changed.</p> <p>Sub-assurance: <i>Services are delivered in accordance with the Person-Centered Plan, including the type, scope, amount, duration, and frequency specified in the Person-Centered Plan.</i></p> <p>6. Number and percent of</p>	<p>is stored. 100% review.</p> <p>5. Record review based on a representative sample with 95% confidence level and margin of error of +/- 5%.</p> <p>6. Record review</p>	<p>review.</p> <p>5. The state or its designee conducts the review.</p> <p>6. The state or its</p>	<p>5. Quarterly</p> <p>6. Quarterly</p>	<p>reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p> <p>5. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p> <p>6. The state or its</p>	<p>Field Reviewers</p> <p>5. Annually Field Reviewers</p>
--	--	--	--	---	--	---

	<p>participants reviewed who received services in the type, scope, amount, duration and frequency specified in the service plan.</p> <p>a. Numerator: Number of participants reviewed who received SRS program services in the type, scope, amount, duration and frequency specified in the service plan</p> <p>b. Denominator: Total number of participants reviewed</p> <p>Sub-assurance: <i>Participants are afforded choice between/among waiver services and providers.</i></p> <p>7. Number and percent of participants notified of their rights to choose among SRS program services and/or providers.</p> <p>a. Numerator: Number of participants notified of their rights to choose among SRS program services and/or providers</p> <p>b. Denominator: Total number of participants reviewed</p>	<p>based on a representative sample with 95% confidence level and margin of error of +/- 5%.</p> <p>7. Record review based on a representative sample with 95% confidence level and margin of error of +/- 5%.</p>	<p>designee conducts the review.</p> <p>7. The state or its designee conducts the review.</p>	<p>7. Quarterly</p>	<p>designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p> <p>7. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than</p>	<p>6. Annually Field Reviewers</p> <p>7. Annually Field Reviewers</p>
--	--	--	---	---------------------	--	---

					90 days.	
<p>The processes and instruments described in the approved Ohio SRS program SPA are applied appropriately and according to the approved description to determine for the individual if the needs-based criteria were met.</p>	<p>Sub-Assurance: An evaluation for needs-based criteria is provided to all applicants for whom there is reasonable indication that services may be needed in the future.</p> <p>8. Number and percent of new enrollees who had an evaluation indicating the individual met LON prior to receipt of services</p> <p>a. Numerator: Number of new enrollees who had an evaluation indicating the individual met LON prior to receipt of services</p> <p>Denominator: Total number new enrollees</p> <p>Sub-Assurance: The processes and instruments described in the approved State Plan are applied appropriately and according to the approved description to determine initial participant LON.</p>	<p>8. Record review, at the independent entity; Record review, based on a representative sample of eligibility packets with 95% confidence level and +/- 5% margin of error.</p>	<p>8. The state or its designee conducts the review.</p>	<p>8. Quarterly</p>	<p>8. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p>	<p>8. Quarterly ODM Report</p>
	<p>9. Number and percent of sampled initial LON</p>	<p>9. Record review, based on a</p>	<p>9. The state or its designee</p>	<p>9. Annually</p>	<p>9. The state or its designee aggregates</p>	<p>9. Annually</p>

	<p>determinations that were completed using the process required by the approved State Plan.</p> <p>a. Numerator: Number of sampled initial LON determinations reviewed that were completed using the process required by the approved State Plan</p> <p>b. Denominator: Total number of sampled initial LON determinations.</p> <p>10. Number and percent of sampled LON redeterminations for SRS program participants that were completed within 365 days of the previous LON determination.</p> <p>a. Numerator: Number of annual LON redeterminations that were completed within 365 days of the previous LON determination</p> <p>b. Denominator: Total number of reviewed LON re-determinations subject to a redetermination</p>	<p>representative sample of eligibility packets with 95% confidence level and +/- 5% margin of error.</p> <p>10. IT system(s) where redetermination records are maintained. Record review, based on a representative sample of eligibility packets with 95% confidence level and margin of error of +/- 5%.</p>	<p>conducts the review.</p> <p>10. The state or its designee conducts the review.</p>	<p>10. Monthly</p>	<p>the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p> <p>10. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p>	<p>Field Reviewers</p> <p>10. Annually Field Reviewers</p>
<p>Providers meet required qualifications.</p>	<p>Sub-Assurance: <i>The State verifies that providers initially and continually meet required participation standards and</i></p>					

	<p><i>minimum qualifications and adhere to other standards prior to their furnishing SRS program services.</i></p> <p>Sub-assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.</p> <p>11. Number and percent of new RMs, that meet provider enrollment requirements prior to providing services.</p> <p>a. Numerator: Number of sampled providers that met enrollment requirements prior to providing services.</p> <p>b. Denominator: Total number of sampled providers who were enrolled during the review period.</p> <p>12. Number and percent of existing RM providers that continue to meet certification requirements at the time of structural compliance review.</p> <p>a. Numerator: Number of existing RM providers that continue to meet requirements at the time</p>	<p>11. 100% record review.</p> <p>12. The state or its designee will review provider enrollment information. 100% review.</p>	<p>11. The state or its designee conducts the review.</p> <p>12. The state or its designee conduct the reviews.</p>	<p>11. Quarterly</p> <p>12. Quarterly</p>	<p>11. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p> <p>12. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity</p>	<p>11. Annually PCG</p> <p>12. Annually PCG</p>
--	---	---	---	---	---	---

	<p>of structural compliance review.</p> <p>b. Denominator: Number of existing RM providers who had a structural compliance review.</p> <p>13. Number and percent of new peer recovery supporters that meet provider enrollment requirements prior to providing services</p> <p>a. Numerator: Number of new providers that met enrollment requirements prior to providing services.</p> <p>b. Denominator: Total number of new providers who were enrolled during the review period.</p> <p>14. Number and percent of peer recovery supporters that continue to meet enrollment requirements at re-enrollment or review.</p> <p>a. Numerator: Number of providers that continue to meet enrollment requirements at re-enrollment or review.</p> <p>b. Denominator: Total number of providers due who received a structural</p>	<p>13. 100% review.</p> <p>14. The state or its designee will review provider enrollment information. 100% review.</p>	<p>13. The state or its designee conducts the review.</p> <p>14. The state or its designee conducts the review.</p>	<p>13. Quarterly</p> <p>14. Quarterly</p>	<p>and nature of specific problems discovered, but are no longer than 90 days.</p> <p>13. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p> <p>14. Ohio MHAS or designee aggregates and analyzes for ODM review.</p>	<p>13. Annually PCG</p> <p>14. Annually PCG</p>
--	--	--	---	---	--	---

	<p>review</p> <p>15. Number and percent of IPS-SE providers who meet provider enrollment requirements prior to providing services</p> <p>a. Numerator: Number of new providers that met provider enrollment requirements prior to providing services.</p> <p>b. Denominator: Total number of new providers who were enrolled during the review period</p> <p>16. Number and percent of IPS-SE providers that continue to meet enrollment requirements at the time of structural compliance review</p> <p>a. Numerator: Number of existing providers that continue to meet enrollment at the time of structural compliance review</p> <p>b. Denominator: Total number of providers who received a structural review</p>	<p>15. The state or its designee will review provider enrollment information. 100% review.</p> <p>16. The state or its designee will review provider enrollment information. 100% review.</p>	<p>15. The state or its designee conducts the review.</p> <p>16. The state or its designee collects and generates.</p>	<p>15. Quarterly</p> <p>16. Quarterly</p>	<p>15. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p> <p>16. ODM or designee aggregates and analyzes for ODM review.</p>	<p>15. Annually. PCG</p> <p>16. Annually. PCG</p>
<p>The SMA retains authority and responsibility for program</p>	<p>Sub-Assurance: <i>The SMA assures compliance with authority for program operation and oversight.</i></p>					

operations and oversight.	<p>17. Number and percent of provider structural reviews required that were completed within the required timeframe.</p> <p>a. Numerator: Number of structural compliance reviews due that were completed within required timeframes.</p> <p>b. Denominator: Number of structural compliance reviews due</p>	<p>17. The state or its designee will review; 100% review.</p>	<p>17. Independent entity under contract with the state or MCP collects and generates, and sends reports to the state.</p>	<p>17. Annually</p>	<p>17. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p>	17. PCG
	<p>18. The number and percent of qualified providers who continue to meet provider requirements at the time of their structural review.</p> <p>a. Numerator: Number of providers who continue to meet provider requirement at the time of their structural review.</p> <p>b. Denominator: Total number of providers who had a structural review.</p>	<p>18. IT system(s) or database. 100% review.</p>	<p>18. The state or its designee conducts the review.</p>	<p>18. Quarterly</p>	<p>18. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p>	
	<p>19. Number and percent of required reports submitted by the IE in a complete and timely manner</p> <p>a. Numerator: Number of required reports</p>	<p>19. Contracted Entity reports to ODM. 100% review.</p>	<p>19. The state monitors the Contracted Entity.</p>	<p>19. Quarterly</p>	<p>19. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance</p>	

	<p>submitted by the IE in a complete and timely manner.</p> <p>b. Denominator: Total number of the required reports</p> <p>20. Number and percent of findings of IE non-compliance that were remediated through an approved CAP or other method as required by the state.</p> <p>a. Numerator: Number of findings of non-compliance that were remediated by an approved CAP or other method</p> <p>b. Denominator: Number of findings of non-compliance</p>	<p>20. 100% review.</p>	<p>20. The state monitors the contractors' compliance.</p>	<p>20. Continuous as non-compliance is identified.</p>	<p>and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p> <p>20. The state or its designee aggregates the data and produces reports. ODM, with other state agencies, reviews performance and determines if remediation is necessary; timeframes for remediation vary based on the severity and nature of specific problems discovered, but are no longer than 90 days.</p>	
<p>The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i)</p>	<p>Sub-Assurance: <i>The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.</i></p> <p>21. Number and percent of claims verified through a</p>	<p>21. ODM's MMIS claims payment</p>	<p>21. ODM or its designee.</p>	<p>21. Semi-Annually</p>	<p>21. ODM</p>	<p>21. Annually</p>

<p>participants by qualified providers.</p>	<p>review of provider documentation to have paid in accordance with the individual's service plans.</p> <p>a. Numerator: Number of claims verified through a review of provider documentation to have paid in accordance with individuals' waiver service plans.</p> <p>b. Denominator: Total number of claims reviewed</p> <p>22. Total number of undocumented claims identified in performance measure 22 that had payment recouped.</p> <p>a. Numerator: Total number of claims sampled in performance measure 22 that had payment recouped.</p> <p>b. Denominator: Total number of undocumented claims identified in performance measure 22.</p>	<p>system, MITS. Claims verification audits and provider performance monitoring; 95% confidence level with a margin of error of +/- 5%</p> <p>22. MITS. Claims verification audits and provider performance monitoring' 95% confidence level with margin of error of +/- 5%.</p>	<p>22. ODM or its designee.</p>	<p>22. Semi-Annually</p>	<p>22. ODM</p>	<p>Data People</p> <p>22. Annually Data people</p>
<p>The State identifies, addresses and seeks to</p>	<p>Sub-Assurance: <i>The State demonstrates on an ongoing basis that it identifies, addresses, and seeks to</i></p>					

<p>prevent incidents of abuse, neglect, and exploitation, including the use of restraints.</p>	<p><i>prevent instances of abuse, neglect, exploitation, and unexplained death.</i></p> <p>23. Number and percent of Incident review/investigations that were initiated regarding reportable death, abuse, neglect, exploitation, misappropriation, and unapproved restraints as required by ODM.</p> <p>a. Numerator: Number of incident review/investigations involving reportable death, abuse, neglect, exploitations, misappropriation, and unapproved restraints for participants that were initiated as required by ODM</p> <p>b. Denominator: Number of incident reviews, including reportable death, abuse, neglect, exploitation, misappropriation, and unapproved restraints.</p> <p>24. Number and percent of incident reviews/investigations involving reportable</p>	<p>23. 100 % review.</p> <p>24. 100% review.</p>	<p>23. ODM or its designee conducts the review.</p> <p>24. ODM or its designee</p>	<p>23. Quarterly</p> <p>24. Quarterly</p>	<p>23. Contracted Incident Management Entity aggregates and analyzes for state review.</p> <p>24. Contracted Incident Management Entity aggregates and</p>	<p>23. quarterly ODM Report</p> <p>24. Quarterly</p>
--	--	--	--	---	--	--

	<p>death, abuse, neglect, exploitation, misappropriation of funds, and unapproved restraints for participants that were completed as required by ODM.</p> <p>a. Numerator: Number of incident reviews/investigations involving reportable death, abuse, neglect, misappropriation of funds, and unapproved restraints that were completed as specified as required by ODM.</p> <p>b. Denominator: Number of incident reviews/investigations involving reportable death, abuse, neglect, exploitation, misappropriation, and unapproved restraints.</p> <p>25. Number and percent incidents reviewed with an incident of abuse, neglect, exploitation, misappropriation, and unapproved restraints who had a plan of prevention/documentation of a plan, developed as a result of the incident.</p> <p>a. Numerator: Number of</p>	<p>25. Sample review. 95% confidence level with margin of error of +/- 5%.</p>	<p>conducts the review.</p> <p>25. ODM or its designee conducts the review.</p>	<p>25. Quarterly</p>	<p>analyzes for state review.</p> <p>25. Contracted Incident Management Entity aggregates and analyzes for state review.</p>	<p>25. Quarterly</p>
--	--	--	---	----------------------	--	----------------------

	<p>incidents reviewed with a plan of prevention/ documentation of a plan, developed as a result of the incident.</p> <p>b. Denominator: Total number of incident investigations in these categories.</p> <p>26. Number and percent of incidences of unapproved restraints, investigated as required by ODM.</p> <p>a. Numerator: Number of instances of unapproved restraints investigated as required by ODM.</p> <p>b. Denominator: Total number of instances of unapproved restraint</p> <p><i>Sub-Assurance: The State establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved SRS program SPA.</i></p> <p>27. Number and percent of SRS program participants who had an ambulatory or preventative visit</p> <p>a. Numerator: Number of</p>	<p>26. 100% review.</p> <p>27. Sample review. 90% confidence level with margin of error of +/- 5%.</p>	<p>26. ODM or its designee conducts the review.</p> <p>27. ODM or its designee conducts the review.</p>	<p>26. Quarterly</p> <p>27. Annually</p>	<p>26. Contracted Incident Management Entity aggregates and analyzes for state review.</p> <p>27. ODM</p>	<p>26. Quarterly ODM Report</p> <p>27. Annually Data People</p>
--	--	--	---	--	---	---

	<p>SRS program participants that were continuously eligible for Medicaid during the measurement year who had an ambulatory or preventative visit during the measurement year.</p> <p>b. Denominator: Number of SRS program participants who were continuously eligible for Medicaid during the measurement year.</p>					
<p>Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (a)(2).</p>	<p>28. Number/percent of HCBS settings meeting appropriate licensure or certification requirements.</p> <p>a. Numerator: Number of SRS program participant residences and HCBS provider settings that meet HCBS setting requirements</p> <p>b. Denominator: Total number of SRS program participant residences and HCBS provider settings</p>	<p>28. 100% review of individuals through recovery manager visits.</p>	<p>28. ODM or its designee conducts the review.</p>	<p>28. Annually</p>	<p>28. Independent Entities under contract with the state aggregates and analyzes for the state to review.</p>	<p>28. Annually</p>

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

Focus on reporting requirements and refining reports.			
Onsite reviews include documentation review and onsite interviews.	The independent entities and the State coordinates and conducts onsite review.	Annually.	Review of clinical operations (utilization management, quality management, care management) as well as fiscal reporting. Compliance issues will require the submission of a corrective action plan to the Independent Entities and the state for approval and ongoing monitoring.
Corrective action plans (CAPs).	Developed by the provider/contractor. Submitted to the independent entities, MCPs, and ODM or its designee for approval. ODM provides oversight and direction.	Areas for improvement will be monitored as per CAP and presented quarterly during quality management meetings.	Analysis of performance data book. Onsite review findings of program non-compliance follow-up.

The Contractor may be required to develop a POC for any instance of noncompliance. All POCs requiring ongoing activity on the part of a Contractor to ensure compliance with a program requirement shall remain in effect for the duration of the contract.

Where the Ohio Department of Medicaid has determined that a specific action must be implemented by the Contractor or if the Contractor has failed to submit an acceptable POC, the Ohio Department of Medicaid may require the Contractor to comply with an Ohio Department of Medicaid developed or "directed" POC.

(J) Liquidated damages

Pursuant to the monitoring set forth in Section (H) above, and as a result of any monitoring and oversight activities conducted in accordance with Rule 5160-43-07 of the Ohio Administrative Code, the Ohio Department of Medicaid will assess points for the Contractor's noncompliance with the Contract. Progressive liquidated damages will be determined based on the number of points accumulated at the time of the noncompliance being cited. Liquidated damages will be assessed when the number of accumulated points falls within the ranges specified below:

0 – 15 Points	=	POC + No assessed liquidated damages
16 – 25 Points	=	POC + Category assessed liquidated damages amount
26 – 50 Points	=	POC + Category assessed liquidated damages amount+\$2500
51 – 70 Points	=	POC + Category assessed liquidated damages amount+\$5000
71 – 100 Points	=	POC + Category assessed liquidated damages amount+\$7500
100+ Points	=	POC + Category assessed liquidated damages amount +\$10,000

On the effective date of the Contract, the Contractor shall begin with 0 points. Points will accumulate over a rolling 12-month schedule. Points more than 12 months old will expire. Liquidated damages, including those additional amounts listed above for accumulation of when the Contractor has accumulated 16 points or more (*i.e.*, "\$2500", "\$5000" and "\$7500"), shall be assessed for each instance of Contractor noncompliance irrespective of whether multiple instances of noncompliance arise out of a single event. As set forth in Section (K) below, the Ohio Department of Medicaid will notify DAS of the assessment of liquidated damages when the number of accumulated points reaches 26 or above.

Category One Noncompliance: The Ohio Department of Medicaid will assess three (3) points for any of the following examples of noncompliance (\$1,000.00)

- (a) A failure to timely provide an individual with their Person-Centered Care Plan and a copy of the individual handbook.
- (b) A failure to obtain the Ohio Department of Medicaid pre-approval of marketing materials and/or external forms or documents used in performance of the Contract.
- (c) A failure to timely submit a report, invoice, or plan of correction.
- (d) A failure to submit an annual audit to the Ohio Department of Medicaid.
- (e) A failure to use person-centered language.

TN: 15-014
Supersedes:
TN: New

Approved: _____
Effective: 07/01/2016

- (f) A failure to maintain normal working hours as required.
- (g) A failure to comply with HIPAA requirements regarding Protected Health Information, or laws or regulations governing the confidentiality and safeguarding of Medicaid recipient information resulting in minimal harm.
- (h) A first-time failure, or subsequent but nonconsecutive failure, to meet a Quality Management Plan Standard.
- (i) Any other deficiency that rises to the level of a Category One Noncompliance Issue, as determined by the Ohio Department of Medicaid.

Category Two Noncompliance: The Ohio Department of Medicaid will assess five (5) points for any of the following examples of noncompliance (\$1,000.00)

- (a) A failure to properly notify an individual of their right to a state hearing when the Contractor proposes to deny, reduce, suspend, or terminate a Medicaid-covered service.
- (b) A failure to comply with a state hearing and/or administrative appeal decision.
- (c) A failure to comply with the resolution of a complaint or adverse outcome.
- (d) A failure to coordinate an individual's care across all providers and transdisciplinary team members.
- (e) A failure to monitor an individual's care.
- (f) A failure to implement a plan of correction.
- (g) A failure to adequately assess an individual's needs.
- (h) A failure to authorize a provider on a Person-Centered Care Plan in compliance with the rules.
- (i) A failure to submit a prior authorization to the Ohio Department of Medicaid within the prescribed time frames, and resulting in delivery of unauthorized program services.
- (j) A failure to assist an individual in accessing needed services by providing linkage and referral.
- (k) A failure to assist an individual in accessing needed services by updating the Person-Centered Care Plan within the required timeframes as outlined in the Recovery Management Guide.
- (l) A failure to conduct required orientation trainings with staff and/or a failure to conduct required annual staff trainings.
- (m) A failure to adapt or accommodate communication methods to meet the needs of individuals.
- (n) A failure to follow the emergency disaster plan.

- (o) A failure to accommodate an individual's preferences regarding contacts or visits.
- (p) A failure to comply with HIPAA requirements regarding Protected Health Information, or laws or regulations governing the confidentiality and safeguarding of Medicaid recipient information resulting in material harm.
- (q) A failure to monitor/update an Acknowledgement of Responsibility on a monthly basis
- (r) A second consecutive failure to meet a Quality Management Plan Standard.
- (s) Any other deficiency that rises to the level of a Category Two Noncompliance Issue, as determined by the Ohio Department of Medicaid.

Category Three Noncompliance: The Ohio Department of Medicaid will assess ten (10) points for each of the following examples of noncompliance (\$1,500.00)

- (a) A failure to maintain the required staff or required staffing ratios.
- (b) A failure to remove a provider from an Person-Centered Care Plan and/or notify the individual when the Contractor is made aware that the individual's provider no longer has a provider agreement, or is inactive or otherwise ineligible to provide services.
- (c) A failure to report an incident in compliance with the rules.
- (d) A failure to implement the individual prevention plan that resulted from an incident.
- (e) A failure to develop a Person-Centered Care Plan that appropriately meets the assessed needs of an individual.
- (f) A failure to appropriately assess the acuity level of an individual.
- (g) A failure to follow the contact/visit schedule based on enrollment and the acuity level of individual.
- (h) A failure to cooperate with incident investigations.
- (i) A provision of false, inaccurate, or materially misleading information to a health care provider, an individual, or an HCBS program applicant.
- (j) A misrepresentation or submission of false information to the Ohio Department of Medicaid.
- (k) A failure to comply with HIPAA requirements regarding Protected Health Information or laws or regulations governing the confidentiality and safeguarding of Medicaid recipient information resulting in in substantial harm.
- (l) A failure to meet a Quality Management Plan Standard three or more consecutive times.
- (m) Any other deficiency that rises to the level of a Category Three Noncompliance Issue, as determined by the Ohio Department of Medicaid.

TN: 15-014
Supersedes:
TN: New

Approved: _____
Effective: 07/01/2016

Category Four Noncompliance: The Ohio Department of Medicaid will assess twenty (20) points for each of the following examples of noncompliance.

- (a) Any Category One, Two or Three noncompliance that results in material harm, or any other failure to ensure the health and welfare of an individual that results in material harm, as determined by the Ohio Department of Medicaid. \$50,000.00
- (b) Any Category One, Two or Three noncompliance that result in irreparable harm, or any other failure to ensure the health and welfare of an individual that results in irreparable harm, as determined by the Ohio Department of Medicaid. \$100,000.00

(K) Complaint to Vendor Process

If the Contractor has accumulated a current total of 26 points or more, the Ohio Department of Medicaid shall file a Complaint to Vendor Form with DAS in accordance with Section 8.17 Contract Non-Compliance in Part Eight: General Terms And Conditions of the Contract.

(L) EXEMPLARY PERFORMANCE AWARD

The Ohio Department of Medicaid is establishing an incentive system for the Contractor to achieve exemplary performance in two specific areas. If the Contractor achieves exemplary performance in both areas, the Contractor could receive an additional \$20,000 in each state fiscal year of the Contract. However, to qualify for the exemplary performance payment, the Contractor must first meet or exceed all of the Quality Management Plan Standards. Incentives do not apply if this Contract is terminated or non-renewed and any exemplary performance awards earned during the fiscal year will be retained by the Ohio Department of Medicaid.

- (1) Avoidable Emergency Department Usage:** Ohio is striving to excel and be a trend-setter in reducing unnecessary emergency department usage. To achieve this goal in partnership with the Contractor, the State will reward the Contractor for exemplary performance demonstrated in this area according to the following formula:

Numerator: Total number of emergency department visits by HCBS program individuals per quarter, per Contractor. A visit is defined as a unique recipient and date of service. Emergency department visits will be identified using the following method: CPT codes 99281-99285 with revenue center code of 450, 451, 452, 459, and 981 with Claim Type of "O" or "W" with Bill Type of "131" or "135".

Denominator: An unduplicated count of the number of HCBS program individuals served by the Contractor in the quarter.

Quarterly Exemplary Performance Award: \$2,500 each quarter that the overall rate of emergency department usage is reduced by at least 5%.

Data Source: DSS (taking into account claims lag)

Who Will Calculate: Ohio Department of Medicaid Staff

- (2) Encouraging Recovery Manager Retention:** Ohio is striving to excel and be a trend-setter in promoting Recovery Manager retention in the area of home and community-based services. To achieve this goal in partnership with the Contractor, the State will reward the

TN: 15-014
Supersedes:
TN: New

Approved: _____
Effective: 07/01/2016

Contractor for exemplary performance demonstrated in this area according to the following formula:

Numerator: The Recovery Managers included in the denominator that are still employed with the Contractor at the end of the state fiscal year.

Denominator: Total number of Recovery Managers employed with the Contractor at the beginning of the State fiscal year.

For example, if the Contractor had 100 Recovery Managers at the beginning of the state fiscal year and 85 of those individuals remained at the end of the state fiscal year, the Recovery Manager retention rate would be 85%.

Exclusions: Recovery Managers who were terminated by the Contractor, retired, or died should be excluded from both the numerator and the denominator.

Annual Exemplary Performance Award: \$10,000 if at least 85% retention

Data Source: Contractor

Who Will Calculate: Contractor, verified by the Ohio Department of Medicaid

ATTACHMENT TWELVE
OHIO MAP REGIONS



Cincinnati
Columbus
Cleveland
Marietta

TN: 15-014
Supersedes:
TN: New

Approved: _____

Effective: 07/01/2016

SPECIALIZED RECOVERY SERVICES PROGRAM RECOVERY

MANAGEMENT AGREEMENT

Signature Page

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date of the signature of the Director of the Ohio Department of Administrative Services.

Contractor

Ohio Department of Administrative Services

Authorized Signature (Blue Ink Please)

Robert Blair, Director

Printed Name

Date

Date

Address

City, State, Zip

TN: 15-014
Supersedes:
TN: New

Approved: _____
Effective: 07/01/2016