

Summary of 1915(i) Public Comments and State Responses

The following is a summary of public input specific from the 1915(i) public comment period.

Dates of the formal public comment period

Ohio's formal public comment period was held from May 6, 2015, through June 6, 2015.

Summary of the public notice and input process used for this amendment

Ohio provided five methods for the public to provide input on the draft transition plan and/or request a non-electronic copy of the plan:

- **E-mail** - Ohio established a dedicated e-mail box named MCD-HCBS feedback.
- **Written comments** - Ohio also provided a U.S. Postal Service address, which was Ohio Department of Medicaid, ATTN: HCBS Transition Plan, P.O. Box 182709, 5th Floor, Columbus, OH 43215.
- **Fax** - Ohio provided a fax number, which was (614) 466-6945.
- **Toll-free phone number** - Ohio provided a toll-free number, 1 (800) 364-3153, with a recorded message advising callers they had reached the CMS HCBS draft transition plan phone message box and offering five minutes in which to leave a message.
- **Courier or in-person submission** to Attn: BLTCSS, Lazarus Building, 50 W. Town St, Columbus OH, 43215

The state did not choose to use a newspaper as a non-electronic method for public notice posting and input. The state leveraged existing relationships and processes by sending the documents to the County Departments of Job and Family Services to publically post and have additional copies on hand for anyone who asks for a hard copy. The CDJFS offices assisted in helping us to reach individuals who may not otherwise be aware of their opportunity to comment. In addition, stakeholder partners were educated on the non-electronic options in order to furnish, upon request, access to hard copies of the plan and information about non-electronic methods to submit comments.

Active Link used to post the entire application

On 5/06/2015, Ohio posted a public notice, summary of the draft plan, the draft plan itself, and questions and answers.

Summary of comments received, any modifications made to the state plan based upon the comments received, and reasons why comments were not adopted.

The state received 126 unduplicated comments on the statewide plan during the formal public comment period. The following is a summary of the comments germane to this state plan.

- 1. Comment:** What is the reason that "community psychiatric supportive treatment" is not included as one to the covered 1915(i) services? This is one of the key services that Medicare will not provide re-imburement for but is often vital to a person's success in the community.

 - **Response:** No change was made to the state plan. When an individual is determined eligible for 1915(i), the individual will have access to a Medicaid card and all Medicaid covered services. Services covered under CPST will be considered as part of the broader state plan behavioral health service redesign effort.

- 2. Comment:** It is important to keep Medicaid for individuals as many services are not covered under Medicare.

 - **Response:** Thank you for your comment. No change was made to the state plan. When an individual is determined eligible for 1915(i), the individual will have access to a Medicaid card and all Medicaid covered services.

- 3. Comment:** The amendment is very needed with the SPMI population. Should funding go away for case management services for these individuals it would have a major impact on our clients and the community as many of them remain stable due to support through CPST.

 - **Response:** Thank you for your comment. No change made to the state plan. When an individual is determined eligible for 1915(i), the individual will have access to a Medicaid card and all Medicaid covered services.

- 4. Comment:** The discrete services of SE/IPS could be provided and thus lead to fragmentation and lack of fidelity to SE/IPS.

 - **Response:** We have changed the state plan to reflect the commenter's concern. The state plan has aligned with the OhioMHAS Employment Rule, Ohio Administrative Code (OAC) 5122-29-11. The state plan now reads, "Consistent with the purpose and intent of this service definition, Individualized Placement and Support-Supported Employment (IPS-SE) shall include the following evidence based and best practice employment activities, as provided

by a (IPS-SE) provider and as listed below". This change can be found on page 31 of Attachment 3.1-G of the state plan.

5. **Comment:** IPS shall include at least one of the following evidence based and best practice employment activities, as offered through a qualified IPS-Supported Employment (SE) provider as listed in the waiver.
- **Response:** We have changed the state plan to reflect the commenter's concern. The language has been edited to address these concerns and maintain consistency with the OhioMHAS Employment Rule, OAC 5122-29-11. The section now reads: Consistent with the purpose and intent of this service definition, Individualized Placement and Support-Supported Employment (IPS-SE) shall include the following evidence based practice employment activities, as provided by a (IPS-SE) provider and as listed below: 1. Vocational Assessment; 2. Development of a Vocational Plan; 3. On-the-job Training and skill development; 4. Job seeking skills training (JSST); 5. Job development and placement; 6. Job coaching; 7. Individualized job supports, which may include regular contact with the employers, family members, guardians, advocates, treatment providers, and other community supports; 8. Benefits planning; 9. General consultation, advocacy, building and maintaining relationships with employers; 10. Rehabilitation guidance and counseling; or, 11. Time unlimited vocational support. This change can be found on pages 31-32 of Attachment 3.1-G of the state plan.
6. **Comment:** Schizophrenia and Bipolar are not specific diagnoses. Consider adding clarification with the use of terms "spectrum disorders", e.g., Schizophrenia spectrum disorder and bipolar spectrum disorder.
- **Response:** No change made to the state plan. Specific diagnoses covered are listed in detail in the 1915(i) services State Plan Amendment, section Evaluation/Reevaluation of Eligibility, Part 7.
7. **Comment:** As written, the statement, "Risk criteria will include potential loss of eligibility, or the inability to access Medicaid eligibility for the provision of HCBS plan services to sustain community living" is unclear. Consider rephrasing or adding additional information for clarity.
- **Response:** The state plan has been changed to reflect the commenter's concern. This language has been removed from the state plan. The 1915(i) risk and needs assessment will protect the most vulnerable Medicaid-enrolled individuals who face the potential loss of their Medicaid eligibility due to the

Transition to the eligibility standards under Section 1634 [42 U.S.C. 1383c] of the Social Security Act. This change can be found on page 12 of Attachment 3.1-G of the state plan.

- 8. Comment:** Peer recovery and support services and group facilitation are very similar services to those currently being covered by case managers. Will CMS allow the two services to exist together?
- **Response:** No change made to the state plan. Yes, CMS will allow these two services to exist together.
- 9. Comment:** Are Peer Recovery Support Services meant to provide peer support as an adjunct to HCBS, or similar state plan services?
- **Response:** No change made to the state plan. Peer support service will be considered as part of the broader state plan behavioral health redesign.
- 10. Comment:** For peer supporters, please explain what a former primary individual or survivor of mental health/SUD services means, including the definition of primary.
- **Response:** The state plan has been clarified. Peer recovery supporters must self-identify as having a lived experience of mental illness as a present or former recipient of mental health services. As a result, family members do not qualify to be a peer recovery supporter. As all paths to recovery are beneficial, the specific path of each peer recovery supporter can be unique. Requirements to be a peer recovery supporter, in addition to a personal lived experience of mental health and/or substance use disorder include: a) Successful completion of 16 hour on-line OhioMHAS E-Based Academy Courses; b) Successful completion of a minimum of 40 hours of peer service delivery training or 3 years of formal peer service delivery; c) Passing the OhioMHAS Peer Recovery Supporter exam. Language regarding primary individual and SUD services was removed and these changes can be found on pages 37-38 of Attachment 3.1-G of the state plan.
- 11. Comment:** The role of “peers” and “senior peers” is confusing. Will peers be supervised by other senior peers? Currently there is no certification for supervising peers. The “peers/peer supervisors” statement can be taken to mean that peers may have two supervisors or that peers will receive clinical supervision.
- **Response:** The state plan has been clarified. Yes, peers will be supervised by other qualified support providers. The definition of a peer supervisor is an individual working as a certified Peer Support provider for a minimum of five

years. However, individuals receiving peer support services under the 1915(i) option will be able to make the final decision as to the provider of their choice. Work is underway to develop a peer supervision curriculum. Language regarding the role of peers and peer supervision has been clarified and these changes can found on page [31 and page 36](#) of Attachment 3.1-G of the state plan.

12. Comment: The PCCP will further complicate access issues as confusion is added because SPMI individuals will not be able to use their current Case Manager, but will have to shift to a distinct from clinical staff PCCP.

- **Response:** The state plan has been changed. A Recovery Manager, distinct from clinical treatment staff, is necessary to comply with conflict-free case management federal regulations. We have redesigned the operational model to provide the opportunity for individuals to choose a Recovery Manager from one of two separate entities in all areas of the state. During the implementation process we will work to ensure effective care coordination and mitigate coordination issues. This change can be found on page 3 of Attachment 3.1-G of the state plan.

13. Comment: The timeline seems rushed.

- **Response:** The state plan has been changed and the implementation date has been pushed back to July 2016. These changes can be found on page 7 of Attachment 3.1-G and page 3 of Attachment 4.19-B of the state plan.

14. Comment: There will be difficulties in implementation from a workforce and coordination of care standpoint.

- **Response:** No change made to the state plan. The departments will design services and programming while taking workforce and care coordination into consideration.

15. Comment: The proposed 1915i does not align with IPS Supported Employment as an Evidence Based Practice, as SE should be fully integrated with Mental Health services. The 1915i could disqualify individuals currently receiving IPS/SE services.

- **Response:** No change made to the state plan. The 1915(i) does not disqualify individuals who are receiving Individualized Placement and Support-Supported Employment (IPS-SE) services or who are interested in participating in (IPS-SE) services. Revisions have been made to the (IPS-SE) section of the 1915(i) to ensure fidelity to the model.

16. Comment: The 1915i as proposed appears cumbersome and disjointed. The individual seeking services may be overwhelmed with referrals which may increase poor outcomes and decrease the likelihood on coordinated primary, behavioral, and specialty care. CMHC's specialize in outreach and client management that could be leveraged to further develop the newly defined Peer Support service. By pulling the three services into a separate agency, there is a risk of marginalization and high dropout rate from services.

- **Response:** The state plan has been changed. In efforts to streamline the eligibility process and care coordination, Ohio Department of Medicaid has assumed operational authority of 1915(i) program services. To further maximize care coordination functionality, Ohio Medicaid will utilize existing managed care plan contracts in applicable regions. The Recovery Manager will work with the contracted managed care plans, if applicable, to achieve comprehensive care coordination responsibilities including primary, behavioral, and specialty care, thus increasing the likelihood of desirable outcomes. During the implementation process we will work to ensure effective care coordination and mitigate coordination issues. A Recovery Manager, distinct from clinical treatment staff, is necessary to comply with conflict-free case management federal regulations. We have redesigned the operational model to provide the opportunity for individuals to choose a Recovery Manager from one of two separate entities in all areas of the state. Individualized Placement and Support-Supported Employment (IPS-SE) services may be provided by CMHCs. These changes can be found on pages [1-3, 24-26, and 37-38](#) of Attachment 3.1-G of the state plan.

17. Comment: Consumer engagement is key, and warm handoffs to both clinical and non-clinical services are known to improve engagement and follow through with collaborative treatment plans.

- **Response:** Thank you for your comment. No change made to the state plan. The Departments will work with providers and consumers to ensure effective engagement and care coordination.

18. Comment: The 1915i creates a process that is overly cumbersome and complicated for people served and the providers. It required the creation of a new position that is not clinically justified.

- **Response:** The state plan has been changed. A Recovery Manager, distinct from clinical treatment staff, is necessary to comply with conflict-free case management federal regulations. We have redesigned the operational model to

provide the opportunity for individuals to choose a Recovery Manager from one of two separate entities in all areas of the state. This change can be found on page 3 [and 31-32](#) of Attachment 3.1-G of the state plan.

19. Comment: The 1915i requires that 3 services be provided outside the community mental health agency including the supported employment model of IPE. The recommendation is not aligned with IPE as an Evidence Based Practice that requires the integration of behavioral health with employment services.

- **Response:** The state plan has been changed. During the implementation process we will work to ensure effective care coordination and mitigate coordination issues. Individualized Placement and Support-Supported Employment (IPS-SE) services may be provided by CMHCs. The language has been edited to address these concerns and maintain consistency with the OhioMHAS Employment Rule, OAC 5122-29-11. The section now reads: Consistent with the purpose and intent of this service definition, Individualized Placement and Support-Supported Employment (IPS-SE) shall include the following evidence based practice employment activities, as offered by a (IPS-SE) provider and as listed below: 1. Vocational Assessment; 2. Development of a Vocational Plan; 3. On-the-job Training and skill development; 4. Job seeking skills training (JSST); 5. Job development and placement; 6. Job coaching; 7. Individualized job supports, which may include regular contact with the employers, family members, guardians, advocates, treatment providers, and other community supports; 8. Benefits planning; 9. General consultation, advocacy, building and maintaining relationships with employers; 10. Rehabilitation guidance and counseling; or, 11. Time unlimited vocational support. This change can be found on pages 31-32 of Attachment 3.1-G of the state plan.

20. Comment: One of the most effective components of supported employment and particularly, the IPS SE employment model, is the co-location and collaboration of the clinical and vocational services. Fragmented services have historically resulted in more hospitalizations for SPMI clients and additional costs to the Medicaid program. Although I understand the need to address “conflicts of interest” I believe there are other ways to address those concerns. Many clients want all of their services from one agency, and we have found that it is easiest to best coordinate clinical and vocational services. If the new 1915 (i) Medicaid coverage would prevent that from occurring, then I think we would be operating outside of client choice or what is likely best for the client.

- **Response:** The state plan has been changed. A Recovery Manager, distinct from clinical treatment staff, is necessary to comply with conflict-free case

management federal regulations. We have redesigned the operational model to provide the opportunity for individuals to choose a Recovery Manager from one of two separate entities in all areas of the state. During the implementation process we will work to ensure effective care coordination and mitigate coordination issues. Individualized Placement and Support-Supported Employment (IPS-SE) services may be provided by CMHCs. The language has been edited to address these concerns and maintain consistency with the OhioMHAS Employment Rule, OAC 5122-29-11. The section now reads: Consistent with the purpose and intent of this service definition, Individualized Placement and Support-Supported Employment (IPS-SE) shall include the following evidence based practice employment activities, as offered by a (IPS-SE) provider and as listed below: 1. Vocational Assessment; 2. Development of a Vocational Plan; 3. On-the-job Training and skill development; 4. Job seeking skills training (JSST); 5. Job development and placement; 6. Job coaching; 7. Individualized job supports, which may include regular contact with the employers, family members, guardians, advocates, treatment providers, and other community supports; 8. Benefits planning; 9. General consultation, advocacy, building and maintaining relationships with employers; 10. Rehabilitation guidance and counseling; or, 11. Time unlimited vocational support. This change can be found on pages 31-32 of Attachment 3.1-G of the state plan.

21. Comment: It is my understanding that if an agency provides mental health services, such as counseling and CPST, that this same agency would not be able to provide supported employment. Instead of everything happening under one roof, moving toward fidelity under 1915 (i) would require the agency providing IPS to come to the mental health agency at least weekly for team meetings (extra cost); have offices close to or share offices with the mental health provider (which may not be geographically or financially feasible) and all services (IPS and MH) would need to be documented in one chart. This may result in added cost for an agency that has an electronic record either by the purchase of additional licenses for each clinical user or additional work by support staff to scan and index items in the EMR. Also, both agencies would have to promote and live the core principles of IPS or have a similar philosophy about employment.

- **Response:** The state plan has been changed to address this concern. Under the 1915(i), there is no prohibition that precludes a mental health agency from providing Individualized Placement and Support-Supported Employment (IPS-SE) and mental health services. The 1915(i) eligible individual must exercise personal

choice to determine their (IPS-SE) provider. (IPS-SE) services may be provided by CMHCs. The language has been edited to address these concerns and maintain consistency with the OhioMHAS Employment Rule, OAC 5122-29-11. The section now reads: Consistent with the purpose and intent of this service definition, Individualized Placement and Support-Supported Employment (IPS-SE) shall include the following evidence based practice employment activities, as offered by a (IPS-SE) provider and as listed below: 1. Vocational Assessment; 2. Development of a Vocational Plan; 3. On-the-job Training and skill development; 4. Job seeking skills training (JSST); 5. Job development and placement; 6. Job coaching; 7. Individualized job supports, which may include regular contact with the employers, family members, guardians, advocates, treatment providers, and other community supports; 8. Benefits planning; 9. General consultation, advocacy, building and maintaining relationships with employers; 10. Rehabilitation guidance and counseling; or, 11. Time unlimited vocational support. This change can be found on pages 31-32 of Attachment 3.1-G of the state plan.

22. Comment: There are strong efforts to replace the “spend down” program for those living with serious and persistent mental illness. This program is incredibly cumbersome and can be very difficult for this population, many of whom live with confused thinking, to monitor and manage. The range of services specified in the proposal: Recovery Management and Behavioral and Primary Healthcare Coordination; IPS Supported Employment; and Peer Recovery Support; are the necessary services. We would like to see the eligibility criteria and scope of services broadened, but not at the risk of watering down the services available to our most ill.

- **Response:** The state plan has been changed. Services have been consolidated to utilize HCBS program contractors. The Ohio Department of Medicaid is leveraging existing infrastructure to incorporate the Independent Validation Entity functionality to the current case management agencies experienced in providing care to those who are severely mentally ill. In addition to this change, the Recovery Manager, distinct from clinical treatment staff, is necessary to comply with conflict-free case management federal regulations. We have redesigned the operational model to provide the opportunity for individuals to choose a Recovery Manager from one of two separate entities in all areas of the state. During the implementation process we will work to ensure effective care coordination and mitigate coordination issues. The 1915(i) has been designed to assure that SPMI individuals have access to appropriate services and

supports to maintain living in the community. These changes can be found on pages 1 [and 23-38](#) of Attachment 3.1-G of the state plan.

23. Comment: We encourage the state to not cave into the demands for Masters-level PCC.

- **Response:** No change made to the state plan. The requirements for a Recovery Manager remain as proposed in the 1915(i). Individuals with lived experience who meet the other defined criteria may qualify as a Recovery Manager.

24. Comment: Why are we not allowing those with income up to 300% FPL eligible for the program? Those with slightly higher income would still benefit. The proposal should target a broader category of persons with mental illness who could benefit from HCBS. According to CMS, the purpose of the 1915i provisions are to make HCBS available to more people.

- **Response:** No change made to the state plan. At this time, Ohio is targeting the 1915(i) for the individuals not otherwise eligible for Medicaid who meet the needs-based criteria for the 1915(i) benefit and have an income that does not exceed 150% of the federal poverty level. By selecting box 2B, 1915(i) services would only be available to HCBS waiver recipients and not the SPMI targeted population.

25. Comment: Undetermined Administrative Infrastructure and Costs: As described, this program adds significant complexity and several new administrative layers at both the state and provider organization levels simply for individuals to maintain Medicaid coverage. It deconstructs existing integrated care delivery systems and will require individuals to obtain services from multiple provider organizations. We request an analysis of estimated costs associated with the implementation and ongoing administration of the 1915(i) program – both for the state and for providers.

- **Response:** Thank you for your comment. We will continue to communicate with stakeholders as we work within both budget constraints and federal regulations to provide services to SPMI individuals. The 1915(i) has been designed to assure that SPMI individuals have access to appropriate services and supports to maintain living in the community.

26. Comment: Funding for “clinical criteria” assessment for eligibility: As currently drafted, it is not clear how the administrative costs, documentation, and completion of the “clinical needs based criteria” or functional assessment will be reimbursed, if at all, particularly for the sub-group currently eligible for Medicaid via spend-down. It appears that this may be cost shifting administrative functions for Medicaid eligibility to

providers without any available funding stream to support the efforts. We recommend inclusion of clear reimbursement methodology for the administrative costs in the proposal.

- **Response:** Thank you for your comment. A Recovery Manager, distinct from clinical treatment staff, is necessary to comply with conflict-free case management federal regulations. During the implementation process we will work to ensure effective care coordination and mitigate coordination issues. We will continue to communicate with stakeholders as we work within both budget constraints and federal regulations to provide services to SPMI individuals. The 1915(i) has been designed to assure that SPMI individuals have access to appropriate services and supports to maintain living in the community.

27. Comment: As proposed, the current program lacks sufficient details and description of the operational expectations for “person centered care planning” that is unique from MHAS defined “individualized treatment/service planning”. Care plans do not replace the requirements for treatment plans, which are much more detailed descriptions of interventions developed/approved by licensed independent professionals (LIPs). We are concerned that this may result in significant duplication and unnecessary additional administrative activities. We recommend that the program design clearly indicate that the “authorization” of services is specific to the three new services included in the 1915(i) program and that other existing services and their corresponding treatment plans may be incorporated by reference.

Furthermore, we remain concerned that the PCCP role, which requires significant understanding of clinical assessments and treatment services, may be filled by a non-licensed individual. We are also concerned that the supervision provided to the PCCP by the Independent Validation Entity (IVE) will not require review by an independently licensed professional. Given that the function of the PCCP and IVE is to “validate” the severity of the presenting mental illness, functional impairment, and need for services, those roles depend on demonstrated clinical competency and additional licensure requirements. We recommend consideration of licensure for the PCCP and, at a minimum, a requirement of LIPs for the IVE.

- **Response:** The state plan has been changed. A Recovery Manager, distinct from clinical treatment staff, is necessary to comply with conflict-free case management federal regulations. We have redesigned the operational model to provide the opportunity for individuals to choose a Recovery Manager from one of two separate entities in all areas of the state. During the implementation process we will work to ensure effective care coordination and mitigate

coordination issues. Work is underway to develop a peer supervision curriculum. This change can be found on pages [3-4 and 10](#) of Attachment 3.1-G of the state plan.

28. Comment: Care plans do not replace the requirements for treatment plans, which are much more detailed descriptions of interventions developed/approved by licensed independent professionals (LIPs). We are concerned that this may result in significant duplication and unnecessary additional administrative activities.

- **Response:** The state plan has been changed. We recognize that care plans do not replace treatment plans. In efforts to streamline the eligibility process and care coordination, Ohio Department of Medicaid has assumed operational authority of 1915(i) program services. To further maximize care coordination functionality, Ohio Medicaid will utilize existing managed care plan infrastructure contracted in applicable regions. The Recovery Manager will work with the contracted managed care plans, if applicable, to achieve comprehensive care coordination responsibilities including primary, behavioral, and specialty care, thus increasing the likelihood of desirable outcomes. Licensed independent professionals serving as the Recovery Manager will work with individuals responsible for the beneficiaries' care and the designated managed care plan (if applicable) to development a Person-Centered Care Plan. This integrated coordination will mitigate unnecessary administrative activities. These changes can be found on pages 1-[3,2625](#) and the Quality Improvement Strategy beginning on page 43 of Attachment 3.1-G of the state plan.

29. Comment: Medicaid Eligibility Criteria Restricts Access to the Benefit: As currently described, we are very concerned that the four step eligibility funnel to access Medicaid coverage through the 1915(i) program will greatly restrict enrollment in the program. In addition to having a monthly income between \$753 and \$2,219, it is our understanding that the individual would also need to have a qualifying diagnosis with demonstrate existing functional impairment, live in an HCBS approved setting, and need and want one of the three services offered under the 1915(i) program. ALL of these must be met to access or maintain Medicaid coverage.

- **Response:** Section 1915(i) of the Social Security Act and federal regulations require states to establish financial eligibility limits and Ohio has chosen 300% of the Federal Benefit Rate which is equivalent to 220% of the Federal Poverty Level. Ohio confirms that the qualifying diagnosis, functional impairment, HCBS living arrangement, and the need for at least one of the 1915(i) services are requirements under Ohio's 1915(i) program. This clarification can be found on

pages 10-11 of Attachment 3.1-G of the state plan.

30. Comment: We are concerned by the very limited diagnosis categories selected that too narrowly define SPMI to essentially include three conditions schizophrenia/schizoaffective disorders, bipolar disorders, and major depression, severe type. This approach severely limits access to Medicaid coverage for individuals with disabling mental health conditions, including most of those currently receiving SUD services, as they tend to carry other MH diagnosis, such as PTSD, anxiety disorders, and personality disorders. This is important because Medicare does not cover SUD services including Medication Assisted Treatment (MAT), a troubling policy choice considering the opioid addiction crisis in Ohio and nationally. Additionally, it should be noted the population targeted for the 1915(i) program tends to be slightly older, has a work history (thus the reason for higher disability income), and tends to be in a stable/maintenance stage of recovery. Analysis is needed to determine whether or not any of the targeted population will demonstrate the need and desire for any of the three services proposed under 1915(i), particularly if that requires a change in the service provider.

If the intent of the 1915(i) program is Medicaid eligibility maintenance for individuals currently covered under the spenddown option that access behavioral health services, then we would recommend ODM use the definition of "Person with severe mental disability" found in ORC 5122-24-01(B)(49). This approach would support maintaining Medicaid coverage for individuals in this sub-group, including those with co-occurring disorders currently receiving treatment.

- **Response:** No change was made to the state plan. Ohio Medicaid has targeted these severe diagnoses to in order to assure that these individuals receive the highly specialized services needed to remain well, and in the community. When the state transitions to Section 1634 [42 U.S.C. 1383c] of the Social Security Act, the state wants to ensure that individuals receive essential mental health services that are not found in plans available in the Federal Health Insurance Marketplace.

31. Comment: Allowable service settings: We are concerned with the manner in which ODM will accommodate adult care facilities, adult group homes, supportive housing, recovery housing, and residential treatment programs within the 1915(i) program. It is not clear if the HCBS definition of allowable setting is limited to HCBS services provided through the 1915(i) program or will create broad exclusions that limit access to all Medicaid covered services delivered under the state plan. We would urge ODM to

define all of the above mentioned housing choices and settings as allowable types of community living and clarify the limitations of the “setting” on service access.

- **Response:** Ohio’s 1915 (i) proposal will be governed by the January 2015 CMS regulations regarding home and community based settings (HCBS). The CMS regulations require that any 1915(i) participants must live in settings that are “non-institutional” and fully integrated in the broader community. (The specific definitions and guidance for what constitutes acceptable HCBS settings can be found at 42 CFR 441.710.) Ohio must follow this guidance as we draft the 1915(i) proposal and Ohio Administrative Code rules regarding HCBS settings for enrollees in 1915(i) and other home and community based programs. The Ohio Department of Medicaid is working with colleagues at the Ohio Department of Mental Health and Addiction Services to assess whether facilities licensed by their agency (including adult care facilities) meet the Federal HCBS guidance and if not, how we might work together with facility operators to make changes that ultimately will meet the federal HCBS guidance. In the interim, each applicant for 1915(i) enrollment and their living setting will be considered individually.

32. Comment: The department is not offering participant-direction State Plan HCBS. Financial Management is not offered. The state does not offer an opportunity for participant-employer authority nor is there an opportunity for participants to direct a budget.

- **Response:** No change made to the state plan. Self-directed care in the 1915(i) state plan will consist of a Person Centered Plan that is driven by the participant’s preferences. Financial management is not offered under this plan.

33. Comment: For organizations that have implemented the Supported Employment model, negative experiences have occurred when attempting to meet fidelity if the provider's client is involved with OOD [\[Opportunities for Ohioans with Disabilities—formerly Ohio Rehabilitation Services Commission\]](#). Their current practices do not support the fidelity requirement of evidence-based models. OOD is not well equipped to understand or work with people with severe and persistent mental disabilities. This ongoing issue in Ohio should be addressed whether or not IPS SE language remains in the 1915i waiver.

- **Response:** Thank you for your comment.

34. Comment: There is concern that this waiver will add complexity, rather than eliminate it, and will falls short of providing the same access to care currently provided to Ohioans. This is due to the blanket policy decision that there will be no "medically needy" category even for the ABD individuals. Pro Seniors are requesting that Ohio

adopt a limited, targeted spend down for aged, blind and disabled individuals only. There will be added administrative costs with the proposed design, thus costing more to the department.

- **Response:** The state plan has not been changed. Transitioning to compliance with Section 1634 [42 U.S.C. 1383c] of the Social Security Act offers a streamlined approach to Medicaid eligibility and continuity of health coverage on a month-to-month basis. The state accepts SSA's (or, in Ohio, OOD's) decision that the individual is eligible for SSI which in turn, automatically enrolls the individual in Medicaid. The individual does not have to apply for Medicaid; the state does not reconsider the determination. Additionally, this transition allows for a more 'fair' application of Medicaid. Currently, individuals under 65 without Medicare can get MAGI adult coverage with income up to 138% FPL. On the contrary, a person 65 or older, or with Medicare, has to spend down to 64%. Finally, two individuals with the same spenddown amount may have very different results based on what treatment they need from what provider – in one case, the provider never actually attempts to collect on the "incurred" bill. In another case, the person has to pay up front to get services. In the circumstance where an individual does not meet the eligibility criteria to receive Medicaid, they will have the option of receiving healthcare through Medicare or the Federal Health Insurance Marketplace (commercial).

35. Comment: The needs assessment conducted by PCCPs who are: distinct from clinical staff and validated by an Independent Entity creates an unnecessary, additional, costly, administrative layer. The ANSA tool has already been identified. The clinicians currently involved in the individual's care would be in the best position to provide information, rather than create an additional person. Costs for the agencies for providing these assessments have not yet been addressed. IPS services cannot be provided by the same agencies that provide the Needs Assessment. The IPS/SE services cannot be provided by the same agencies. This will also be a problem when there is one agency in the geographic area that can provide both of these services.

- **Response:** The state plan has been changed. A Recovery Manager, distinct from clinical treatment staff, is necessary to comply with conflict-free case management federal regulations. We have redesigned the operational model to provide the opportunity for individuals to choose a Recovery Manager from one of two separate entities in all areas of the state. During the implementation process we will work to ensure effective care coordination and mitigate coordination issues. Individualized Placement and Support-Supported

Employment (IPS-SE) services may be provided by CMHCs. These changes can be found on pages 3-4 of Attachment 3.1-G of the state plan.

36. Comment: The program does not offer retroactive coverage as required under 42 U.S.C. 1396(a)(34). This section of the SSA is not waived, rather mandatory of the state of Ohio and its Medicaid program, including HCBS and retroactive coverage must be included. Provision of services should be made retroactive just as they are with state plan services.

- **Response:** Thank you for your comment. It is unnecessary to address section 42 U.S.C. 1396a(a)(34) in this State Plan Amendment (SPA), therefore the SPA will not be changed.