Ohio | Common Sense Initiative

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Business Impact Analysis

Agency, Board, or Commission Name: Ohio Department of Medicaid

Rule Contact Name and Contact Information:

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Regulation/Package Title (a general description of the rules' substantive content):

Specialized Recovery Services Program

Rule Number(s): 5160-43-04, 5160-43-07

Included for reference only: 5160-43-01, 5160-43-02, 5160-43-03, 5160-43-08, 5160-43-09

Date of Submission for CSI Review: 05/12/2021

Public Comment Period End Date: 05/19/2021

Rule Type/Number of Rules:

New/___ rules

No Change/____ rules (FYR? ___)

Amended/ 2 rules (FYR? Yes)

Rescinded/____ rules (FYR? ___)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies

should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. **R.C. 106.03 and 106.031 require agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.**

   Which adverse impact(s) to businesses has the agency determined the rule(s) create?

   The rule(s):

   a. ☐ **Requires a license, permit, or any other prior authorization to engage in or operate a line of business.**

   b. ☒ **Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.**

   c. ☒ **Requires specific expenditures or the report of information as a condition of compliance.**

   d. ☒ **Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.**

Regulatory Intent

2. **Please briefly describe the draft regulation in plain language.**

   The specialized recovery services program (SRSP) provides Medicaid eligibility and home and community-based services (HCBS) to adults diagnosed with a serious and persistent mental illness (SPMI) and/or diagnosed chronic conditions (DCC) who also meet the financial, clinical, needs and risk eligibility criteria specified in the 1915 (i) State Plan Amendment and in the rules set forth in Chapter 5160-43 of the Ohio Administrative Code (OAC). The rules in Chapter 5160-43 of the OAC were amended for five-year rule review and in alignment with the requested renewal of the State Plan Amendment. The following changes were made to the rules:

   OAC 5160-43-04, entitled "Specialized recovery services program covered services and provider requirements" describes the covered services available to individuals through the program and the requirements of providers to deliver services. Changes to the rule include revising the language describing Recovery Management activities in paragraph (D)(2) to align with State Plan Amendment

language. Also, provisions were added in paragraph (D)(2) to allow increased flexibility in the way evaluations occur to include telephone or video conference in addition to face-to-face visits.

OAC 5160-43-07, entitled "Specialized recovery services program compliance: provider monitoring, oversight, and investigations" describes the processes for monitoring and oversight of providers to ensure compliance. Changes to the rule include adding a provision to paragraph (B)(3) to clarify that providers will need to provide reports on performance as requested by ODM where data is not accessible. Additionally, paragraph (C) was removed as ODM does not conduct structural reviews specific to SRSP but instead follows the monitoring and oversight process described in paragraph (B) and previous paragraph (D).

3. **Please list the Ohio statute(s) that authorize the agency, board or commission to adopt the rule(s) and the statute(s) that amplify that authority.**

   Ohio Revised Code (ORC) Section 5164.02

4. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**
   Yes, these rules operate in conjunction with the 1915 (i) Medicaid State Plan Amendment (SPA) which allows Ohio to participate in a federal program. Under Section 1915 (i) of the Social Security Act, states can offer a variety of services under a State Plan Home and Community-Based Services (HCBS) benefit. The SPA must be approved by the Centers for Medicare & Medicaid Services (CMS) in order to receive federal funding. In order for CMS to approve a 1915(i) SPA, a state must make certain assurances concerning the operation of the program. These assurances are specified within the 1915 (i) SPA and the SPA was previously approved for a period of 5 years which expires August 1, 2021. The proposed rules will allow ODM to continue to implement the Specialized Recovery Services program in alignment with 1915 (i) SPA renewal request, while safeguarding the health and welfare of individuals participating in the program and ensuring provider compliance to prevent fraud and waste.

5. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

   These rules do not exceed federal requirements and do not include provisions not specifically required by the federal government. The rules are aligned with the approved 1915(i) SPA which is consistent with the federal requirements found in 42 C.F.R. 441.710.

6. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

   The public purpose of these rules is to assure the health and welfare of individuals participating in the SRSP through the enrollment of eligible individuals and provision of person-centered program services by qualified providers.

7. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

   The effectiveness of these rules is measured through a finding of compliance with the standards set forth in the rules as determined by provider monitoring and oversight. ODM meets at least monthly with Recovery Management providers to review any changes to processes related to program rules and to manage barriers and challenges to successful outcomes. ODM also connects with stakeholders and external agencies to address provider concerns and review program policy expectations.

8. **Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931?**

   No, none of the proposed rules contained in this rule package are pursuant to any of these sections of the Revised Code.

Development of the Regulation

9. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**

   ODM meets at least monthly with Recovery Management Providers regarding program policy, challenges and barriers to successful outcomes and specific case inquiries. ODM also meets with external stakeholders as needed regarding program policy and any identified issues or concerns. The Stakeholder Group includes:

   • Ohio Department of Aging (ODA)
   • Ohio Department of Developmental Disabilities (DODD)
   • Ohio Department of Mental Health and Addiction Services (MHAS)
   • Ohio Department of Health (ODH)
   • Providers, ODM-Administered Home and Community-Based Services
   • Providers, ODM Managed Care Plans
   • Linking Employment, Abilities & Potential (LEAP)
   • Ohio Long Term Care Ombudsmen

   On March 17, 2021 drafts of all OAC rules in Chapter 5160-43 were sent to the stakeholders for review and comments. Stakeholders were asked to provide feedback by March 25, 2021.

10. **What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?**

    Feedback regarding the amended OAC rules was discussed thoroughly to ensure stakeholder input was integrated before the rules were finalized. The only comments received were from providers of the Recovery Management service and they provided feedback on updating language in rule 5160-43-01 and providing additional clarification for some of the activities defined in rule 5160-43-04. After

all comments and inquiries were received, ODM held discussions via video conference and email communications to discuss feedback received, apply corresponding language changes to the draft rules as appropriate and provide resolution to comments received.

11. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?

No scientific data was used to develop any of the rules or associated measurable outcomes.

12. What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?

No alternative regulations were considered, as these regulations align with state and federal requirements. There is no regulatory alternative that would have had less of an adverse impact on businesses that would meet CMS approval.

13. Did the Agency specifically consider a performance-based regulation? Please explain. ***Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.***

No, a performance-based regulation is not deemed appropriate for this program.

14. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

SRSP is a unique program in Ohio and at rule implementation ODM consulted with external agencies and completed internal review to ensure the program does not duplicate any existing Ohio regulation.

15. Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.

Both program participants and program service providers will be notified of plans to implement the amendments to the rules in OAC Chapter 5160-43. Notification will occur via a variety of communication methods and guidance regarding process and procedures for Recovery Management agencies will be updated accordingly and distributed to providers.

Adverse Impact to Business

16. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:

a. Identify the scope of the impacted business community; and

The business communities impacted by these rules are the ODM-contracted recovery management providers and the Individualized Placement and Support- Supported Employment (IPS-SE) and

Peer Recovery Support (PRS) service providers through OhioMHAS. There is currently an average of 250 recovery management staff at each of the 2 recovery management agencies that are qualified to provide the service. There are currently 6 agencies that are certified to provides IPS-SE service specific to the SRS program and 4 PRS providers. The amendments to these regulations result in no additional cost of compliance.

b. Identify the nature of all adverse impact (e.g., fees, fines, employer time for compliance,); and

OAC 5160-43-04 requires providers of IPS-SE and PRS to be certified by OhioMHAS in accordance with ORC Section 5119.36 and to maintain a record for each individual served in a manner that protects the confidentiality of the record. Recovery Managers are responsible for evaluating eligibility for potential participants and coordinating program services or needed resources for the individual. The rule requires recovery managers to have training specific to the evaluation and management of the SRS populations. Recovery managers are also required to maintain a record for each individual served in a manner that protects confidentiality.

OAC 5160-43-07 requires all SRS service providers and contractors to comply with monitoring and oversight processes set forth by ODM per the Medicaid provider agreement or contract. Providers are expected to fully cooperate with all requests made by ODM including making all requested information available at the time of review and providing reports as requested by ODM. When any issues with compliance are identified ODM has set forth processes for the provider or contractor to submit a plan of correction for approval and once approved the provider or contractor must adhere to the plan and ODM continues to monitor for compliance. Failure to comply with the terms of the provider agreement or contract and/or plan of correction may result in suspension or termination of the Medicaid provider agreement pursuant to ORC 5164.38 and OAC 5160-1-17.5 and 5160-1-17.6.

c. Quantify the expected adverse impact from the regulation.
The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

The cost of certification through OhioMHAS is based upon the budget of the agency that is applying for certification. The fee schedule showing the correlation between the agency's budget and the certification cost is located in OhioMHAS OAC rule 5122-25-08. A provider already certified by OhioMHAS, requesting to add an additional service(s) pays a fee based only upon their budget for the new service(s). When the agency has appropriate accreditation from The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), or Council on Accreditation (COA) there is no certification fee owed to OhioMHAS.

Record retention is a requirement of all Medicaid providers and is not specific to the Specialized Recovery Services Program (SRSP). The cost of maintaining a record of services provided to the individual can vary depending on the size of the provider agency, the amount of services provided and the method of retention. During the process of gathering input from providers for the proposed rule amendments, providers informed ODM that they do not separately track record retention costs, but the costs are included in their overall administrative costs. The estimated overhead cost per person served varied by agency but ranged from 15% to 20% which includes unrelated items such as supervision, record keeping, internet service, etc. One recovery management agency estimated that their cost is $6,048 annually based on current enrollment levels. Administrative costs are incorporated into the Medicaid payment rate resulting in at least partial reimbursement for these costs.

The recovery management service is provided by ODM-contracted case management agencies and the training of the recovery management agency staff is a requirement within the scope of work and specifications of deliverables of the current contract. The training requirements set forth in these rules are consistent with professional standards, and are imposed for program integrity purposes. The estimated timeframes to complete the various trainings is between thirty and ninety minutes. Based on the Bureau of Labor Statistics data, the median salary of a recovery manager is between $24.26/hour or $50,470/year for a social worker and $35.24/hour or $73,300/year for a registered nurse (RN). Both recovery management agencies provided current average salary information for their recovery management staff and report average salaries as $23.08-$26.96/hour or $48,000-$56,076/year which is in line with the national median salary for social workers. Based on the information median salary data, the expected cost for a social worker to complete a training can be between $12.13 and $36.39 per training. The expected cost for an RN to complete the training can be between $17.62 and $52.86 per training. Recovery Managers are also required to be trained in the administration of the Adult Needs and Strengths Assessment (ANSA) through the Praed foundation and the cost of that training is $12.00/hr; staff are paid their applicable hourly rate during training. The average time for completion of the training and certification for the ANSA is 4 hours.

Costs/time spent for provider staff related to the monitoring and oversight requirements set forth in OAC 5160-43-07 may vary due to the nature of any documents or corrective action plans requested by ODM. Any related costs would be included in administrative costs for providers to communicate and submit information via email or mail and average salary for employees.

17. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

Participation in this program is optional and at the provider's discretion. Compliance with provider certification and incident reporting criteria is consistent with the Medicaid program and providers who choose to participate may incur administrative costs associated the compliance with these requirements. All participating providers will be subject to these requirements. These requirements are necessary to comply with federal law to ensure health and safety and to ensure program integrity.

Regulatory Flexibility

18. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

No, this is not applicable to this program.

19. How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

Not applicable to this program.

20. What resources are available to assist small businesses with compliance of the regulation?

The Ohio Department of Medicaid, Bureau of Provider Services renders technical assistance to providers through its hotline at 1-(800) 686-1516.

DRAFT - NOT FOR FILING

5160-43-01 Specialized recovery services program definitions.

(A) This rule contains the definitions used in Chapter 5160-43 of the Administrative Code applicable to the specialized recovery services program.

(B) Definitions.

~~(1)~~ (1) ~~"Acknowledgment of responsibility" means the document created between the Ohio department of medicaid (ODM) or its designee and an individual enrolled in the program that identifies the interventions recommended by the recovery manager to remedy risks to the health and welfare of the individual.~~

~~(2)~~ (1) "Adult Needs and Strengths Assessment (ANSA)" ~~(7/2016)~~(8/2021) is an integration information assessment tool for use in the development of individualized person-centered care plans, to monitor outcomes, and to help design and plan systems of care for adults with behavioral health challenges.

~~(3)~~ (2) "Alert" means an incident that must be reported to ODM due to the severity and/or impact on the individual enrolled in the program.

~~(4)~~ (3) "Authorized representative" means a person the individual appoints to act on his or her behalf in accordance with rule ~~5160:1-1-33~~5160-1-33 of the Administrative Code.

~~(5)~~ (4) "Clinical record" is a record containing written documentation that must be maintained by a service provider.

(5) "Health and safety action plan" means the document created between the Ohio department of medicaid (ODM) or its designee and an individual enrolled in the program that identifies the interventions recommended by the recovery manager to remedy risks to the health and welfare of the individual.

(6) "Home and community-based services (HCBS) setting" has the same meaning as set forth in rule 5160-44-01 of the Administrative Code.

(7) "Incident" means an alleged, suspected or actual event that is not consistent with the routine care of and/or service delivery to an individual as set forth in rule ~~5160-43-06~~5160-44-05 of the Administrative Code. Incidents include, but are not limited to abuse, neglect, exploitation, misappropriation, and inappropriate service delivery.

(8) "Individual" means a person who is pending enrollment or who is enrolled in the specialized recovery services program and therefore is directed to adhere to the rules in Chapter 5160-43 of the Administrative Code.

(9) "Individualized placement and support - supported employment (IPS-SE)" means the implementation of evidence-based practices allowing individuals to obtain and maintain meaningful employment by providing training, ongoing individualized support, and skill development to promote recovery. IPS-SE is an evidence based practice which is integrated and coordinated with mental health treatment and rehabilitation designed to provide individualized placement and support to assist individuals with a severe and persistent mental illness to obtain, maintain, and advance within competitive community integrated employment positions.

(10) "Legally responsible family member" means an individual's spouse, or in the case of a minor, the

individual's birth or adoptive parent.

(11) "Peer recovery support" means a service that provides community-based supports to an individual with a mental illness with individualized activities that promote recovery, self-determination, self-advocacy, well-being and independence through a relationship that supports the person's ability to promote his or her own recovery. Peer recovery supporters use their own experiences with mental illness to help individuals reach their recovery goals.

(12) "Person-centered ~~care~~service plan" means a ~~person-centered plan~~document that identifies goals, objectives, and interventions selected by the individual. The plan identifies and addresses the assessed needs, services, and supports of the individual and is developed in accordance with 42 CFR 441.725(a) (as in effect on October 1, 2020).

(13) "Provider" means a person or entity who has a provider agreement with ODM and who delivers a specialized recovery services program service, any other service provider that is directed to adhere to this rule, and all of their respective staff who have direct contact with individuals.

(14) "Provider occurrence" means any alleged, suspected or actual performance or operational issue by a provider furnishing program services that does not meet the definition of an incident as set forth in this rule. Provider occurrences include, but are not limited to, alleged violations of provider eligibility and/or service specification requirements, and billing issues including overpayments and medicaid fraud.

(15) "Recovery management" means the coordination of all specialized recovery services program services received by an individual and assisting him or her in gaining access to needed medicaid services, as well as medical, social, educational, and other resources, regardless of funding source.

(16) "Recovery manager" means the person responsible for performing the needs-based assessment and monitoring the provision of services included in the person-centered ~~care~~service plan to ensure the individual's needs, preferences, health and welfare are supported as described in rule 5160-43-04 of the Administrative Code.

(17) "Significant change" means a variation in the health, care or needs of an individual that warrants further evaluation to determine if changes to the type, amount or scope of services are needed.

(18) "Specialized recovery services" means recovery management, peer recovery support and IPS-SE.

(19) "Specialized recovery services program" means the home and community-based services (HCBS) program jointly administered by ODM and the Ohio department of mental health and addiction services (OhioMHAS) or only ~~adminstered~~administered by ODM to provide services to individuals with qualifying diagnoses of severe and persistent mental illness or diagnosed chronic conditions.

(20) "Trans-disciplinary care team" or "care team" means the group of persons freely chosen by the individual to assist and support him or her in the collaboration of creating and implementing a person-centered ~~care~~service plan. The team is led by the individual where possible and must include a recovery manager. It may also include, but is not limited to, the individual's friends, family and natural supports, the physician(s) and other professionals and providers.

DRAFT - NOT FOR FILING

5160-43-02 Specialized recovery services program individual eligibility and program enrollment.

(A) ~~To~~An individual may be eligible for enrollment in the specialized recovery services program~~, an individual shall meet~~ if they meet all of the following ~~requirements~~:

(1) Be at least twenty-one years of age;

(2) Be determined eligible for Ohio medicaid in accordance with Chapters 5160:1-1 to 5160:1-5 of the Administrative Code;

(3) Have a behavioral health diagnosis, be active on the solid organ or soft tissue waiting list, or have a diagnosed chronic condition as listed in ~~the appendix to this rule~~qualifying diagnosis appendix which is available on the ODM website at https://medicaid.ohio.gov/resources-for-providers/special-programs-and-initiatives/srs;

(4) Participate in an initial assessment using the "Adult Needs and Strengths Assessment (ANSA)" ~~(7/2016)~~(8/2021) and obtain a qualifying score of either:

(a) Two or greater on at least one item in the "~~mental health~~behavioral/emotional needs" or "risk behaviors" sections; or

(b) Three on at least one item in the "life ~~domain~~ functioning" section.

(5) Demonstrate needs related to the management of his or her behavioral health or diagnosed chronic condition as documented in the "ANSA" ~~(7/2016)~~(8/2021);

(6) Have at least one of the following risk factors prior to enrollment in the program:

(a) One or more psychiatric inpatient admissions at an inpatient psychiatric hospital; or

(b) A discharge from a correctional facility with a history of inpatient or outpatient behavioral health treatment while residing in that correctional facility; or

(c) Two or more emergency department visits with a psychiatric diagnosis or diagnosed chronic condition; or

(d) A history of treatment in an intensive outpatient rehabilitation program for greater than ninety days; or

(e) One or more hospital inpatient admissions due to a diagnosed chronic condition as listed in the ~~appendix to this rule.~~qualifying diagnosis appendix available at https://medicaid.ohio.gov/resources-for-providers/special-programs-and-initiatives/srs.

(7) Meet at least one of the following:

(a) Currently have a need for one or more of the specialized recovery services to maintain stability, improve functioning, prevent relapse, maintain residency in the community, and be assessed and found that, if not for the provision of home and community-based services (HCBS) for stabilization and maintenance purposes, he or she would decline to prior levels of need (i.e., subsequent

medically necessary services and coordination of care for stabilization and maintenance is needed to prevent decline to previous needs-based functioning); or

(b) Previously have met the needs-based criteria described in paragraph (A)(6) of this rule within two years of the date of initial assessment, and be assessed and found that, but for the provision of HCBS for stabilization and maintenance purposes, he or she would decline to prior levels of need (i.e., subsequent medically necessary services and coordination of care for stabilization and maintenance is needed to prevent decline to previous needs-based functioning).

(8) Reside in an HCBS setting;

(9) Demonstrate a need for specialized recovery services, and not otherwise receive those services;

(10) Have needs that can be safely met through the program in an HCBS setting as determined by the Ohio department of medicaid (ODM) or its designee; and

(11) Participate in the development of a person-centered ~~care~~service plan.

(B) To be enrolled in and to maintain enrollment in the specialized recovery services program, an individual shall be determined by ODM or its designee to meet all of the following requirements:

(1) Be determined eligible for the program in accordance with paragraph (A) of this rule;

(2) Maintain residency in an HCBS setting;

(3) Agree to and receive recovery management services in accordance with his or her person-centered ~~care~~service plan from ODM or its designee including, but not limited to:

(a) ~~Annual~~ Participation in reassessments at least annually and ongoing reassessments~~,~~ as needed;

(b) Participation in the development and implementation of the person-centered ~~care~~service plan and consent to the plan by signing and dating it; and

(c) Participation in quality assurance and participant satisfaction activities during his or her enrollment in the program including, but not limited to, in-person visits.

(C) If an individual fails to meet any of the requirements set forth in paragraph (A) of this rule, the individual shall be denied enrollment in the program.

(D) Once enrolled in the program, an individual's level of need shall be reassessed at least annually, and more frequently if there is a significant change in the individual's condition that may impact his or her health and welfare. If the reassessment determines the individual no longer meets the requirements set forth in paragraph (B) of this rule, he or she shall be disenrolled from the program.

(E) If, at any time, it is determined that an individual enrolled in the program no longer meets the requirements set forth in paragraph (A) and/or paragraph (B) of this rule, he or she shall be disenrolled from the program. Reassessment pursuant to paragraph (D) of this rule is not required to make this determination.

(F) If an individual is denied enrollment in the program pursuant to paragraph (C) of this rule, or is disenrolled from the program pursuant to paragraph (D) or (E) of this rule, the individual shall be afforded notice and

hearing rights in accordance with division 5101:6 of the Administrative Code.

Appendix to rule 5160-43-02

Qualifying Diagnoses for Specialized Recovery

Services Program:

ICD-10 CODES	DIAGNOSIS CATEGORY DESCRIPTION FOR SEVERE AND PERSISTENT MENTAL ILLNESS
~~**B20-B97.35**~~	~~HIV/AIDS~~
~~**C15.3-C26.9**~~	~~Malignancy~~
~~**C33-C43.9**~~	~~Malignancy~~
~~**C45-C45.9**~~	~~Malignancy~~
~~**C50.011-C68.9**~~	~~Malignancy~~
~~**C70.0-C96.Z**~~	~~Malignancy~~
~~**D00.08-D04.0**~~	~~Malignancy~~
~~**D05.00-D09.19**~~	~~Malignancy~~
~~**D09.3-D09.9**~~	~~Malignancy~~
~~**D37.5-D49.9**~~	~~Malignancy~~
~~**D56.4-D58.2**~~	~~Sickle Cell Anemia~~
~~**D65-D68.9**~~	~~Hemophilia~~
~~**D83.0-D83.2**~~	~~Immune Deficiency~~
~~**E84.0-E84.9**~~	~~Cystic Fibrosis~~
F06.0	Psychotic disorders with hallucinations or delusions
F06.2	Psychotic disorder with delusions
F06.30-F06.34	Mood disorders
F06.4	Anxiety disorders
F07.0	Personality change
F20.0-F29	Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorder
F30.10-F30.9	Manic episodes
F31.0-F31.9	Bipolar disorder
F32.0-F39	Major depressive and mood disorders
F40.00-F40.11	Phobic and other anxiety disorders
F40.240	Claustrophobia
F40.241	Acrophobia
F40.8	Other phobic anxiety disorders
F41.0	Panic disorder without agoraphobia
F41.1	Generalized anxiety disorder
F42.2-F42.9	Obsessive-compulsive disorder
F43.10-F43.12	Post-traumatic stress disorder
F43.20-F43.25	Adjustment disorders
F44.0	Dissociative amnesia
F44.1	Dissociative fugue
F44.4-F44.9	Dissociative and conversion disorders
F45.0-F45.9	Somatoform disorders
F48.1, ~~**F48.3-**~~ **F48.9**	Other nonpsychotic mental disorders
F50.00-F50.9	Eating disorders

F53	Postpartum depression
F60.3	Borderline Personality Disorder
F633-F63.9	Impulse disorders
F64.~~1~~-F64.9 ~~68.8~~	Gender identity disorders
~~**F65.0-F66**~~	~~Paraphilias and other sexual disorders~~
F68.10-F68.8	Disorders of adult personality and behavior
F90.0-F90.9	Attention-deficit hyperactivity disorders
F91.0-F91.9	Conduct disorders
F93.0-F93.9	Emotional disorders with onset specific to childhood
F94.0-F94.9~~0~~	Disorders of social functioning with onset specific to childhood and adolescence
~~**F**~~	
~~**N18.6**~~	~~End Stage Renal Disease (ESRD)~~
~~**Q85.00-85.09**~~	~~Malignancy~~
~~**Z21**~~	~~HIV/AIDS~~
~~**Z48.21-Z95.4**~~	~~Previous Transplant~~
~~**Z51.11**~~	~~Malignancy~~

ICD-10 CODE	Diagnosis Category Description for Diagnosed Chronic Conditions (DCC)
B20	Human immunodeficiency virus [HIV] disease
B91	Sequelae of poliomyelitis
C15	Malignant neoplasm of esophagus
C16	Malignant neoplasm of stomach
C20	Malignant neoplasm of rectum
C21	Malignant neoplasm of anus and anal canal
C22	Malignant neoplasm of liver and intrahepatic bile ducts
C23	Malignant neoplasm of gallbladder
C24	Malignant neoplasm of other and unspecified parts of biliary tract
C25	Malignant neoplasm of pancreas
C26	Malignant neoplasm of other and ill-defined digestive organs
C30	Malignant neoplasm of nasal cavity and middle ear
C31	Malignant neoplasm of accessory sinuses
C32	Malignant neoplasm of larynx
C33	Malignant neoplasm of trachea
C34	Malignant neoplasm of bronchus and lung
C38	Malignant neoplasm of heart, mediastinum and pleura
C45	Mesothelioma
C46	Kaposi's sarcoma
C47	Malignant neoplasm of peripheral nerves and autonomic nervous system
C48	Malignant neoplasm of retroperitoneum and peritoneum
C51	Malignant neoplasm of vulva
C52	Malignant neoplasm of vagina

C56	Malignant neoplasm of ovary
C58	Malignant neoplasm of placenta
C64	Malignant neoplasm of kidney, except renal pelvis
C65	Malignant neoplasm of renal pelvis
C66	Malignant neoplasm of ureter
C67	Malignant neoplasm of bladder
C68	Malignant neoplasm of other and unspecified urinary organs
C70	Malignant neoplasm of meninges
C71	Malignant neoplasm of brain
C72	Malignant neoplasm of spinal cord, cranial nerves and other parts of central nervous system
C74	Malignant neoplasm of adrenal gland
C7A	Malignant neuroendocrine tumors
C7B	Secondary neuroendocrine tumors
C81	Hodgkin lymphoma
C82	Follicular lymphoma
C83	Non-follicular lymphoma
C84	Mature T/NK-cell lymphomas
C85	Other specified and unspecified types of non-Hodgkin lymphoma
C86	Other specified types of T/NK-cell lymphoma
C88	Malignant immunoproliferative diseases and certain other B-cell lymphomas
C90	Multiple myeloma and malignant plasma cell neoplasms
C91	Lymphoid leukemia
C92	Myeloid leukemia
C93	Monocytic leukemia
C94	Other leukemias of specified cell type
C95	Leukemia of unspecified cell type
C96	Other and unspecified malignant neoplasms of lymphoid, hematopoietic and related tissue
D57	Sickle-cell disorders
D58	Other hereditary hemolytic anemias
D65	Disseminated intravascular coagulation [defibrination syndrome]
D66	Hereditary factor VIII deficiency
D67	Hereditary factor IX deficiency
E84	Cystic fibrosis
N18.6	End Stage Renal Disease (ESRD)
Q85	Phakomatoses, not elsewhere classified
Z94	Transplanted organ and tissue status
Z21	Asymptomatic human immunodeficiency virus [HIV] infection status

DRAFT - NOT FOR FILING

5160-43-03 Specialized recovery services program individual rights and responsibilities.

(A) Enrollment in the specialized recovery services program is voluntary. Individuals enrolled in the program in accordance with rule 5160-43-02 of the Administrative Code shall be informed of their rights and responsibilities. Individuals also have choice and control over the arrangement and provision of home and community-based services (HCBS), and the selection and control over the direction of approved services.

(B) An individual enrolled in a specialized recovery services program has the right to:

(1) Be treated with dignity and respect.

(2) Be protected from abuse, neglect, exploitation and other threats to personal health, safety and well-being.

(3) Appoint an authorized representative to act on his or her behalf in accordance with rule ~~5160:1-1-55.1~~5160-1-33 of the Administrative Code.

(4) Receive program services in a person-centered manner that is in accordance with an approved person-centered ~~care~~service plan, that is attentive to the individual's needs and maximizes personal independence.

(5) Choose his or her recovery management agency and recovery managers from among qualified and available providers; and

(a) Have the recovery manager explain the program, how it will assist the individual, and his or her rights and responsibilities;

(b) Participate with the recovery manager and the care team in the person-centered ~~care~~service plan development process, and when possible, lead the process;

(c) Request assistance from the recovery manager with recruitment of providers;

(d) Effectively communicate with the recovery manager and care team and receive information in a manner that is easy to understand;

(e) Be able to meet privately with the recovery manager;

(f) Receive ongoing assistance from the recovery manager; and

(g) Be able to request a change of recovery management agency or recovery manager.

(6) Make informed choices regarding the HCBS and supports he or she receives and from whom those services are received.

(7) Obtain the results of criminal records checks for current agency providers or provider applicants pursuant to section 5164.34 of the Revised Code. All personal identifying information such as home address, social security number, and home phone number may be redacted to ensure the safety and security of the provider.

(8) Access files, records or other information related to his or her health care.

(9) Be assured of confidentiality of protected health information pursuant to relevant confidentiality and

information disclosure laws.

(10) Request assistance with problems, concerns, and issues, and suggest changes without fear of repercussion.

(11) Be fully informed about how to contact the recovery manager and the Ohio department of medicaid (ODM) or its designee, with problems, concerns, issues, or inquiries.

(12) Be informed of the right to appeal decisions made by ODM or its designee about program eligibility or services pursuant to division 5101:6 of the Administrative Code.

(C) Upon enrollment in the program, the individual must accept responsibility to:

(1) Participate in, and cooperate during assessments to determine ongoing program eligibility and service needs.

(2) Decide who, in addition to the recovery manager, will participate in the service planning process.

(3) Participate in, and cooperate with, the recovery manager and care team in the development and implementation of the person-centered ~~care~~service plan.

(4) Participate in the recruitment, selection and dismissal of his or her provider(s).

(5) Not direct any HCBS provider to act in a manner that is contrary to relevant ODM-administered HCBS program requirements, medicaid rules, regulations and all other applicable laws, rules and regulations.

(6) Work with the recovery manager when he or she wants to make a change in provider. Notification to the recovery manager shall include the end date of the former provider and the start date of the new provider.

(7) Authorize the exchange of information for development of the person-centered ~~care~~service plan between the care team and his or her service providers, and in compliance with the "Health Insurance Portability and Accountability Act of 1996" (HIPAA) regulations set forth in 45 C.F.R. parts 160 and 164 ~~(as in effect on February 1, 2016)~~(as in effect on October 1, 2020), confidentiality of alcohol and drug abuse patient records as set forth in 42 C.F.R part 2 ~~(as in effect on February 1, 2016)~~(as in effect on October 1, 2020) and the medicaid safeguarding information requirements set forth in 42 C.F.R. parts 431.300 to 431.307 ~~(as in effect on February 1, 2016)~~(as in effect on October 1, 2020) along with sections 5160.45 to 5160.481 of the Revised Code.

(8) Provide accurate and complete information including up-to-date contact information and medical history.

(9) Utilize services in accordance with the approved person-centered ~~care~~service plan.

(10) Report to the recovery manager any service delivery issue(s) including, but not limited to, service disruption, complaints, and concerns about the provider and/or health and safety issues.

(11) Keep and attend scheduled appointments and notify the provider and recovery manager if he or she is going to miss a scheduled visit or service.

(12) Treat the recovery manager, care team and providers with respect.

(13) Report to the recovery manager any significant change as defined in rule 5160-43-01 of the Administrative Code that may affect the provision of services;

(14) Report to the recovery manager and when applicable, the managed care plan care manager, in accordance with rule ~~5160-43-06~~5160-44-05 of the Administrative Code, incidents that may impact his or her health and welfare.

(15) Refuse to participate in dishonest or illegal activities involving providers, caregivers and care team members.

DRAFT - NOT FOR FILING

5160-43-04 Specialized recovery services program covered services and provider requirements.

(A) This rule sets forth the covered services available to an individual enrolled in the specialized recovery services program (SRSP) and the requirements for providers of those services.

(B) Individualized placement and support - supported employment (IPS-SE) is the implementation of evidence-based practices allowing individuals to obtain and maintain meaningful employment by providing training, ongoing individualized support, and skill development to promote recovery. IPS-SE is an evidence based practice which is integrated and coordinated with mental health treatment and rehabilitation designed to provide individualized placement and support to assist individuals with a severe and persistent mental illness obtain, maintain, and advance within competitive community integrated employment positions.

(1) IPS-SE activities include:

(a) Benefits planning;

(b) Development of a vocational plan;

(c) General consultation, including advocacy and building and maintaining relationships with employers;

(d) Individualized job supports, including regular contact with the individual's employer(s), family members, guardians, advocates, treatment providers, and other community supports;

(e) Job coaching;

(f) Job development and placement;

(g) Job seeking skills training;

(h) On-the-job training and skill development;

(i) Vocational rehabilitation guidance and counseling;

(j) Time unlimited vocational support; and

(k) Vocational assessment.

(2) IPS-SE activities may include the following when provided in conjunction with an IPS-SE activity listed in paragraph (B)(1) of this rule:

(a) Facilitation of natural supports;

(b) Peer services; and/or

(c) Transportation.

(3) The following activities are not payable under IPS-SE:

(a) Adaptations, assistance and training used to meet the employer's responsibility to fulfill requirements for reasonable accommodations under the Americans with Disabilities Act, 42 U.S.C. 12101 et. seq. ~~(July 1, 2017)~~(as in effect on January 1, 2021);

(b) Job placements paying below minimum wage;

(c) Supervision, training, support and adaptations typically available to the general workforce filling similar positions in the business;

(d) Supervisory activities rendered as the normal part of business setting;

(e) Unpaid internships, unless they are considered crucial for job placement and such experience is vital to the individual achieving his or her vocational goal(s);

(f) Services which are not provided in integrated settings including sheltered work or other types of vocational services in specialized facilities, or incentive payments, subsidies, or unrelated vocational training expenses such as the following:

(i) Incentive payments made to an employer to encourage hiring the individual;

(ii) Payments that are passed through to the individual; or

(iii) Payments for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business; or payments used to defray the expenses associated with starting up or operating a business.

(4) To be a provider and submit a claim for payment of IPS-SE services, the provider delivering the service must meet all of the following requirements:

(a) Comply with all rules set forth in this chapter and Chapter 5160-27 of the Administrative Code;

(b) Request payment for the provision of services in accordance with rule ~~5160-27-05~~5160-27-03 of the Administrative Code;

(c) Be certified by the Ohio department of mental health and addiction services (OhioMHAS) under section 5119.36 of the Revised Code;

(d) Not be the individual's legally responsible family member, as defined in rule 5160-43-01 of the Administrative Code;

(e) Be identified as the provider and have specified on the individual's person-centered ~~care~~service plan, that is prior approved by the Ohio department of medicaid (ODM) or its designee, the number of hours the provider is authorized to furnish program services to the individual;

(f) Provide services that are supported by an identified need or recovery goal in a manner that supports and respects the individual's communication needs including translation services, and/or assistance with communication devices; and

(g) Not provide IPS-SE services simultaneously with other rehabilitation services available under the medicaid state plan.

(5) IPS-SE providers must maintain a record for each individual served in a manner that protects the confidentiality of those records. At a minimum, the record must contain:

(a) A copy of the current person-centered ~~care~~service plan;

(b) Documentation of each service interaction including the duration IPS-SE was provided; and

(c) Documentation that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973, 29 U.S.C. 701 et. seq. (July 1, 2017), relating to vocational rehabilitation services, or the Individuals with Disabilities Education Act (1990), set forth in 20 U.S.C. section 1400 et. seq. ~~(as in effect on February 1, 2016)~~(as in effect on January 1,2021), relating to special education.

(C) Peer recovery support provides community-based supports to an individual with a mental illness with individualized activities that promote recovery, self-determination, self-advocacy, well-being and independence through a relationship that supports the person's ability to promote his or her own recovery. Peer recovery supporters use their own experiences with mental illness to help individuals reach their recovery goals.

(1) Peer recovery support activities include:

(a) Assisting the individual with accessing and developing natural support systems in the community;

(b) Attending and participating in care team meetings;

(c) Conducting outreach to connect individuals with resources;

(d) Coordinating and/or assisting in crisis interventions and stabilization as needed;

(e) Developing and working toward achievement of the individual's personal recovery goals;

(f) Facilitating development of daily living skills;

(g) Modeling personal responsibility for recovery;

(h) Promoting coordination among similar providers;

(i) Providing group facilitation that addresses symptoms, behaviors, and thought processes to assist an individual in eliminating barriers to seeking and maintaining recovery, employment, education, and housing;

(j) Supporting individuals in achieving personal independence as identified by the individual; and

(k) Teaching skills to effectively navigate the health care delivery system to utilize services.

(2) The following activities are not payable under peer recovery support:

(a) Assistance with activities of daily living as defined in rule 5160-3-05 of the Administrative Code;

(b) Management of medications; and

(c) Performance of activities covered under other services.

(3) To be a provider and submit a claim for payment of peer recovery support services, the provider delivering the service must meet all of the following requirements:

(a) Comply with all rules set forth in this chapter and Chapter 5160-27 of the Administrative Code;

(b) Request payment for the provision of services in accordance with rule ~~5160-27-05~~5160-27-03 of the

Administrative Code;

(c) Be certified by OhioMHAS under section 5119.36 of the Revised Code;

(d) Not be the individual's legally responsible family member, as defined in rule 5160-43-01 of the Administrative Code;

(e) Be identified as the provider and have specified on the individual's person-centered ~~care~~service plan, that is prior approved by ODM or its designee, the number of hours the provider is authorized to furnish services to the individual;

(f) Provide services that are supported by an identified need or recovery goal in a manner that supports and respects the individual's communication needs including translation services, and/or assistance with communication devices;

(g) Not provide peer recovery support activities simultaneously with other rehabilitation services available under the state plan; and

(h) Be supervised by other senior peers or non-peer staff that have been certified to supervise peers and receive regularly scheduled clinical supervision from a person meeting the qualifications of a behavioral health professional with experience regarding this specialized behavioral health service.

(4) All peer recovery support providers must maintain a record for each individual served in a manner that protects the confidentiality of those records. At a minimum, the record must contain:

(a) A copy of the current person-centered ~~care~~service plan;

(b) Documentation of each service interaction including the duration peer recovery support was provided; and

(c) Documentation that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973, relating to vocational rehabilitation services, or the Individuals with Disabilities Education Act (1990) set forth in 20 U.S.C. section 1400 et. seq. (as in effect on February 1, 2016), relating to special education.

(D) Recovery management is the coordination of all SRSP services received by an individual and assisting him or her in gaining access to needed medicaid services, as well as medical, social, educational, and other resources, regardless of funding source.

(1) Recovery managers shall:

(a) Be a registered nurse, or hold at least a bachelor's degree in social work, counseling, psychology, or related field;

(b) Have a minimum of three years post degree experience working with individuals with severe and persistent mental illness or have a minimum of one year post degree experience working with individuals with diagnosed chronic conditions;

(c) Possess an active medicaid provider agreement or be employed by an entity that has an active medicaid provider agreement;

(d) Demonstrate knowledge of issues affecting people with severe and persistent mental illness (SPMI) or diagnosed chronic conditions (DCC) and community-based interventions/resources for those individuals;

(e) Attend training activities including, but not limited to:

(i) Person-centered ~~care~~service planning;

(ii) Administering the "Adult Needs and Strengths Assessment (ANSA)" ~~(7/2016)~~(8/2021);

(iii) Home and community-based services (HCBS) settings;

(iv) "Health Insurance Portability and Accountability Act of 1996" (HIPAA) regulations set forth in 45 C.F.R. parts 160 and 164 ~~(as in effect on July 1, 2017)~~(as in effect on October 1, 2020);

(v) 42 C.F.R. part 2 ~~(as in effect on July 1, 2017)~~(as in effect on October 1, 2020), confidentiality of alcohol and drug abuse patient records; and

(vi) Incident management as described in rule ~~5160-43-06~~5160-44-05 of the Administrative Code.

(f) Be supervised by clinical staff who possess a current, valid and unrestricted license with the appropriate licensure board from the fields of nursing, social work, psychology, or psychiatry.

(2) Recovery management activities include:

(a) Face-to-face eligibility evaluation, including:

(i) Administration of the "ANSA" ~~(7/2016)~~(8/2021);

(ii) Verification of the individual's residence in an HCBS setting;

(iii) Verification of the individual's qualifying behavioral health diagnoses or diagnosed chronic conditions as described in the ~~appendix to rule 5160-43-02 of the Administrative Code~~qualifying diagnosis appendix which is available on the ODM website at https://medicaid.ohio.gov/resources-for-providers/special-programs-and-initiatives/srs ; and

(iv) Evaluation of all other eligibility criteria as described in paragraph (A) of rule 5160-43-02 of the Administrative Code.

(v) Evaluations may be conducted by video conference or telephonically in lieu of face-to-face, unless the individual's needs require a face-to-face visit.

(b) Person-centered care planning and updating the individual's service plan;~~.~~

(c) Facilitation of ~~community transition~~transitioning to the community for individuals who receive ~~Medicaid~~medicaid-funded institutional services. Recovery management activities for individuals leaving institutions shall be coordinated with, and shall not duplicate, institutional, mycare and managed care plan discharge planning, and other community ~~transition programs~~resources. ~~This service may be provided up to one hundred eighty days in advance of anticipated movement to the~~

~~community.~~

(d) Informing the individual about SRSP services, person centered planning, resources for recovery, and individual rights and responsibilities;

(e) Supporting the review and approval of the individual's person-centered service plan in accordance with rule 5160-44-02 of the Administrative Code;

(f) Monitoring the individual's service plan;

(g) Identifying and resolving issues that impede access to needed SRSP services;

(h) Identifying resources in the person-centered service plan to support the individual's recovery goals, including non-HCBS medicaid, medicare, private insurance, and community resources;

(i) Coordinating with other service providers and systems;

(j) Assisting with accessing resources necessary to complete medicaid redetermination and retain HCBS and medicaid eligibility;

~~(j)~~ (k) Responding to and assessing emergency situations~~,~~ and incidents and assuring that appropriate actions are taken to protect the health, welfare, wellness, and safety of the individual in accordance with rule 5160-44-05and ~~assisting~~assist in meeting the needs of the individual in those situations;

~~(k)~~ (l) Evaluating the individual's progress in meeting his or her goals;

~~(l)~~ (m) Participating in quality oversight activities and reporting activities as described in ~~Chapter 5160-43~~rule 5160-43-07 of the Administrative Code;

~~(m)~~ (n) Participating in case consultations regarding an individual's progress with a trans-disciplinary care team, as defined in rule 5160-43-01 of the Administrative Code. When an individual is assigned to or enrolled in a comprehensive care management program operated by an accountable entity (e.g. patient centered medical home or managed care plan), the recovery manager will support access to the individual's full set of medicaid and medicare benefits and community resources across the continuum of care, including behavioral, medical, LTSS and social services;

~~(n)~~ (o) Updating the assessment at least annually, making revisions to the individual's service plan, and making recommendations to the accountable care management entity, as appropriate;

~~(o)~~ (p) Educating the individual about hearing and appeal rights; and

~~(p)~~ (q) Assisting the individual with preparing and submitting a hearing request, as needed.

(3) Recovery management activities do not include:

(a) Travel time incurred by the recovery manager billed as a discrete unit of service;

(b) Services that constitute the administration of another program such as child welfare, child protective services, foster care, parole and probation functions, legal services, public guardianship, and special

education;

(c) Representative payee functions; and

(d) Other activities identified by ODM.

(4) To be a provider and submit a claim for payment of recovery management services, the provider delivering the service shall meet all of the following requirements:

(a) Comply with all rules set forth in this chapter of the Administrative Code;

(b) Request payment for the provision of services in accordance with rule 5160-43-08 of the Administrative Code;

(c) Not be the individual's legally responsible family member;

(d) Be identified as the provider and have specified on the individual's person-centered ~~care~~service plan, that is prior approved by ODM or its designee, the number of hours the provider is authorized to furnish services to the individual;

(e) Provide services that are supported by an identified need or recovery goal in a manner that supports and respects the individual's communication needs including translation services, and/or assistance with communication devices.

(5) All recovery management activities shall be documented in a record using the process prescribed by ODM for each individual served in a manner that protects the confidentiality of these records. At a minimum, the record shall contain:

(a) A copy of the current person-centered ~~care~~service plan;

(b) Documentation of each service interaction including the duration recovery management was provided; and

(c) Documentation that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973, 29 U.S.C. 701 et. seq. ~~(July 1, 2017)~~(as in effect on January 1, 2021) relating to vocational rehabilitation services, or the Individuals with Disabilities Education Act, of 1990 set forth in 20 U.S.C. 1400 et. seq. ~~(as in effect on February 1, 2016)~~(as in effect on January 1, 2021), relating to special education.

DRAFT - NOT FOR FILING

5160-43-05 Specialized recovery services program provider conditions of participation.

(A) Specialized recovery service program providers shall maintain professional relationships with the individuals they serve. Providers shall furnish services in a person-centered manner that is in accordance with the individual's approved person-centered ~~care~~service plan, is attentive to the individual's needs and maximizes the individual's independence. Providers shall refrain from any behavior that may detract from the goals, objectives and services outlined in the individual's approved person-centered ~~care~~service plan and/or that may jeopardize the individual's health and welfare.

(B) Specialized recovery services program providers shall:

(1) Maintain an active, valid medicaid provider agreement as set forth in rule 5160-1-17.2 of the Administrative Code.

(2) Comply with all applicable provider requirements set forth in this chapter of the Administrative Code, including but not limited to:

(a) Provider requirements as set forth in rule 5160-43-04 of the Administrative Code;

(b) Incident reporting as set forth in rule ~~5160-43-06~~5160-44-05 of the Administrative Code;

(c) Provider monitoring, oversight, reviews and investigations as set forth in rule 5160-43-07 of the Administrative Code; and

(d) Criminal records checks for providers of home and community-based services (HCBS) as set forth in rule 5160-43-09 of the Administrative Code.

(3) Deliver services in a person-centered manner, professionally, respectfully and legally.

(4) Ensure that individuals to whom the provider is furnishing services 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 rule ~~5160-43-06~~5160-44-05 of the Administrative Code regarding incident management procedures.

(5) Work with the individual and his or her trans-disciplinary care team to coordinate service delivery, including, but not limited to:

(a) Agreeing to provide and providing services in the amount, scope, location and duration they have capacity to provide, and as specified on the individual's approved person-centered ~~care~~service plan.

(b) Contacting the individual, the recovery manager and/or his or her supervisor, as applicable, when the provider is unable to render services on the appointed date and time, and verify their receipt of information about the absence. ~~In the event of a planned absence, the provider shall make contact no later than seventy-two hours prior to the absence.~~

(6) To the extent not otherwise required by rule ~~5160-43-06~~5160-44-05 of the Administrative Code, notify the Ohio department of medicaid (ODM) or its designee within twenty-four hours when the provider is

aware of issues that may affect the individual and/or provider's ability to render services as directed in the individual's person-centered ~~care~~service plan. Issues may include, but are not limited to:

(a) The individual consistently declines services,

(b) The individual plans to or has moved to another residential address,

(c) There are significant changes in the physical, mental and/or emotional status of the individual,

(d) There are changes in the individual's environmental conditions,

(e) The individual's caregiver status has changed causing service delivery to be impacted or interrupted,

(f) The individual no longer requires medically necessary services as defined in rule 5160-1-01 of the Administrative Code,

(g) The individual's actions toward the provider are threatening or the provider feels unsafe in the individual's environment,

(h) The individual's requests conflict with his or her person-centered ~~care~~service plan and may jeopardize his or her health and welfare, and

(i) Any other situation that affects the individual's health and welfare.

(7) Upon request and within the time frame prescribed in the request, provide information and documentation to ODM, its designee and the centers for medicare and medicaid services (CMS).

(8) Cooperate with ODM and its designee during all provider monitoring and oversight activities by being available to answer questions during reviews, and by ensuring the availability and confidentiality of documentation that may be requested regarding service delivery to individuals.

(9) Participate in all provider trainings mandated or sponsored by ODM or its designees, including but not limited to those set forth in rule 5160-43-04 of the Administrative Code.

(10) Be knowledgeable about and comply with all applicable federal and state laws, including the "Health Insurance Portability and Accountability Act of 1996" (HIPAA) regulations set forth in 45 C.F.R. parts 160 and 164 ~~(as in effect on February 1, 2016)~~(as in effect on October 1, 2020), confidentiality of alcohol and drug abuse patient records set forth in 42 C.F.R part 2 ~~(as in effect on February 1, 2016)~~(as in effect on October 1, 2020), and the medicaid safeguarding information requirements set forth in 42 C.F.R. parts 431.300 to 431.307 ~~(as in effect on February 1, 2016)~~(as in effect on October 1, 2020), along with sections 5160.45 to 5160.481 of the Revised Code.

(11) Ensure that the provider's contact information, including but not limited to address, telephone number, fax number and email address, is current. When contact information changes, the provider shall notify ODM via the medicaid information technology system (MITS) and its designee, no later than seven calendar days after such changes have occurred.

(12) Make arrangements to accept all correspondence sent by ODM or its designee, including certified mail.

(13) Maintain and retain all required documentation related to the services delivered during a visit including

but not limited to: an individual-specific description and details of the services provided or not provided in accordance with the person-centered ~~care~~service plan.

(a) Validation of service delivery shall include, but not be limited to, the date and location of service delivery, arrival and departure times and the dated signature of the provider.

(b) Retain all records of service delivery and billing for a period of six years after the date of receipt of the payment based upon those records, or until any initiated audit is completed, whichever is longer.

(14) Submit written notification to the individual and ODM or its designee at least thirty calendar days before the anticipated last date of service if the provider is terminating the provision of program services to the individual. Exceptions to the thirty-day advance notification requirement include:

(a) A verbal and written notification to the individual and ODM or its designee at least ten days before the anticipated last date of services when the individual:

(i) Has been admitted to a hospital;

(ii) Has entered into an institutional setting; or

(iii) Has been incarcerated.

(b) ODM may waive advance notification for a provider upon request and on a case-by-case basis.

(C) Specialized recovery services program providers shall not:

(1) Engage in any behavior that causes or may cause physical, verbal, mental or emotional abuse or distress to the individual.

(2) Engage in any behavior that may compromise the health and welfare of the individual.

(3) Engage in any behavior that may take advantage of the individual, his or her family, household members or authorized representative, or that may result in a conflict of interest, exploitation or any other advantage for personal gain. This includes but is not limited to:

(a) Misrepresentation;

(b) Accepting, obtaining, attempting to obtain, borrowing, or receiving money or anything of value including but not limited to gifts, tips, credit cards or other items;

(c) Being designated on any financial account including, but not limited to bank accounts and credit cards;

(d) Using real or personal property of another;

(e) Using information of another;

(f) Lending or giving money or anything of value;

(g) Engaging in the sale or purchase of products, services or personal items;

(h) Engaging in any activity that takes advantage of or manipulates specialized recovery services program rules.

(4) Falsify the individual's signature, including copies of the signature.

(5) Make fraudulent, deceptive or misleading statements in the advertising, solicitation, administration or billing of services.

(6) Submit a claim for program services rendered while the individual is hospitalized, institutionalized, ~~or~~ incarcerated, or otherwise residing in a setting that does not meet the HCBS setting requirements set forth in rule 5160-44-01 of the Administrative Code.

(D) While rendering services, specialized recovery services providers shall not:

(1) Take the individual to the provider's place of residence;

(2) Bring animals which are not service animals, children, friends, relatives, or any others to the individual's place of residence;

(3) Provide care to persons other than the individual;

(4) Smoke without consent of the individual;

(5) Sleep;

(6) Engage in any distracting activity that is not related to the provision of services which may interfere with service delivery. Such activities include, but are not limited to:

(a) Using electronic devices for personal or entertainment purposes including, but not limited to watching television, using a computer or playing games;

(b) Making or receiving personal communications; and

(c) Engaging in socialization with persons other than the individual.

(7) Deliver services when the provider is medically, physically or emotionally unfit;

(8) Use or be under the influence of the following while providing services:

(a) Alcohol,

(b) Illegal drugs,

(c) Chemical substances, or

(d) Controlled substances that may adversely affect the provider's ability to furnish services.

(9) Engage in any activity that may reasonably be interpreted as sexual in nature, regardless of whether it is consensual;

(10) Engage in any behavior that may reasonably be interpreted as inappropriate involvement in the individual's personal beliefs or relationships including, but not limited to discussing religion, politics or personal issues; or

(11) Consume the individual's food and/or drink without his or her offer and consent.

(E) Program service providers shall not be designated to serve or make decisions for the individual in any capacity involving a declaration for mental health treatment, general power of attorney, health care power of attorney, financial power of attorney, guardianship pursuant to court order, as an authorized representative, or as a representative payee.

(F) Providers shall pay applicable federal, state and local income and employment taxes in compliance with federal, state and local requirements. Federal employment taxes include medicare and social security.

(G) Failure to meet the requirements set forth in this rule may result in any of the actions set forth in rules ~~5160-43-06~~5160-44-05 and 5160-43-07 of the Administrative Code including, but not limited to, termination of the medicaid provider agreement in accordance with rule 5160-1-17.6 of the Administrative Code. When ODM proposes termination of the medicaid provider agreement, the provider shall be entitled to a hearing under Chapter 119. of the Revised Code in accordance with Chapter 5160-70 of the Administrative Code.

DRAFT - NOT FOR FILING

5160-43-07 Specialized recovery services program compliance: provider monitoring, oversight, ~~structural reviews~~ and investigations.

(A) The Ohio department of medicaid (ODM) is responsible for the ongoing monitoring and oversight of all providers of specialized recovery services (hereafter referred to as providers) and contractors to ensure compliance with program requirements.

(B) Monitoring and oversight of specialized recovery services program providers and recovery management contractors:

(1) ODM and/or its designee (hereafter referred to as ODM) shall conduct ongoing monitoring and oversight of providers and contractors, to verify each provider is:

(a) Complying with the terms and conditions of its medicaid provider agreement or contract, the program and all applicable federal, state and local regulations;

(b) Ensuring the health and welfare of individuals to whom they provide services; and

(c) Ensuring the provision of quality services as part of the program.

(2) Monitoring and oversight may include, but is not limited to:

(a) Interviews with individuals enrolled in the program and/or their authorized representative or legal guardian, providers and contractor staff;

(b) Visits to the provider's place of business or another agreed upon location for the purpose of examining or collecting records, reviewing documentation, and conducting structural reviews; and

(c) Reviews of electronic and/or hard copy records and billing documentation.

(3) Providers and contractors shall fully cooperate with all requests made by ODM, as part of the monitoring and oversight process. This includes, but is not limited to:

(a) Upon request, arranging for or furnishing an adequate workspace for ODM to conduct visits. This workspace must be in a secure location which protects sensitive information from being disclosed contrary to relevant confidentiality and information disclosure laws;

(b) Making all requested information available at the time of review, and in accordance with the terms of compliance with contracts, as applicable; ~~and~~

(c) Providing reports as requested by ODM to monitor performance; and

~~(c)~~ (d) Ensuring the availability of supervisors and/or other staff who may possess relevant information to answer questions.

(4) At the conclusion of a provider monitoring and oversight review:

(a) ODM shall notify the provider or contractor in writing of its findings.

(b) ODM may:

(i) Request the provider or contractor submit to ODM a plan of correction within the prescribed time

frame. The plan of correction shall set forth the action(s) that must be taken by the provider or contractor to correct each finding, and establish a target date by which the corrective action must be completed. If ODM does not approve the submitted plan of correction, ODM may request a new plan of correction or take other appropriate action;

(ii) Provide technical assistance to the provider or contractor;

(iii) Refer the provider or contractor to other regulatory and oversight entities for further investigation;

(iv) Issue the provider or contractor a notice of operational deficiency based upon the review and findings;

(v) Propose suspension or termination of the provider's medicaid provider agreement pursuant to section 5164.38 of the Revised Code and rules 5160-1-17.5 and 5160-1-17.6 of the Administrative Code, as applicable; or

(vi) Terminate the contractor's contract pursuant to its terms.

~~(C) Structural reviews.~~

~~(1) All service providers shall be subject to structural reviews by ODM during each of the first three years after a provider begins furnishing billable services. Thereafter, structural reviews shall be conducted annually unless, at the discretion of ODM, biennial structural reviews may be conducted with a provider when all of the following apply;~~

~~(a) There were no findings against the provider during the provider's most recent structural review;~~

~~(b) The provider was not substantiated to be the violator in an incident described in rule 5160-43-06 of the Administrative Code; and~~

~~(c) The provider was not the subject of more than one provider occurrence during the previous twelve months.~~

~~(2) All program service providers may be subject to an announced or unannounced structural review at any time as determined by ODM.~~

~~(3) Structural reviews must be conducted in person between the provider and ODM, unless prior-approved by ODM, and in a manner consistent with paragraph (B)(3) of this rule.~~

~~(4) All structural reviews must use an ODM-approved structural review tool.~~

~~(5) Structural reviews shall not occur while the provider is furnishing services to an individual.~~

~~(6) The structural review process consists of the following activities:~~

~~(a) Except for unannounced structural reviews, the provider shall be notified in advance of the review to arrange a mutually acceptable time, date and location for the review. Advance notification shall also include identification of the time period for which the review is being conducted and a list of the types of documents required for the review.~~

~~(b) The provider shall ensure the availability of required documents and maintain the confidentiality of~~

~~information about the individual enrolled in the program.~~

~~(c) ODM shall examine any incident reports or provider occurrences related to the provider. Documented findings of non-compliance shall be addressed during the review.~~

~~(d) An evaluation of compliance with the rules within this chapter of the Administrative Code shall be conducted by ODM.~~

~~(e) A unit of service verification shall be conducted by ODM to assure that all program services are authorized, delivered and reimbursed in accordance with the individual's approved person-centered care plan.~~

~~(f) An evaluation to determine whether the provider has implemented all plans of correction that were approved since the last review.~~

~~(g) At the conclusion of the review, ODM shall conduct an exit conference with the provider to discuss preliminary findings, any remediation and other required follow-up.~~

~~(7) ODM shall issue a written findings report to the provider. The report shall summarize the overall outcome of the structural review, specify the Administrative Code rules that are the basis for which non-compliance has been determined, and outline the specific findings of non-compliance that the provider must address in a plan of correction, including any remediation.~~

~~(8) Plans of correction for structural reviews must be submitted to ODM for all identified findings of noncompliance, including any remediation, within forty-five calendar days after the date on the written report.~~

~~(9) If ODM finds the provider's plan of correction acceptable, it shall acknowledge, in writing, to the provider that the plan addresses the findings outlined in the written report. If ODM determines that it cannot approve the provider's plan of correction, ODM shall inform the provider of this determination in writing, require the provider to submit a new plan of correction and specify the required actions that must be included in the plan of correction. The provider must submit the new plan of correction within ten calendar days.~~

~~(10) If ODM determines through the structural review process that an overpayment of a provider claim has occurred, the provider shall make all payment adjustments in accordance with rule 5160-1-19 of the Administrative Code and the provider's approved plan of correction.~~

~~(11) ODM may take action against the provider as specified in paragraph (B)(4)(b) of this rule for failure to comply with the structural review requirements set forth in this rule.~~

~~(D)~~ (C) Investigation of provider occurrences.

(1) Upon discovery, ODM or its designee shall investigate provider occurrences including requesting any documentation required for the investigation.

(2) If ODM substantiates the provider occurrence, it shall notify the provider in a manner that confirms provider receipt. The notification shall specify:

(a) The provider's action or inaction that constituted the provider occurrence;

(b) The Administrative Code rule(s) that support the finding(s) of non-compliance; and

(c) Actions the provider must take to correct the finding(s) of non-compliance, including any remediation or required payment adjustments.

(3) Plans of correction for provider occurrences must be submitted to ODM for all identified findings of non-compliance, including any remediation, within forty-five calendar days after the date on the written report.

(4) If ODM finds the provider's plan of correction acceptable, it shall acknowledge, in writing, to the provider that the plan addresses the findings outlined in the written report. If ODM determines that it cannot approve the provider's plan of correction, it shall inform the provider of this determination in writing, require the provider to submit a new plan of correction and specify the required actions that must be included in the plan of correction. The provider must submit the new plan of correction within ten calendar days.

(5) If ODM determines through the investigation of a provider occurrence that an overpayment of a provider claim has occurred, the provider shall make all payment adjustments in accordance with rule 5160-1-19 of the Administrative Code and the provider's approved plan of correction.

(6) ODM may take action against the provider as specified in paragraph (B)(4)(b) of this rule for failure to comply with the investigation of provider occurrences requirements set forth in this rule.

DRAFT - NOT FOR FILING

5160-43-08 Specialized recovery services program billing procedures and payment rates for recovery management.

(A) Definitions of terms used for billing and calculating rates.

(1) "Billing unit" as used in column 4 of paragraph (C) of this rule, means a single fixed item, amount of time or measurement.

(2) "Unit rate" as used in column 3 of paragraph (C) of this rule, means the amount reimbursed by the Ohio department of medicaid (ODM) for each fifteen minutes of service delivered.

(B) Payment rates for individualized placement and support - supported employment and peer recovery support services may be found in rule 5160-27-03 and rule 5160-1-60 of the Administrative Code.

(C) Recovery management billing code table.

Column 1	Column 2	Column 3	Column 4
Billing code	Service	Unit rate	Billing unit
T1016	Recovery management	$19.00	15 minutes

(D) Claims shall be submitted to ODM via the medicaid information technology system (MITS), and paid in accordance with Chapter 5160-1 of the Administrative Code.

DRAFT - NOT FOR FILING

5160-43-09 Specialized recovery services program criminal records checks for providers.

(A) This rule sets forth the process and requirements for the criminal records checks of providers of home and community-based services (HCBS) to individuals enrolled in the specialized recovery services program. HCBS include recovery management, peer recovery support and individualized placement and support-supported employment (IPS-SE). This rule only applies to all persons under final consideration for employment with an agency and existing employees in a full-time, part-time or temporary position who are providing HCBS and billing medicaid for these services.

(B) For the purposes of this rule:

(1) "Agency" means an entity certified by the Ohio department of mental health and addiction services under section 5119.36 of the Revised Code.

(2) "Chief administrator" means the head of an agency, or his or her designee.

(3) "Criminal records check" has the same meaning as in section 109.572 of the Revised Code.

(4) "Disqualifying offense" means any of the following:

(a) A violation of one or more Revised Code section(s) set forth in the appendix to this rule;

(b) A violation of section 2923.01, 2923.02, or 2923.03 of the Revised Code when the underlying offense that is the object of the conspiracy, attempt, or complicity is a violation of one of the sections set forth in the appendix to this rule; or

(c) A violation of an existing or former municipal ordinance or law of the state of Ohio, any other state or the United States that is substantially equivalent to any of the disqualifying offenses as set forth in paragraphs (B)(4)(a) and (B)(4)(b) of this rule.

(5) "Employ" means to hire a provider applicant to be an employee as defined in paragraph (B)(6) of this rule.

(6) "Employee" means a person employed by an agency in a full-time, part-time or temporary position, including conditional employment as described in paragraph (D)(4) of this rule, that involves providing HCBS ~~services~~ including peer recovery support and IPS-SE when medicaid is billed for these services.

(7) "Provider applicant" means a person who is under final consideration for employment with an agency in a full-time, part-time or temporary position, when the position provides HCBS when medicaid is billed for these services.

(C) No agency shall employ a provider applicant or continue to employ an employee in a position that involves providing HCBS if the provider applicant or employee:

(1) Is included in one or more of the following databases:

(a) The system for award management (SAM) maintained by the United States general services administration;

(b) The list of excluded individuals and entities maintained by the office of inspector general in the United States department of health and human services pursuant to 42 U.S.C. part 1320a-7 ~~(as in~~

~~effect on February 1, 2016)~~(as in effect on January 1, 2021) and 42 U.S.C. part 1320c-5 ~~(as in effect on February 1, 2016)~~(as in effect on January 1, 2021).

(c) The Ohio department of developmental disabilities (DODD) online abuser registry established under section 5123.52 of the Revised Code;

(d) The internet-based sex offender and child-victim offender database established under division (A)(11) of section 2950.13 of the Revised Code;

(e) The internet-based database of inmates established under section 5120.66 of the Revised Code; or

(f) The state nurse aide registry established under section 3721.32 of the Revised Code, and there is a statement detailing findings by the director of health that the provider applicant or employee neglected or abused a long-term care facility or residential care facility resident or misappropriated property of such a resident.

(2) Fails to:

(a) Submit to a criminal records check conducted by the bureau of criminal identification and investigation (BCII), including failing to access, complete and forward to the superintendent the form or the standard fingerprint impression sheet; or

(b) Instruct the superintendent of BCII to submit the completed report of the criminal records check directly to the chief administrator of the agency.

(3) Except as provided for in paragraphs (F) and (G) of this rule, the provider applicant or employee has been convicted of, or pleaded guilty to, a disqualifying offense, regardless of the date of the conviction or data of entry of the guilty plea.

(D) Process for conducting criminal records checks.

(1) At the time of each provider applicant's initial application for employment in a position that involves providing HCBS for an individual enrolled in the specialized recovery services program, the chief administrator of the agency shall conduct a review of the databases listed in paragraph (C)(1) of this rule to determine whether the agency is prohibited from employing the provider applicant in that position. The chief administrator of the agency shall provide the provider applicant with a copy of any disqualifying information disclosed in the review of the databases.

(2) Except as otherwise noted in paragraph (C)(1) of this rule, the chief administrator of an agency shall require each provider applicant to request that the BCII superintendent conduct a criminal records check with respect to the provider applicant, and pursuant to section 109.572 of the Revised Code. The provider applicant must provide a set of fingerprint impressions as part of the criminal records check.

(a) If a provider applicant does not present proof of having been a resident of the state of Ohio for the five-year period immediately prior to the date the criminal records check is requested, or provide evidence that within that five-year period the superintendent has requested information about the provider applicant from the federal bureau of investigation (FBI) in a criminal records check, the chief administrator shall require the provider applicant to request that the superintendent obtain information from the FBI as part of the criminal records check.

(b) Even if a provider applicant presents proof of having been a resident of the state of Ohio for the five-

year period, the chief administrator may require the provider applicant to request that the superintendent obtain information from the FBI in the criminal records check.

(3) The chief administrator of an agency shall provide the following to each provider applicant for whom a criminal records check is required by this rule:

(a) Information about accessing, completing and forwarding to the superintendent the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and the standard fingerprint impression sheet presented pursuant to division (C)(2) of that section; and

(b) Written notification that the provider applicant is to instruct the superintendent to submit the completed report of the criminal records check directly to the chief administrator of the agency.

(4) Conditional employment.

(a) An agency may conditionally employ a provider applicant for whom a criminal records check is required by this rule prior to obtaining the results of that check, provided that the agency has conducted a review of the databases listed in paragraph (C)(1) of this rule and has determined the agency is not prohibited from employing the provider applicant in that position. The chief administrator must require the provider applicant to request a criminal records check no later than five business days after he or she begins conditional employment.

(b) The agency shall terminate conditional employment if the results of the criminal records check, other than the results of any request for information from the FBI, are not obtained within sixty days of the criminal records check request.

(5) If the results of the criminal records check indicate that the provider applicant has been convicted of, or has pleaded guilty to any of the disqualifying offenses set forth in paragraph (B)(4) of this rule, and regardless of the date of conviction or the date of entry of the guilty plea, then the agency shall either:

(a) Terminate his or her employment; or

(b) Choose to employ the provider applicant because he or she meets the conditions set forth in paragraph (F) of this rule.

(6) If the agency determines that two or more convictions or guilty pleas result from or are connected with the same act or result from offenses committed at the same time, they shall be counted as one conviction or guilty plea.

(7) Termination of employment shall be considered just cause for discharge for the purposes of division (D)(2) of section 4141.29 of the Revised Code if the employee makes any attempt to deceive the agency about his or her criminal record.

(8) An agency shall pay to BCII the fee prescribed pursuant to division (C)(3) of section 109.572 of the Revised Code for any criminal records check required by this rule. However, an agency may require a provider applicant to pay to BCII the fee for a criminal records check for the applicant. If the agency pays the fee for a provider applicant, it may charge the provider applicant a fee not exceeding the amount the agency pays to BCII if the agency notifies the provider applicant at the time of application for employment of the amount of the fee and that, unless the fee is paid, he or she will not be considered for employment.

(9) Reports of any criminal records checks conducted by BCII in accordance with this rule are not public records for the purposes of section 149.43 of the Revised Code and shall not be made available to any person other than the following:

(a) The person who is the subject of the criminal records check or their representative;

(b) The chief administrator of the agency that requires the provider applicant or employee to request the criminal records check or the administrator's representative;

(c) The director and staff of the Ohio department of medicaid (ODM) who are involved in the administration of the Ohio medicaid program;

(d) An individual enrolled in the specialized recovery services program who receives, or may receive, HCBS from the person who is the subject of the criminal records check provided that the social security number, address and telephone number have been redacted from the record; and

(e) Any court, hearing officer or other necessary individual involved in a case dealing with a denial of employment of the provider applicant or termination of the employee; employment or unemployment benefits of the provider applicant or employee; or a civil or criminal action regarding the Ohio medicaid program.

(E) As a condition of continuing to employ an employee in a position that involves providing HCBS, the chief administrator of the agency shall follow the same process set forth in paragraphs (D)(1) to (D)(9) of this rule. The chief administrator:

(1) Shall conduct a criminal records check of an employee who does not currently have a criminal records check on file with the agency no later than ninety days after ~~July 1, 2016~~August 1, 2021;

(2) Shall conduct a criminal records check no later than thirty days after each employee anniversary date every five years;

(3) May conduct a criminal records check on any employee more frequently than every five years without any need to conduct a criminal records check according to the schedules set forth in paragraphs (E)(1) and (E)(2) of this rule.

(F) An agency may choose to employ a provider applicant or continue to employ an employee who has been convicted of, or has pleaded guilty to, a disqualifying offense set forth in paragraph (B)(4) of this rule when the provider applicant or employee has:

(1) Satisfied the conditions associated with the exclusionary periods set forth in paragraph (G) of this rule; or

(2) Obtained a certificate of qualification for employment issued by a court of common pleas with competent jurisdiction pursuant to section 2953.25 of the Revised Code, except when the provider applicant or employee has been convicted of or pleaded guilty to a tier I offense as described in paragraph (G)(1) of this rule; or

(3) Obtained a certificate of achievement and employability in an HCBS-related field, issued by the Ohio department of rehabilitation and corrections pursuant to section 2961.22 of the Revised Code, except when the provider applicant or employee has been convicted of or pleaded guilty to a tier I offense as described in paragraph (G)(1) of this rule; and

(4) Agreed, in writing, to have the agency inform each individual enrolled in the specialized recovery services program who may receive services from the provider applicant or employee of the disqualifying offense, and has acknowledged, in writing, that the individual has the right to select or reject to receive services from the provider applicant or employee, prior to commencing service delivery.

(G) An agency may employ a provider applicant or continue to employ an employee who has been convicted of or pleaded guilty to an offense listed in paragraph (B)(4) of this rule in a position providing HCBS to an individual enrolled in the specialized recovery services program pursuant to the following timeframes:

(1) Tier I, permanent exclusion.

(a) No agency shall employ a provider applicant or continue to employ an employee in a position that involves providing HCBS to an individual enrolled in the specialized recovery services program, when any of the following applies:

(i) The provider applicant or employee has been convicted of or pleaded guilty to any tier I offense as listed in the appendix to this rule; or

(ii) The provider applicant or employee has been convicted of or pleaded guilty to an offense in section 2923.01 (conspiracy), 2923.02 (attempt), or 2923.03 (complicity) of the Revised Code in relation to any other tier I offense; or

(iii) The provider applicant or employee has a violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the tier I offenses or violations as described in the appendix to this rule.

(b) Tier I permanent exclusion applies when the provider applicant or employee has a conviction related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct involving a federal or state-funded program, excluding the disqualifying offenses set forth in section 2913.46 of the Revised Code (illegal use of supplemental nutrition assistance program (SNAP) or women, infants, and children (WIC) program benefits) and paragraph (G)(2) of this rule.

(2) Tier II, ten-year exclusionary period.

(a) No agency shall employ a provider applicant or continue to employ an employee in a position that provides HCBS to an individual enrolled in the specialized recovery services program for a period of ten years from the date the provider applicant or employee was fully discharged from all imprisonment, probation or parole, when the following applies:

(i) The provider applicant or employee has been convicted of or pleaded guilty to any tier II offense as listed in the appendix to this rule; or

(ii) The provider applicant or employee has been convicted of or pleaded guilty to an offense in section 2923.01 (conspiracy), 2923.02 (attempt), or 2923.03 (complicity) of the Revised Code in relation to any other tier II offense; or

(iii) The provider applicant or employee has a violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the tier II offenses or violations as described in the appendix to this rule.

(b) If a provider applicant or employee has been convicted of multiple disqualifying offenses, including a

tier II offense, and another tier II, tier III or tier IV offense or offenses, the provider applicant or employee is subject to a fifteen-year exclusionary period beginning on the date the provider applicant or employee was fully discharged from all imprisonment, probation or parole for the most recent offense.

(3) Tier III, seven-year exclusionary period.

(a) No agency shall employ a provider applicant or continue to employ an employee in a position that provides HCBS to an individual enrolled in the specialized recovery services program for a period of seven years from the date the provider applicant or employee was fully discharged from all imprisonment, probation or parole, when the following applies:

(i) The provider applicant or employee has been convicted of or pleaded guilty to any tier III offense as listed in the appendix to this rule; or

(ii) The provider applicant or employee has been convicted of or pleaded guilty to an offense in section 2923.01 (conspiracy), 2923.02 (attempt), or 2923.03 (complicity) of the Revised Code in relation to any other tier III offense; or

(iii) The provider applicant or employee has a violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the tier III offenses or violations as described in the appendix to this rule.

(b) If a provider applicant or employee has been convicted of multiple disqualifying offenses, including a tier III offense, and another tier III or tier IV offense or offenses, the provider applicant or employee is subject to a ten-year exclusionary period beginning on the date the provider applicant or employee was fully discharged from all imprisonment, probation or parole for the most recent offense.

(4) Tier IV, five-year exclusionary period.

(a) No agency shall employ a provider applicant or continue to employ an employee in a position that provides HCBS to an individual enrolled in the specialized recovery services program for a period of five years from the date the provider applicant or employee was fully discharged from all imprisonment, probation or parole, when the following applies:

(i) The provider applicant or employee has been convicted of or pleaded guilty to any tier IV offense as listed in the appendix to this rule; or

(ii) The provider applicant or employee has been convicted of or pleaded guilty to an offense in section 2923.01 (conspiracy), 2923.02 (attempt), or 2923.03 (complicity) of the Revised Code in relation to any other tier IV offense;

(iii) The provider applicant or employee has a violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the tier IV offenses or violations as described in the appendix to this rule.

(b) If a provider applicant or employee has been convicted of multiple disqualifying tier IV offenses, the provider applicant or employee is subject to a seven-year exclusionary period beginning on the date the provider applicant or employee was fully discharged from all imprisonment, probation or parole for the most recent offense.

(5) Tier V, no exclusionary period.

(a) An agency may employ a provider applicant or continue to employ an employee in in a position that provides HCBS to an individual enrolled in the specialized recovery services program if the provider applicant or employee has been convicted of or pleaded guilty to any tier V offense as listed in the appendix to this rule.

(b) No exclusionary period applies when the provider applicant or employee has a violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the tier V offenses or violations as described in the appendix to this rule.

(H) Pardons.

(1) A conviction of, or a plea of guilty to an offense as set forth in paragraph (B)(4) of this rule shall not prevent any agency from considering a provider applicant for employment or an employee for continued employment if the provider applicant or employee has been granted any of the following:

(a) An unconditional pardon for the offense pursuant to Chapter 2967. of the Revised Code;

(b) An unconditional pardon for the offense pursuant to an existing or former law of the state of Ohio, any other state, or the United States, if the law is substantially equivalent to Chapter 2967. of the Revised Code; or

(c) A conditional pardon for the offense pursuant to Chapter 2967. of the Revised Code, and the condition(s) under which the pardon was granted have been satisfied.

(2) A conviction of, or plea of guilty to an offense as set forth in paragraph (B)(4) of this rule shall not prevent any agency from considering a provider applicant for employment or an employee for continued employment if the provider applicant's or employee's conviction or guilty plea has been set aside pursuant to law.

(I) Documentation of compliance. Each agency shall maintain a roster of provider applicants and employees, accessible by the ODM director or designee, which includes but is not limited to:

(1) The name of each provider applicant and employee;

(2) The date the employee started work;

(3) The date the criminal records check request is submitted to BCII;

(4) The date the criminal records check is received by the agency; and

(5) A determination of whether the results of the check revealed that the provider applicant or employee committed a disqualifying offense(s).