Application for

Section 1915(b) (4) Waiver
Fee-for-Service
Selective Contracting Program

July, 2026

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Application for Section 1915(b)(4) Waiver
Fee-for-Service (FFS) Selective Contracting Program

Facesheet

The **State** of Ohio requests an amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is Recovery Management Services under the Specialized Recovery Services Program (1915(i) HCBS program). (List each program name if the waiver authorizes more than one program.).

Type of request. This is:

☐An initial request for new waiver. All sections filled.
☐A request to amend an existing waiver, which modifies Section/Part A and B
☑A renewal request

Section A is: *

☐ Replaced in full
☐ Carried over with no changes ☐ Changes noted in **BOLD**.

Section B is: *

☐ Replaced in full
☐ Changes noted in **BOLD**.

*Redlined copy of amendment with technical changes shared with CMS.

Effective Dates: This waiver amendment is requested for a period of 5 years beginning October 1, 2026 and ending September 30, 2031.

State Contact: The State contact person for this waiver is John Dunn and can be reached by telephone at (614) 466-4693 or email at john.dunn@medicaid.ohio.gov. (List for each program)

Section A – Waiver Program Description

Part I: Program Overview

Tribal Consultation:

Describe the efforts the State has made to ensure that Federally-recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal (if additional space is needed, please supplement your answer with a Word attachment).

N/A – There are no Federally-recognized tribes in Ohio.

Program Description:

Provide a brief description of the proposed selective contracting program or, if this is a request to amend an existing selective contracting waiver, the history of and changes requested to the existing program. Please include the estimated number of enrollees served throughout the waiver (if additional space is needed, please supplement your answer with a Word attachment).

Effective October 1, 2026, this fee-for-service selective contracting 1915(b)(4) waiver operates concurrently with Ohio's state plan home- and community-based services waiver as described in Attachment 3.1-i as renewed and amended by OH SPA TN26-0005. This 1915(b)(4) waiver includes Recovery Management services under the 1915(i) State Plan HCBS program, and focuses on providing recipients with the supports needed to maintain them in the community. This program uses the Recovery Management provider qualifications under the 1915(i) and selectively contracts with a Recovery Management Provider to provide that service.

Recovery Management includes coordinating all services received by an individual and assisting the individual in gaining access to needed Medicaid State Plan and 1915(i) services, as well as medical, social, educational, and other resources, regardless of funding source. Recovery Managers are responsible for monitoring the provision of services included in the Person-Centered Plan to ensure that the individual's needs, preferences, health, and welfare are promoted. This program is projected to have 1,000 – 7,800[1] enrollees over the renewed five-year waiver period. This range includes the number of enrollees in year 1 and considering the reductions of Fee For Service members converting to MyCare.

In addition to the functions of coordinating, developing and monitoring all aspects of the Person-Centered Plan, Recovery Management includes functions necessary to facilitate community transition for individuals who receive Medicaid-funded institutional services. Recovery management activities for individuals leaving institutions must be coordinated with, and must not duplicate, institutional and managed care plan discharge planning and other community transition programs.

[1] Reduction estimates based on ODM 2425-0010 SRS Request for Proposal for 5-year period anticipated due to MyCare Expansion.

This waiver seeks to limit freedom of choice of providers of the Recovery Management service and to selectively contract with at least two Recovery Management entities to provide Recovery Management services directly or employs or contracts with individual Recovery Managers. Ohio wants to ensure conflict free evaluation, assessment and service plan monitoring in the 1915(i) program.

Waiver Services:

Please list all existing State Plan services the State will provide through this selective contracting waiver (if additional space is needed, please supplement your answer with a Word attachment).

The State Plan service provided under this selective contracting waiver is the 1915(i) HCBS service of Recovery Management Services provided through the Specialized Recovery Services 1915(i) HCBS Program.

Recovery Management Services include coordinating all services received by an individual and assisting the individual in gaining access to needed Medicaid State Plan and 1915(i) services, as well as medical, social, educational, and other resources, regardless of funding source. Recovery Managers are responsible for coordinating, developing and monitoring the provision of services included in the Person-Centered Plan to ensure that the individual's needs, preferences, health, and welfare are promoted.

A. Statutory Authority

1. **Waiver Authority.** The State is seeking authority under the following subsection of 1915(b):

☑ 1915(b)(4) – FFS Selective Contracting program

2. **Sections Waived.** The State requests a waiver of these sections of 1902 of the Social Security Act:

Section 1902(a)(1) – Statewideness
☐Section 1902(a)(10)(B) – Comparability of Services
☑Section 1902(a)(23) – Freedom of Choice
☐Other Sections of 1902 – (please specify)

B. Delivery Systems

1. **Reimbursement**. Payment for the selective contracting program is:

☑ The same as stipulated in the State Plan

☐ Is different than stipulated in the State Plan (please describe)

2. **Procurement.** The State will select the contractor in the following manner:
☑Competitive procurement
☐Open cooperative procurement
☐Sole source procurement
☑Other (please describe)
To meet the element of choice, ODM contracted with an additional qualified provider.

C. Restriction of Freedom of Choice

1. Provider Limitations:

☐Beneficiaries will be limited to a single provider in their service area.
☑Beneficiaries will be given a choice of providers in their service area.

(NOTE: Please indicate the areas(s) of the State where the waiver program will be implemented)

Individuals eligible for the MyCare program will be enrolled under the 1915(b) freedom of choice waiver for MyCare and not under this 1915(b)(4) waiver. Prior to January 1, 2026, MyCare was only available in 29 counties in Ohio. On January 1, 2026, Ohio began implementation of Next Generation MyCare, beginning in those 29 counties and expanding statewide in phases through August 1, 2026. For SRS members who are eligible for and enrolled in Next Generation MyCare, Recovery Management under this 1915(b)(4) waiver for the Specialized Recovery Services remains a distinct, selectively contracted service. The Recovery Management Provider coordinates with the members' MyCare plan and other service providers to support access to needed Medicaid State Plan, 1915(i), Medicare, behavioral health, long - term services and supports, and other community resources and is intended to complement and not duplicate managed care plan coordination, discharge planning or other covered plan functions.

The waiver program will be implemented statewide through a Multiple Award Contract (MAC) that contracts with at least two Recovery Management Provider entities to provide recovery management services directly or which employs or contracts with individual recovery management providers. The state also ensures it will comply with 42 CFR 431.55(f).

The applicant/recipient will be assigned to a Recovery Management Provider. Individuals may also request a new Recovery Manager within the provider agency if they do not wish to remain with the assigned manager. Individuals can request transfer to an alternative Recovery Management Provider by contacting the state; however, individuals in Managed Care will be restricted to the Recovery Management Provider with which their plan contracts. Once again, however, they can request a new Recovery Manager within their provider agency. The selected Recovery Manager will explain the process for making an informed choice of provider under the 1915(i) HCBS program and answer questions regarding that choice.

An HCBS assurance on choice of providers (including Recovery Management) is included in Attachment 3.1-i for on-going state monitoring and reporting.

2. State Standards.
Detail any difference between the state standards that will be applied under this waiver and those detailed in the State Plan coverage or reimbursement documents (if additional space is needed, please supplement your answer with a Word attachment).

There are no differences in state standards under this waiver than those detailed in the State Plan coverage or reimbursement documents. The proposed waiver does not change the provider/service standards and expectations outlined in Attachment 3.1-i.

D. Populations Affected by Waiver

(May be modified as needed to fit the State's specific circumstances)

This waiver does not change the target population, as defined in Attachment 3.1-i and addressed above under the "Program Description" section.

1. Included Populations. The following populations are included in the waiver:

- ☐Section 1931 Children and Related Populations
- ☐Section 1931 Adults and Related Populations
- ☑Blind/Disabled Adults and Related Populations
- ☐Blind/Disabled Children and Related Populations
- ☑Aged and Related Populations
- ☐Foster Care Children
- ☐Title XXI CHIP Children

Excluded Populations. Indicate if any of the following populations are excluded from participating in the waiver:

- ☐Dual Eligibles
- ☐Poverty Level Pregnant Women
- ☐Individuals with other insurance
- ☑Individuals residing in a nursing facility or ICF/IID
- ☐Individuals enrolled in a managed care program
- ☑Individuals participating in a HCBS Waiver program (other than the 1915(i) HCBS program).
- ☐American Indians/Alaskan Natives
- ☐Special Needs Children (State Defined). Please provide this definition.
- ☐Individuals receiving retroactive eligibility.
- ☑Other (Please define): No children will be covered under this program.

This waiver does not change the target population, as defined in Attachment 3.1-i and addressed above under the Program Description section. There will be new admissions as well as discharges each year.

Part II: Access, Provider Capacity and Utilization Standards

A. Timely Access Standards

Describe the standard that the State will adopt (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has adopted) defining timely Medicaid beneficiary access to the contracted services, *i.e.*, what constitutes timely access to the service?

1. How does the State measure (or propose to measure) the timeliness of Medicaid beneficiary access to the services covered under the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment)?

The State of Ohio has assurances in place to ensure the timeliness of Medicaid beneficiary access to the Recovery Management service consistent with the HCBS assurances. The State monitors the access to Recovery Management services timeframes as a part of the HCBS program quality assurance reviews. The State conducts regularly scheduled service quality audits to ensure agency compliance with the State's expectations and the federal assurances.

The Recovery Managers will be held to specific standards that impact the timeliness of a beneficiary's access to the service which are as follows: The assessment process should be initiated no later than 10 business days after the brief screen is conducted by the applicable entry point. The Recovery Manager finalizes initial documentation gathering and ensures that plans of care are developed within 45 days of the initiation of the assessment process.

The Recovery Manager updates the assessment, as applicable, and the Person-Centered Plan, based on information discovered during ongoing monitoring, which must occur as expeditiously as the individual's needs warrant but no later than fourteen (14) calendar days from the date the change in need/status is identified. Revisions to the Person-Centered Plan should occur no less frequently than annually.

The Recovery Manager responds to and assesses emergency situations and incidents and assures that appropriate actions are taken to protect the health, welfare, wellness, and safety of individuals as expeditiously as the situation requires but no longer than 72 hours from notification of the situation/incident. The Recovery Manager monitors health, welfare, wellness, and safety through regular monthly contacts (calls and visits with the individual, paid and unpaid supports, and natural supports) wherever the individual lives, works, or has activities. The Recovery Manager monitors Person-Centered Plan services, which includes but is not limited to the review of providers' service documentation, the individual's participation and satisfaction with services and evaluating appropriate utilization, quality of services, gaps in care. Through the ongoing monitoring process, if there is discovery of a significant change event (e.g., inpatient hospital admission), the Recovery Manager will contact the individual by telephone by the end of the next

calendar day. If there is confirmation of a significant change event, then a face-to-face visit must take place by the end of the third calendar day following the discovery.

The State of Ohio monitors the Recovery Management Service as part of the 1915(i) program quality assurance reviews for Level of Need, Person-Centered Plan and provider qualifications as outlined in Attachment 3.1-i, pages 37-52.

Discovery Activities				
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** ***(Source of Data & sample size)***	**Monitoring Responsibilities**	**Frequency**
Person-Centered Plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.	**Sub-assurance:** *Person-Centered Plans address all members' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.*			
	1. Number and percent of participants reviewed whose service plans adequately address their assessed needs. **a. Numerator:** Number of participants whose service plans adequately address their assessed needs, including health and safety risk factors, and personal goals. **b. Denominator:** Total number of participants reviewed	1. Record review based on a representative sample with 95% confidence level and margin of error of +/- 5%.	1. The state or its designee conducts the review.	1. Semiannually
	2. Number and percent of participants reviewed whose person-centered plans have strategies to address and mitigate their health and welfare risk factors.	2. Record review based on a representative sample with 95% confidence level and margin of error of +/- 5%.	2. The state or its designee conducts the review.	2. Semiannually

	a. Numerator: Number of			

	participants whose service plans adequately address their health and welfare risk factors. **b. Denominator:** Total number of participants reviewed			
	3. Number and percent of service plans reviewed that address individuals' personal goals. **a.Numerator:** The number of service plans reviewed that address individuals' personal goals. **b. Denominator:** Total number of service plans reviewed **Sub-assurance:** *Person-Centered Plans are updated/revised at least annually or when warranted by changes in the 1915(i) participant's needs.*	3. Record review based on a representative sample with 95% confidence level and margin of error of +/- 5%.	3. The state or its designee conducts the review.	3. Semiannually
	4. Number and percent of participants whose person-centered plans were updated at least once in the last twelve months **a.Numerator:** Number of service plans reviewed that were updated at least annually **b. Denominator:** Total number of participants reviewed	4. IT system(s) or database where service plan data is stored. 100% review.	4. The state or its designee conducts the review.	4. Semiannually
	5. Number and percent of sampled 1915(i) participants whose service plans were revised, as needed, to address changing needs.	5. Record review based on a representative sample with 95% confidence	5. The state or its designee conducts the review.	5. Semiannually

	a.Numerator: Number of service plans reviewed that were updated when the participant's needs changed **b. Denominator:** Total number of participants reviewed whose needs changed. **Sub-assurance:** *Services are delivered in accordance with the Person-Centered Plan, including the type, scope, amount, duration, and frequency specified in the Person-Centered Plan.*	level and margin of error of +/- 5%.		
	6. Number and percent of participants reviewed who received services in the type, scope, amount, duration and frequency specified in the service plan. **a.Numerator:** Number of participants reviewed who received 1915(i) services in the type, scope, amount, duration and frequency specified in the service plan **b. Denominator:** Total number of participants reviewed **Sub-assurance:** *Participants are afforded choice between/among waiver services and providers.*	6. Record review based on a representative sample with 95% confidence level and margin of error of +/- 5%.	6. The state or its designee conducts the review.	6. Semiannually

The processes and instruments described in the approved Attachment 3.1-i are applied appropriately and according to the approved description to determine for the individual if the needs-based criteria were met.	**7. Number and percent of participants notified of their rights to choose among 1915(i) services and/or providers.** **a. Numerator:** Number of participants notified of their rights to choose among 1915(i) services and/or providers **b. Denominator:** Total number of participants reviewed ***Sub-Assurance:*** *An evaluation for needs-based criteria is provided to all applicants for whom there is reasonable indication that services may be needed in the future.* **8. Number and percent of new enrollees who had an evaluation indicating the individual met LON prior to receipt of services** a. **Numerator:** Number of new enrollees who had an evaluation indicating the individual met LON prior to receipt of services b. **Denominator:** Total number new enrollees ***Sub-Assurance:*** *The processes and instruments described in the approved State Plan are applied appropriately and according to the approved description to determine initial participant LON.*	7. Record review based on a representative sample with 95% confidence level and margin of error of +/- 5%. 8. Record review, at the independent entity; 100% review.	7. The state or its designee conducts the review. 8. The state or its designee conducts the review.	7. Semiannually 8. Semiannually

	9. Number and percent of initial LON determinations that were completed using the process required by the approved State Plan. **a. Numerator:** Number of initial LON determinations reviewed that were completed using the process required by the approved State Plan **b. Denominator:** Total number of initial LON determinations.	9. Record review, 100% review	9. The state or its designee conducts the review.	9. Annually
	10. Number and percent of LON redeterminations for 1915(i) participants that were completed within 365 days of the previous LON determination. **a. Numerator:** Number of LON redeterminations that were completed within 365 days of the previous LON determination **b. Denominator:** Total number of LON re-determinations for individuals	10. IT system(s) where redetermination records are maintained. Record review,100% review.	10. The state or its designee conducts the review.	10. Monthly

Providers meet required qualifications.	***Sub-Assurance:*** *The State verifies that providers initially and continually meet required participation standards and minimum qualifications and adhere to other standards prior to their furnishing 1915(i) services.* **Sub-assurance:** The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. **11. Number and percent of RM providers who meet provider enrollment requirements prior to providing services.** **a. Numerator:** Number of providers who meet enrollment requirements prior to providing authorized services. **b. Denominator:** Total number of providers who were enrolled during the review period.	11. 100% record review.	11. The state or its designee conducts the review.	11. Semiannually
	12. Number and percent of RM providers who continue to meet certification requirements. a. **Numerator:** Number of providers who met certification requirements one year ago and who continue to meet enrollment requirements at reenrollment or review. b. **Denominator:** Total number of providers who met certification requirements one year ago.	12. The state or its designee will review provider enrollment information. 100% review.	12. The state or its designee conduct the reviews.	12. Semiannually

The State of Ohio also has the following processes in place to monitor the timeliness of Medicaid beneficiary access to Recovery Management summarized below.

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

Annual Recovery Management Provider Review – The Ohio Department of Medicaid will issue an annual review report and the Recovery Management Provider will be required to develop and submit a Plan of Correction related to all identified deficiencies. The Ohio Department of Medicaid will continue to monitor the Recovery Management Provider's compliance with that Plan of Correction.

Quarterly Management Reports – Management Reports, based on a format defined by ODM, must be submitted to ODM quarterly, i.e. no later than 30 calendar days after September 30, December 30, March 30, and June 30 or on the next business day when the 30th calendar day falls on a Saturday, Sunday, or State or Federal holiday. The Management Report must detail performance trends/patterns and their impact on the Quality Management Plan components. The report must summarize:

a. How monthly performance results impact the Quality Management Plan.
b. What actions the Recovery Management Provider plans for continuous improvement of the day-to-day management of programs.

Monthly Performance Report – Performance Reports, based on a format defined by ODM, must be submitted to ODM monthly. All reports are due by the 25th calendar day of the following month or on the next business day when the 25th falls on a Saturday, Sunday, or State or Federal holiday. The first report must be submitted following the first full month after the contract is initiated. Each performance report must include waiver program specific data about how well the overall Recovery Management Provider is meeting key waiver program assurances described in the Scope of Work. There is not a separate payment for this Deliverable.

Site Reviews – Site Reviews include documentation review and interviews.

The Ohio Department of Medicaid reserves the right to set and/or change minimum standards for Monthly and Quarterly reports after the first six months of the Recovery Management Provider performance.

System Improvement: (This chart extracted from Attachment 3.1-i) *(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)*			
Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
Program performance data book: • Track and trend system performance. • Analyze discovery.	The independent entities and the state will collect, collate, and review. The State Medicaid agency will review the data and have final direction over corrective action plans.	Updated and reported semiannually.	• Set performance benchmarks. • Review service trends. • Review program implementation. • Focus on quality improvement. The Independent Entities and the state will track and trend system performance, analyze the discovery, synthesize the data and with the State Medicaid agency, make corrective action plans regarding quality improvement. This will include reviewing QI recommendations quarterly and building upon those improvements through CQI.
Quality management meetings: • Assess system changes. • Focus on reporting requirements and refining reports.	The independent entities and the State will collect, analyze, and report.	Quarterly meetings.	• Monitoring contract and 1915(i) HCBS compliance for service delivery. • Review of Person-Centered Plan client outcome measures (i.e. personal goals).
Reviews include documentation review and interviews.	The independent entities and the State coordinates and conduct review.	Semi-annually.	• Review of clinical operations (utilization management, quality management, care management) as well as fiscal reporting.

			• Compliance issues will require the submission of a corrective action plan to the Independent Entities and the state for approval and ongoing monitoring.
Corrective action plans (CAPs).	Developed by the provider/contractor. Submitted in accordance with the	Areas for improvement will be monitored as per CAP and presented quarterly	• Analysis of performance data book. • Review findings of program non-compliance follow-up.
	contract established between the provider and ODM to the independent entities, MCPs, and ODM or its designee for approval. ODM provides oversight and direction.	during quality management meetings.	

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiaries are unable to access the contracted service in a timely fashion (if additional space is needed, please supplement your answer with a Word attachment).

The Recovery Management providers and their managers are required to provide or make provision for services to support and meet the individual's identified needs in a timely manner. The Recovery Management provider will need to adhere to the following remedies in place in instances that the contracted entity requires improvement to meet the timely access standards:

Notice of Adverse Outcomes – If the ongoing or targeted review by ODM identifies Recovery Management Provider deficiencies, ODM staff will follow the State's adverse outcome protocol. As part of the protocol, ODM will communicate any adverse findings to the Recovery Management Provider and require immediate action and/or a plan of correction. The Recovery Management Provider shall submit a plan of correction within the required timeframes. If ODM approves the plan of correction, the Recovery Management Provider shall implement the plan of correction immediately.

Notice of Noncompliance and Plans of Correction – Pursuant to Rule 5160-45-09 and 5160-4307 of the Ohio Administrative Code, the ODM will identify operational deficiencies and will issue all notices of noncompliance in writing to the Recovery Management Provider. The notice of noncompliance will require the Recovery Management Provider to develop and submit a Plan of Correction (POC). In addition to the requirement of a POC from the Recovery Management Provider, actual and liquidated damages will be assessed, and other remedial actions permitted

under the contract may be taken, when appropriate as determined by ODM, in coordination with the Department of Administrative Services.

Ohio Department of Medicaid Initiated Plan of Correction – A POC is a structured activity, process or quality improvement initiative implemented by the Recovery Management Providers to improve identified operational and clinical quality deficiencies, or to otherwise address identified areas of noncompliance with program rules and/or with waiver requirements. It is the expectation that POCs are to be implemented immediately after ODM has reviewed and approved the plan.
The Recovery Management Provider may be required to develop a POC for any instance of noncompliance. All POCs requiring ongoing activity on the part of a Recovery Management Provider to ensure compliance with a program requirement shall remain in effect for the duration of the contract.

Where ODM has determined that a specific action must be implemented by the Recovery Management Provider or if the Recovery Management Provider has failed to submit an acceptable POC, ODM may require the Recovery Management Provider to comply with an ODM developed or "directed" POC.

Liquidated damages

Pursuant to the monitoring set forth above, and as a result of any monitoring and oversight activities conducted in accordance with Rule 5160-45-09 and 5160-43-07 of the Ohio Administrative Code, ODM will assess points for the Recovery Management Provider's noncompliance with the contract. Progressive liquidated damages will be determined based on the number of points accumulated at the time of the noncompliance being cited. Liquidated damages will be assessed when the number of accumulated points exceeds the thresholds in the regulations.

B. Provider Capacity Standards

Describe how the State will ensure (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has ensured) that its selective contracting program provides a sufficient supply of contracted providers to meet Medicaid beneficiaries' needs.

1. Provide a detailed capacity analysis of the number of providers (e.g., by type, or number of beds for facility-based programs), or vehicles (by type, per Recovery Management Provider for non-emergency transportation programs), needed per location or region to assure sufficient capacity under the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

The State issued a mandatory-use Multiple Award Contract (MAC). A MAC is a contract designed to allow more than one Recovery Management Provider for the same or similar services at varying prices for delivery within the same geographic area. In the event the selected Recovery Management Provider is terminated for any reason, the sole Recovery Management Provider will be required to service all individuals until another MAC Recovery Management Provider is selected. Ohio's MAC process yielded one contractor. To allow for member choice ODM contracted directly with an additional Recovery Management Provider, resulting in two Recovery Management Providers.

Each Recovery Management Provider was evaluated on the description of their current capacity, their plan for case manager to individual ratio and how that ratio will be maintained. Recovery Management Providers were also evaluated on their capacity to provide a diverse and experienced workforce to meet the needs of all populations served and its ability to absorb the additional workload resulting from this project. This also includes a contingency plan that shows the Recovery Management Provider has the ability to add more staff if needed to meet capacity.

In addition to providing capacity plans, in order to be awarded the contract, the Recovery Management Provider had to have at least one physical office location in the state.

Based on the history of the number of persons needing 1915(i) service across the state, there are some areas where the potential need for Recovery Management services is greater than in others. However, this analysis indicates that two Recovery Management agencies should be sufficient to meet Medicaid beneficiaries' needs if each agency hires at least one Recovery Manager for every 60 expected 1915(i) beneficiaries.

2. Describe how the State will evaluate and ensure on an ongoing basis that providers are appropriately distributed throughout the geographic regions covered by the selective contracting program so that Medicaid beneficiaries have sufficient and timely access throughout the regions affected by the program (if additional space is needed, please supplement your answer with a Word attachment).

The State will continue to monitor the Recovery Management Provider's capacity, its case manager to individual ratio, and its capacity to provide a diverse and experienced workforce through quarterly reviews. At a minimum, there are two MAC Recovery Management Providers and each Recovery Management Provider will be expected to maintain a ratio of one Recovery Manager to sixty beneficiaries. When a timely access issue is found, the State will use the remedies outlined above/below to request corrective action and provide technical assistance and training in order to assist the agency in correcting the issue. If the issue is not remediated satisfactorily, further sanctions are applied, up to and including termination of the agency. In the event of such an outcome, ODM will assign another MAC provider agency to ensure continued recipient access to Recovery Management services.

The State has the following remedies in place in instances that the contracted entity requires improvement to meet the provider capacity standards:

Notice of Adverse Outcomes – If the ongoing or targeted review by ODM identifies Recovery Management Provider deficiencies, ODM staff will follow the State's adverse outcome protocol.

As part of the protocol, ODM will communicate any adverse findings to the Recovery Management Provider and require immediate action and/or a plan of correction. The Recovery Management Provider shall submit a plan of correction within the required timeframes. If ODM approves the plan of correction, the Recovery Management Provider shall implement the plan of correction immediately.

Notice of Noncompliance and Plans of Correction – Pursuant to Rule 5160-45-09 and 5160-4307 of the Ohio Administrative Code, ODM will identify operational deficiencies and will issue all notices of noncompliance in writing to the Recovery Management Provider. The notice of noncompliance will require the Recovery Management Provider to develop and submit a Plan of Correction (POC). In addition to the requirement of a POC from the Recovery Management Provider, actual and liquidated damages will be assessed, and other remedial actions permitted under the contract may be taken, when appropriate as determined by ODM, in coordination with the Department of Administrative Services.

Ohio Department of Medicaid Initiated Plan of Correction – A POC is a structured activity, process or quality improvement initiative implemented by the Recovery Management Provider to improve identified operational and clinical quality deficiencies, or to otherwise address identified areas of noncompliance, with program rules and/or with waiver requirements. It is the expectation that POCs are to be implemented immediately after ODM has reviewed and approved the plan.

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

Where ODM has determined that a specific action must be implemented by the Recovery Management Provider or if the Recovery Management Provider has failed to submit an acceptable POC, ODM may require the Recovery Management Provider to comply with an ODM developed or "directed" POC.

Liquidated damages

Pursuant to the monitoring set forth above, and as a result of any monitoring and oversight activities conducted in accordance with Rule 5160-45-09 and 5160-43-07 of the Ohio Administrative Code, ODM will assess points for the Recovery Management Provider's noncompliance with the contract. Progressive liquidated damages will be determined based on the number of points accumulated at the time of the noncompliance being cited. Liquidated damages will be assessed when the number of accumulated points meets the thresholds in the regulations.

C. Provider Utilization Standards

Describe the State's utilization standards specific to the contracting program.

The State of Ohio expects each recipient to receive Recovery Management services authorized by the State eligibility determination process in the amounts needed to address the coordination of all services received by the individual and assisting the individual in gaining access to needed Medicaid state plan and 1915(i) services, as well as medical, social, educational, and other resources regardless of funding source. The utilization standard will be monitored through ongoing review of the Recovery Management's performance and on-going monitoring and compliance with the HCBS assurances as outlined in Attachment 3.1-i.

1. How will the State (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State) regularly monitor(s) the selective contracting program to determine appropriate Medicaid beneficiary utilization, as defined by the utilization standard described above (if additional space is needed, please supplement your answer with a Word attachment)?

The State of Ohio has the following processes in place to monitor the timeliness of Medicaid beneficiary access to Recovery Management:

- Site Reviews – Annual site reviews include documentation review and interviews including a review of clinical operations (utilization management, quality management, care management)

- Annual Recovery Management Provider Review – The Ohio Department of Medicaid will issue an annual review report and the Recovery Management Provider will be required to develop and submit a plan of correction related to all identified deficiencies. The Ohio Department of Medicaid will continue to monitor the Recovery Management Provider's compliance with that plan of correction.

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

- Quarterly Management Reports – Management Reports, based on a format defined by ODM must be submitted to ODM quarterly, i.e. no later than 30 calendar days after September 30, December 30, March 30, and June 30 or on the next business day when the 30th calendar day falls on a Saturday, Sunday, or State or Federal holiday. The Management Report must detail performance trends/patterns and their impact on the Quality Management Plan components. The report must summarize:

    a. How monthly performance results impact the Quality Management Plan.
    b. What actions the Recovery Management Provider plans for continuous improvement of the day-to-day management of programs.

- Monthly Performance Report – Performance Reports, based on a format defined by ODM, must be submitted to ODM monthly. All reports are due by the 25th calendar day of the following month or on the next business day when the 25th falls on a Saturday, Sunday, or State or Federal holiday. The first report must be submitted following the first full month after the contract is initiated. Each performance report must include waiver program specific data about how well the Recovery Management Provider is meeting key waiver program assurances described in the Scope of Work. There is not a separate payment for this Deliverable.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiary utilization falls below the utilization standards described above (if additional space is needed, please supplement your answer with a Word attachment).

The State has the following remedies in place in instances that the contracted entity requires improvement to meet the provider utilization standards:

Notice of Adverse Outcomes – If the ongoing or targeted review by ODM identifies Recovery Management deficiencies, ODM staff will follow the State's adverse outcome protocol. As part of the protocol, ODM will communicate any adverse findings to the Recovery Management Provider and require immediate action and/or a plan of correction. The Recovery Management Provider shall submit a plan of correction within the required timeframes. If ODM approves the plan of correction, the Recovery Management Provider shall implement the plan of correction immediately.

Notice of Noncompliance and Plans of Correction – Pursuant to Rule 5160-45-09 and 5160-4307 of the Ohio Administrative Code, ODM will identify operational deficiencies and will issue all notices of noncompliance in writing to the Recovery Management Provider. The notice of noncompliance will require the Recovery Management Provider to develop and submit a Plan of Correction (POC). In addition to the requirement of a POC from the Recovery Management Provider, actual and liquidated damages will be assessed, and other remedial actions permitted under the contract may be taken, when appropriate as determined by ODM, in coordination with the Department of Administrative Services.

Ohio Department of Medicaid Initiated Plan of Corrections – A POC is a structured activity, process or quality improvement initiative implemented by the Recovery Management Provider to improve identified operational and clinical quality deficiencies, or to otherwise address identified areas of noncompliance with this contract, with program rules and/or with waiver requirements. It is the expectation that POCs are to be implemented immediately after ODM has reviewed and approved the plan.

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

Where ODM has determined that a specific action must be implemented by the Provider or if the Recovery Management Provider has failed to submit an acceptable POC, ODM may require the Recovery Management Provider to comply with an ODM developed or "directed" POC.

Liquidated damages

Pursuant to the monitoring set forth above, and as a result of any monitoring and oversight activities conducted in accordance with Rule 5160-45-09 and 5160-43-07 of the Ohio Administrative Code, ODM will assess points for the Recovery Management Provider's noncompliance with the contract. Progressive liquidated damages will be determined based on the number of points accumulated at the time of the noncompliance being cited. Liquidated damages will be assessed when the number of accumulated points exceeds regulatory thresholds.

Part III: Quality

A. Quality Standards and Contract Monitoring

1. **Describe the State's quality measurement standards specific to the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).**

a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

The State's quality measurement standards for the Recovery Manager Services are noted in the 1915(i) State Plan Amendment and are as follows:

- Person-Centered Plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.
- The processes and instruments described in Attachment 3.1-i are applied appropriately and according to the approved description to determine for the individual if the needs-based criteria were met.
- Providers meet required qualifications.
- The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.
- The number and percentage of level of care assessments assigned to the Recovery Management Provider that resulted in timely eligibility determination, including:
  - Priority applications **(Standard is 95%)**; and
  - Non-priority applications **(Standard is 95%)**.
- The number and percentage of annual assessments completed timely **(Standard is 100%).**

i. Regularly monitor(s) the contracted providers to determine compliance with the State's quality standards for the selective contracting program.

The State has the following standards monitors in place:

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

Annual Recovery Management Provider Review – The Ohio Department of Medicaid will issue an annual review report and the Recovery Management Provider will be required to develop and submit a plan of correction related to all identified deficiencies. The Ohio Department of Medicaid will continue to monitor the Recovery Management Provider's compliance with that plan of correction.

Quarterly Management Reports – Management Reports, based on a format defined by ODM, must be submitted to ODM quarterly, i.e. no later than 30 calendar days after September 30, December 30, March 30, and June 30 or on the next business day when the 30th calendar day falls on a Saturday, Sunday, or State or Federal holiday. The Management Report must detail performance trends/patterns and their impact on the Quality Management Plan components. The report must summarize:

a. How monthly performance results impact the Quality Management Plan.
b. What actions the Recovery Management Provider plans for continuous improvement of the day-to-day management of programs.

Monthly Performance Report – Performance Reports, based on a format defined by ODM, must be submitted to ODM monthly. All reports are due by the 25th calendar day of the following month or on the next business day when the 25th falls on a Saturday, Sunday, or State or Federal holiday. The first report must be submitted following the first full month after the contract is initiated. Each performance report must include waiver program specific data about how well the Recovery Management Provider is meeting key waiver program assurances described in the Scope of Work. There is not a separate payment for this Deliverable.

Site Reviews – Site Reviews include documentation review and interviews.

The Ohio Department of Medicaid reserves the right to set and/or change minimum standards for Monthly and Quarterly reports after the first six months of Recovery Management Provider performance.

ii. Take(s) corrective action if there is a failure to comply.

The State has the following remedies in place in instances that the contracted entity requires improvement to meet standards.

Notice of Adverse Outcomes – If the ongoing or targeted review by ODM identifies Recovery Management Provider deficiencies, the ODM staff will follow the State's adverse outcome

protocol. As part of the protocol, the ODM will communicate any adverse findings to the Recovery Management Provider and require immediate action and/or a POC. The Recovery Management Provider shall submit a POC within the required timeframes. If ODM approves the plan of correction, the Recovery Management Provider shall implement the plan of correction immediately.

Notice of Noncompliance and Plans of Correction – Pursuant to Rule 5160-45-09 and 5160-4307 of the Ohio Administrative Code, ODM will identify operational deficiencies and will issue all notices of noncompliance in writing to the Recovery Management Provider. The notice of noncompliance will require the Recovery Management Provider to develop and submit a POC. In addition to the requirement of a POC from the Recovery Management Provider, actual and liquidated damages will be assessed, and other remedial actions permitted under the contract may be taken, when appropriate as determined by ODM, in coordination with the Department of Administrative Services.

Ohio Department of Medicaid Initiated Plan of Corrections – A POC is a structured activity, process or quality improvement initiative implemented by the Recovery Management Provider to improve identified operational and clinical quality deficiencies, or to otherwise address identified areas of noncompliance, with program rules and/or with waiver requirements. It is the expectation that POCs are to be implemented immediately after ODM has reviewed and approved the plan.

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

Where ODM has determined that a specific action must be implemented by the Recovery Management Provider or if the Recovery Management Provider has failed to submit an acceptable POC, ODM may require the Recovery Management Provider to comply with an ODM developed or "directed" POC.

Liquidated damages

Pursuant to the monitoring set forth above, and as a result of any monitoring and oversight activities conducted in accordance with Rule 5160-45-09 and 5160-43-07 of the Ohio Administrative Code, ODM will assess points for the Recovery Management Provider's noncompliance with the contract. Progressive liquidated damages will be determined based on the number of points accumulated at the time of the noncompliance being cited. Liquidated damages will be assessed when the number of accumulated points exceeds regulatory thresholds.

2. **Describe the State's contract monitoring process specific to the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).**

The State has the following standards monitors in place:

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

Annual Recovery Management Provider Review – The Ohio Department of Medicaid will issue an annual review report and the Recovery Management Provider will be required to develop and submit a plan of correction related to all identified deficiencies. The Ohio Department of Medicaid will continue to monitor the Recovery Management Provider's compliance with that plan of correction.

Quarterly Management Reports – Management Reports, based on a format defined by ODM, must be submitted to ODM quarterly, i.e. no later than 30 calendar days after September 30, December 30, March 30, and June 30 or on the next business day when the 30th calendar day falls on a Saturday, Sunday, or State or Federal holiday. The Management Report must detail performance trends/patterns and their impact on the Quality Management Plan components. The report must summarize:

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Site Reviews – Site Reviews include documentation review and interviews.

The Ohio Department of Medicaid reserves the right to set and/or change minimum standards for Monthly and Quarterly reports after the first six months of Recovery Management Provider performance.

B. Coordination and Continuity of Care Standards

Describe how the State assures that coordination and continuity of care is not negatively impacted by the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

The purpose of Recovery Management services is to provide enrollees in the 1915(i) with coordination of care and ensure continuity of care. This service ensures that a full-continuum of care will be provided based upon his/her individualized needs. The state understands that the eligibility recipient meeting criteria for 1915(i) services will likely require other types of services

(such as pharmacy, Other Licensed Practitioner, and Rehabilitation services) in addition to the HCBS services under Attachment 3.1-i to support him/her safely in the community. The Recovery Managers are best positioned to provide the timely access or linkage to those additional Medicaid services and supports as well as other community resources when indicated.

Ohio will closely monitor the overall effectiveness of Recovery Management, including the extent to which selective contracting has a negative impact on coordination and continuity of care as noted above. This service being requested under this waiver is an existing service in addition to existing benefits. The Recovery Management Providers are existing Medicaid Recovery Management Providers and the case management vendors have already agreed to comply with these above indicated standards and requirements.

Part IV: Program Operations

A. Beneficiary Information

Describe how beneficiaries will get information about the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

Recipients receive information about the 1915(i) and the selective contracting program at the time they are assessed for 1915(i) program eligibility. They will receive information on their rights at any time a service is denied, terminated, or reduced. If recipients are concerned with their services, they may request a fair hearing (to dispute a denial or limitation) or file a formal grievance with ODM.

With the initial launch and ramp-up of the program, the State sent personalized letters to individuals identified as potentially eligible for the Specialized Recovery Services Program (SRS) that were sent prior to the start of this service. Providers were enlisted to assist individuals identified as potentially eligible in enrolling to the SRS program. Currently, individuals eligible for the SRS program are assessed for program eligibility by Recovery Managers and are enrolled through the existing Medicaid enrollment process.

B. Individuals with Special Needs

The State has special process in place for persons with special needs (Please provide detail).

Individuals enrolled in the 1915(i) HCBS Specialized Recovery Services Program are identified as having special needs based on their mental illness or diagnosed chronic conditions (e.g., all individuals in the 1915(i) HCBS program are considered to be special needs individuals). A requirement of the Specialized Recovery Services Program is that persons must be age 21 and over and diagnosed with one of the behavioral health diagnoses or chronic condition diagnoses identified in Attachment 3.1-i. In addition, in order to be eligible for enrollment, the individual must also be assessed using the Adult Needs and Strengths Assessment (ANSA) and score based on certain level of need and care management of that need, meet the Social Security Administration's definition of disability and have at least one of the identified risk factors.

Section B – Waiver Cost-Effectiveness and Efficiency

Efficient and economic provision of covered care and services:
1. Provide a description of the State's efficient and economic provision of covered care and services (if additional space is needed, please supplement your answer with a Word attachment).

1915(i) program recipients benefit from the State's MAC Recovery Management Provider process designating a limited number of Recovery Management Providers for the following reasons:

1. The MAC process ensures that the Recovery Management Providers are conflict-free case Managers meeting the HCBS regulation conflict of interest standards and do not provide other HCBS services for the beneficiaries.
2. A single point of entry into the 1915(i) program simplifies the application process for beneficiaries applying for the new program.
3. Increased continuity and coordination of care. The Recovery Management Providers are required to ensure that the recipient has timely and coordinated access to a variety of health services and supports that may be necessary to support the recipient so he/she may live safely within the community.
4. Standardization of processes. The Recovery Management Providers are trained and proficient in administering the ODM-approved clinical assessment tool in the 1915(i) evaluation process to identify recipient needs and strengths.
5. Beneficiaries continue to have a choice of provider of HCBS services to ensure quality of care and person-centered planning.

2. Project the waiver expenditures for the upcoming waiver period. From Attachment 3.1-i:

Annual Period	From	To	Projected Number of Participants
Year 1	10/01/2026	9/30/2027	4,234[2]
Year 2	10/01/2027	9/30/2028	1,414[3]
Year 3	10/01/2028	9/30/2029	1,414[3]
Year 4	10/01/2029	9/30/2030	1,414[3]
Year 5	10/01/2030	9/30/2031	1,414[3]

Recovery Management Service Expenditures

[2] Year 1 was based on annualized 6 months of SRS population as of April 2026 Invoice (7,068), combined with an annualized 6-month SRS anticipated population with 80% reduction (1,414) from 7/1/2026 – 12/31/2026 due to full implementation of MyCare Next Generation.
[3] Years 2 – 5 represent the expected number after FFS reductions with little to no growth expected. Reduction estimates based on ODM 2425-0010 SRS Request for Proposal after MyCare Expansion beginning 1/1/2026.

Expenditures for this waiver have been projected considering current expenditure trends of 1915(b) Recovery Management service only, not inclusive of all 1915(i) services expenditures. The Ohio Department of Medicaid will set up an ongoing process to monitor and report service and administrative expenditures for all 1915(i) services accordingly on future CM 64.9 and 64.10 filings.

Year 1 from: _10/1/2026 to 9/30/2027

Projected pre-waiver cost $11,896,693.20
Projected Waiver cost $11,896,693.20
Difference: $0

Year 2 from: _10/1/2027 to _9/30/2028

Projected pre-waiver cost $3,973,057.20
Projected Waiver cost $3,973,057.20
Difference: $0

Year 3 from: _10/1/2028 to _9/30/2029
(For renewals, use trend rate from previous year and claims data from the CMS-64)

Projected pre-waiver cost $3,973,057.20
Projected Waiver cost $3,973,057.20
Difference: $0

Year 4 from: _10/1/2029 to _9/30/2030
(For renewals, use trend rate from previous year and claims data from the CMS-64)

Projected pre-waiver cost $3,973,057.20
Projected Waiver cost $3,973,057.20
Difference: $0

Year 5 from: _10/1/2030_ to _9/30/2031
(For renewals, use trend rate from previous year and claims data from the CMS-64)

Projected pre-waiver cost $3,973,057.20
Projected Waiver cost $3,973,057.20
Difference: $0