Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Indiana** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Aged & Disabled Waiver

C. Waiver Number:IN.0210
Original Base Waiver Number: IN.0210.90.R2

D. Amendment Number:IN.0210.R06.05

E. Proposed Effective Date: (mm/dd/yy)

07/01/20

Approved Effective Date: 07/01/20
Approved Effective Date of Waiver being Amended: 07/01/18

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

Throughout the waiver changes were made in regard to spacing, consistency (such as consistency of capitalization, of names, and acronyms) and grammar.
The Family and Social Services Administration (FSSA) proposes to amend the Aged and Disabled (A&D) waiver to do the following by section:
Purpose: Any required changes deemed necessary by CMS to allow for the permanent continuance of the expedited eligibility process and,
Appendix B: the amendment would increase the number of waiver slots available in year four of the current amendment from 37,604 to 40,609, and in year five of the current amendment from 39,201 to 47,680 and,
Appendix C: Increase those able to perform care management and,
Appendix C: address attendant care transportation and expand the availability of participant directed services within the waiver and,
Appendix C: the proposed amendment adds two new services, the first is caregiver coaching and behavioral management and the second is goal engagement and,
Appendix J: incorporate the legislatively approved assisted living rate increase.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	
☒ Appendix A Waiver Administration and Operation	Administration and Operation 2, 3,4,7, and 8
☒ Appendix B Participant Access and Eligibility	Appendix B-3
☒ Appendix C Participant Services ☒	Care management qualifications, two new services caregiver coaching & behavioral management and goal engagement, attendant care to match Appendix K authority.
Appendix D Participant Centered Service Planning and Delivery	
☒ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☐ Appendix G Participant Safeguards	
☒ Appendix H	
☒ Appendix I Financial Accountability	
☐ Appendix J Cost-Neutrality Demonstration	Updated tables

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☐ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☐

Revise cost neutrality demonstration

☐ **Add participant-direction of services**

Other
Specify:

Throughout the waiver changes were made in regards to spacing, consistency (such as consistency of capitalization, of names, and acronyms) and grammar.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Indiana** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Aged & Disabled Waiver

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: IN.0210
Waiver Number:IN.0210.R06.05
Draft ID: IN.004.06.05

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/18
Approved Effective Date of Waiver being Amended: 07/01/18

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection

of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**
Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**
Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

PURPOSE: This waiver is requested in order to provide home and community-based services to participants who, but for the provision of such services, would require nursing facility level of care. Through the use of the Aged & Disabled Waiver (A&D), the Family Social Service Administration (FSSA)'s Division of Aging (DA) seeks to increase availability and access to cost-effective aged and disabled waiver services.
GOALS: The A&D Waiver provides an alternative to nursing facility admission for adults and persons of all ages with a disability. The waiver is designed to provide services to supplement informal supports for people who would require care in a nursing facility if waiver or other supports were not available. Waiver services can be used to help people remain in their own homes, as well as assist people living in nursing facilities return to community settings such as their own homes, apartments, assisted living or adult family care.
OBJECTIVE: This waiver amendment anticipates serving the following unduplicated participants

Year 1 (2019)	27,167
Year 2 (2020)	31,885
Year 3 (2021)	35,501
Year 4 (2022)	40,609
Year 5 (2023)	47,680

ORGANIZATIONAL STRUCTURE: The FSSA is the Single State Medicaid Agency. The Indiana DA, a division under the FSSA, has been given the authority to administer the A&D Waiver. The Office of Medicaid Policy and Planning (OMPP) also a division under the FSSA has been given the administrative authority for the A&D waiver by the FSSA. The Indiana DA performs the daily operational tasks of the waiver.
PERSON CENTERED SUPPORT PLANNING
Service Plans:
The service plan will display all funded services the medical and other services (regardless of funding sources) to be furnished, their frequency, expected activity to address needs and the type of provider who will furnish each service. The care manager is responsible to monitor and evaluate the effectiveness for all service plans. The service plan will be subject to the approval of the DA.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ◉ **Not Applicable**
- ○ **No**
- ○ **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ○ **No**
- ◉ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☒ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

For the Participant-Directed Home Care Service will be limited to select postal codes. This is a continuing service which is still be evaluated and if successful, then the expectation would be make it available in more areas of the state.

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source,

including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

Public notice period was not required in this amendment because the changes are technical corrections.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English

Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Teague

First Name: Brian Gilbert

Title: Senior Manager, Program Administration

Agency: Indiana Family & Social Services Administration Office of Medicaid Policy & Planning

Address: 402 West Washington Street, Room W374 (MS07)

Address 2:

City: Indianapolis

State: **Indiana**

Zip: 46204

Phone: (317) 232-7294 **Ext:** ☐ **TTY**

Fax: (317) 232-7382

E-mail: breann.teague@fssa.in.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Wyatt

First Name: Jesse

Title: Deputy Director of Division of Aging

Agency: Indiana Family & Social Services Administration, Division of Aging

Address: 402 West Washington Street, Room W454

Address 2:

City: Indianapolis

State: **Indiana**

Zip: 46204

Phone: (317) 232-0604 **Ext:** ☐ **TTY**

Fax: (317) 233-2182

E-mail: jesse.wyatt@fssa.in.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: BreAnn Teague

State Medicaid Director or Designee

Submission Date: Feb 17, 2021

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Taylor

First Name: Allison

Title: Indiana Medicaid Director

Agency: Indiana Family & Social Service Administration, Office of Medicaid Policy & Planning

Address: 402 West Washington Street, Room W374 (MS07)

Address 2:

City: Indianapolis

State: **Indiana**

Zip: 46204-2739

Phone:

(317) 234-8725 **Ext:** ☐ **TTY**

Fax:

(317) 232-7382

E-mail:

allison.taylor@fssa.in.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

◉ **The waiver is operated by the state Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

◉ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

Division of Aging

(Complete item A-2-a).

○ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

The Family Social Services Administration (FSSA) is the single state Medicaid agency authorized to administer the waiver.

The waiver is operated by FSSA's DA, a division under the single State Medicaid agency.

The FSSA's OMPP, a division under the single state Medicaid Agency, is responsible for monitoring DA's operation of the waiver.
The following lists many of the functions for which each division has accepted responsibility: Division of Aging:

- Developing a Quality Assurance Plan and submitting quality reports to OMPP
- Maintenance of an incident reporting and complaints tracking and resolution process
- Training and documentation of initial and ongoing qualifications of waiver care managers
- Drafting Medicaid waivers, amendments and renewals
- Establishing provider standards and promulgating rules that include such standards
- Process waiver provider applications for approval and re-approval
- Prepare and present testimony in administrative appeals
- Assist with preparation of annual financial reports

Office of Medicaid Policy and Planning:

- Review and approve provider claims and respond to inquiries related to claims payment
- Retains final authority for rate setting and coverage criteria for all Medicaid services
- Enrolls qualified providers into Medicaid
- Ongoing and periodic reporting and analysis of claims data
- Provider Education of proper billing procedures
- Review and approve manuals, modules, bulletins, communications and policy
- Review, approve and submit Medicaid waivers, amendments and renewals
- Prepare and submit annual waiver financial reports
- Participates in quality improvement processes

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

A contract exists between the Medicaid Agency and each contracted entity listed below that sets forth the responsibilities and performance requirements of the contracted entity. The contract(s) under which these entities conduct waiver operational functions are available to CMS upon request through FSSA (as applicable).

Specific to the operational and administrative functions of this waiver, the following activities are conducted by contracted entities.

FISCAL AGENT is responsible for:
- Reimbursement of claims for authorized waiver services submitted by authorized waiver providers;
- Qualified providers are enrolled as providers of waiver services;
- Provider training is performed periodically and technical assistance is provided concerning waiver requirements
- Monthly and quarterly reporting for all contracted activities is compiled and submitted timely.
- Collecting and analyzing waiver paid claims data
- Compiling this data for the annual waiver reporting to CMS

UTILIZATION MANAGEMENT FUNCTIONS:
The waiver auditing function is incorporated into the Surveillance Utilization Review (SUR) functions of the contract between the Medicaid agency and SUR contractor. FSSA has expanded its Program Integrity activities by using a multipronged approach to SUR activity that includes provider self-audits, contractor desk audits, and full on-site audits. The SUR contractor sifts and analyzes claims data and identifies providers and claims that indicate aberrant billing patterns or other risk factors, such as correcting claims.
The FSSA or any other legally authorized governmental entity (or their agents) may at any time during the term of the service agreement and in accordance with Indiana Administrative Regulation conduct audits for the purposes of assuring the appropriate administration and expenditure of the monies provided to the provider through this service agreement. Additionally, the FSSA may at any time conduct audits to assure appropriate administration and delivery of services under the service agreement.
The following Program Integrity and SUR activities describe post-payment financial audits to ensure the integrity of IHCP payments. Detailed information on SUR policy and procedures is available in the IHCP Provider and Member Utilization Review provider reference module:

http://provider.indianamedicaid.com/media/155481/provider%20and%20member%20utilization%20review.pdf

The State of Indiana's Program Integrity has an agreement with the FSSA Audit Group to investigate allegations of Medicaid HCBS waiver provider fraud, waste, and abuse. Program Integrity and FSSA Audit are part of FSSA Quality & Compliance so there is a natural level of collaboration and cooperation between the two groups. FSSA Audit's auditors are knowledgeable of each waiver's service definitions, documentation standards, provider qualifications, and any required staffing ratios making them well equipped to investigate allegations of wrongdoing in the waiver programs. Program Integrity does not have staff with this kind of expertise.

Program Integrity receives allegations of Medicaid provider fraud, waste, and abuse and tracks these in its case management system. When it receives an allegation regarding a waiver provider, Program Integrity forwards it to FSSA Audit to begin their research and audit process. To begin investigating these allegations, FSSA Audit works with Program Integrity to vet the providers with the Medicaid Fraud Control Unit (MFCU). Once it receives MFCU's clearance FSSA Audit determines how to best validate the accuracy of the allegation. FSSA Audit may choose to audit a statistically valid random sample of consumers and then Program Integrity's Fraud Abuse and Detection (FADS) vendor will pull such a sample for their audit.

FSSA Audit conducts its audit activities and develops a findings report for the provider which may include a corrective action plan and request for overpayment. FSSA Audit shares copies of its findings reports with Program Integrity so Program Integrity can track that the allegation was reviewed and follow-up action taken as necessary. The FSSA maintains oversight throughout the entire Program Integrity process. Although the FADS contractor may be incorporated in the audit process, no audit is performed without the authorization of the FSSA. The FSSA's oversight of the contractor's aggregate data is used to identify common problems to be audited, determine benchmarks, and offer data to peer providers for educational purposes, when appropriate.
On a more proactive level, FSSA Audit also routinely meets with each of the State Medicaid Agency's units that operate the waivers to identify and conduct audits on providers that have been identified as potentially not billing correctly.

ACTUARIAL CONTRACTOR is responsible for
- Completing cost neutrality calculations for the waiver
- Budget planning and forecasting, and waiver development

ACCOUNTING CONTRACTOR is responsible for:
- Developing and assessing rate methodology for home and community based services
- Cost surveys and calculates rate adjustments

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

○ **Not applicable**

◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☒ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Area Agencies on Aging (AAAs) through their qualified care managers are responsible for preparing a service plan for each waiver participant. The service plan will display the medical home care services. The service plans will display the service frequency, and the type of provider/community resources who will furnish each service, with person centered goals and preferences from the individual. The service plan will be subject to the approval of the DA and/or the OMPP. Federal Financial Participation (FFP) will not be claimed for waiver services prior to the development of the service plan. FFP will not be claimed for waiver services which are not included in the participant written service plan.

Each of the fifteen (15) Aging and Disability Resource Center (ADRCs) are responsible for disseminating information regarding the waiver to potential enrollees, assisting individuals in the waiver enrollment application process, conducting level of care evaluation activities, recruiting providers to perform waiver services, and conducting training and technical assistance concerning waiver requirements.

Independent care managers are also responsible for preparing service plans for each participant. The service plan will describe the medical and other services (regardless of funding source) to be furnished,their frequency, and the type of provider who will furnish each service. The service plan will be subject to the approval of the DA. FFP will not be claimed for waiver services prior to the development of the service plan. FFP will not be claimed for waiver services which are not included in the participant service plan.

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

FSSA is responsible for assessing performance of the Medicaid Fiscal Agent Contractor's provision of training and technical assistance concerning waiver requirements and, in collaboration with DA, the execution of the Medicaid Provider Agreements for enrollment of waiver providers.

- The DA monitors the AAAs and non-AAA care management entities through the electronic care management system, monthly communication with AAAs to verify compliance with performance and on site follow up through quality assurance surveys using the Provider Compliance Tool (PCT).

- The State Medicaid Agency has oversight responsibility of the Financial Analysis contractor.
- The oversight of the performance of SUR Contractor's FADS contract is performed by Program Integrity, under the direct supervision of the FSSA Chief Compliance Officer.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Performance based agreements are written with the AAAs and are audited by the Indiana State Board of Accounts and the FSSA's Audit Unit. These audits are performed on a biannual basis.

The provider relations specialist oversees and assures that providers are appropriately enrolled through the Medicaid Fiscal Contractor. The required Waiver Enrollments and Updates Weekly Report is sent by the Fiscal Contractor to the provider relations specialist. Providers are to be enrolled by the dedicated Fiscal Contractor provider enrollment specialist within an average of thirty (30) days from receipt of the completed provider agreement paperwork.

The DA forwards complaints about the timeliness or performance of the Fiscal Contractor to the OMPP Director of Provider Relations.

FSSA Compliance exercises oversight and monitoring of the deliverables stipulated within the FADS contract in order to ensure the contracting entity satisfactorily performs waiver auditing functions under the conditions of its contract. Reporting requirements are determined as agreed upon within the fully executed contract. The FADS Contractor is required to submit recommendations for review based on their data.

FSSA Compliance oversees the contractor's aggregate data to identify common problems, determine benchmarks and offer data to providers to compare against aggregate data.

Final review and approval of all audits and audit-related functions falls to FSSA Program Integrity. The direction of the FADS process is a fluid process, allowing for modification and adjustment in an on-going basis to ensure appropriate focus.

The OMPP has an accounting service under contract to develop and assess rate methodology for HCBS. Rate methodology for A&D services is assessed and reviewed every five years at renewal. The accounting contractor completes the cost surveys and calculates rate adjustments. The OMPP reviews and approves the fee schedule to ensure consistency, efficiency, economy, quality of care, and sufficient access to providers for A&D services.

The State Medicaid Agency contracts with an actuarial contractor, who provides financial analysis and actuarial consultant services for Indiana Medicaid. The contractor performs Medicaid enrollment and expenditure forecasts, by program, which aids in monitoring expenses and supports state budgeting. Forecasting is done on both a paid basis and service incurred basis. Trends are determined and vary by population as appropriate. Trends are developed taking into account historical Indiana Medicaid trends, State and National trends, trends used by the CMS Office of the actuary, and future program changes. Final documentation from the actuarial contractor includes an executive summary, detailed results, and sources of data, methodologies, and assumptions.

The actuarial contract, which is currently monitored by FSSA/Finance, is not a performance based contract.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☒	☐	☒
Waiver enrollment managed against approved limits	☒	☐	☐
Waiver expenditures managed against approved levels	☒	☐	☐

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Level of care evaluation	☒	☐	☒
Review of Participant service plans	☒	☐	☒
Prior authorization of waiver services	☒	☐	☐
Utilization management	☒	☒	☐
Qualified provider enrollment	☒	☐	☒
Execution of Medicaid provider agreements	☒	☐	☐
Establishment of a statewide rate methodology	☒	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☐	☐
Quality assurance and quality improvement activities	☒	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
A.1 Number and percent of quarterly performance measure data reports submitted to the OMPP by the Division of Aging within the required time period. Numerator: Total number of quarterly performance measure data reports submitted within the required time period. Denominator: Total number of quarterly performance measure data reports due.

Data Source (Select one):
Other
If 'Other' is selected, specify:

Quarterly performance measure data reports

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.2 Number and percent of enrolled waiver providers who met all provider enrollment requirements corresponding to the executed contract. Numerator: Total number of enrolled waiver providers who met all provider enrollment requirements. Denominator: The total number of waiver service providers who were enrolled by the fiscal contractor.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Weekly waiver provider report

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Fiscal Contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: Fiscal Contractor	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.3 Number and percent of providers assigned a Medicaid provider number according to the required timeframe specified in the contract with the fiscal contractor. Numerator: The number of providers assigned a Medicaid provider number by the fiscal contractor according to the required timeframe specified in the contract. Denominator: The total number of providers assigned a Medicaid provider number.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Weekly Waiver Provider Report

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence

		Interval =
☒ **Other** Specify: Fiscal Contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: Fiscal Contractor	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

A.4 Number and percent of waiver policies and procedures developed by the Division of Aging that were approved by OMPP prior to implementation. Numerator: Total number of waiver policies and procedures developed by the Division of Aging that were approved by OMPP prior to implementation. Denominator: Total number of waiver policies and

procedures implemented.

Data Source (Select one):
Presentation of policies or procedures
If 'Other' is selected, specify:
DA Provider Policy and Procedure Manual

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

OMPP meets at least monthly with DA to review and aggregate data, respond to questions, identify areas of concern and resolve issues to ensure the successful implementation of the waiver program. OMPP exercises oversight over the performance of the waiver function by the DA, contractors and providers through on-going review and approval of the waiver, revisions to the plan, policies, as well as participation in numerous councils and committees. OMPP also participates with DA in all conference calls with CMS pertaining to the waiver.

OMPP works with the DA to ensure that problems are addressed and corrected. OMPP participates in the data aggregation and analysis of individual performance measures throughout the waiver application.
Between scheduled meetings, problems are regularly addressed through written and/or verbal communications to ensure timely remediation. The DA and OMPP discuss the circumstances surrounding an issue or event and what remediation actions should be taken.

In some cases, informal actions, such as obtaining an explanation of the circumstances surrounding the event, or verification that remediation actions have been taken, may be sufficient to deem the problem resolved. In other situations, more formal actions may be taken. This may consist of elevating the issue for a cross agency executive level discussion and remediation.

The State Medicaid Agency meets at least monthly with the fiscal contractor to review reports, respond to questions, identify areas of concern and resolve issues to ensure contractual compliance. Corrective actions vary according to the scope and severity of the identified problem. In some cases, informal actions, such as obtaining an explanation of the circumstances surrounding the event, or verification that remediation actions have been taken, may be sufficient to deem the problem resolved. In other situations, more formal actions may be taken. This may consist of a written corrective action plan (CAP).

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					
	☒	**Aged**	65		☒
	☒	**Disabled (Physical)**	0	64	
	☒	**Disabled (Other)**	0	64	
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐

Target Group	Included	Target SubGroup	Minimum Age			Maximum Age			
						Maximum Age Limit			No Maximum Age Limit
	☐	HIV/AIDS							☐
	☐	Medically Fragile							☐
	☐	Technology Dependent							☐
☐ Intellectual Disability or Developmental Disability, or Both									
	☐	Autism							☐
	☐	Developmental Disability							☐
	☐	Intellectual Disability							☐
☐ Mental Illness									
	☐	Mental Illness							☐
	☐	Serious Emotional Disturbance							

b. Additional Criteria. The state further specifies its target group(s) as follows:

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Participants who are in the Disabled (Physical) and Disabled (Other) target subgroups are seamlessly transitioned to the Aged target subgroup upon reaching age 65.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

◉ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

The limit specified by the state is *(select one)*

○ **A level higher than 100% of the institutional average.**

Specify the percentage:

○ **Other**

Specify:

○ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

○ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the state is *(select one)*:

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	27167
Year 2	31885
Year 3	35501
Year 4	40609
Year 5	47680

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)*:

◉ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

○ **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

○ **Not applicable. The state does not reserve capacity.**

◉ **The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

Purposes
Community transition of institutionalized person due to "Money Follows the Person" initiative

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Community transition of institutionalized person due to "Money Follows the Person" initiative

Purpose *(describe):*

The State reserves capacity within the waiver to implement the vision of moving individuals from institutional care to home and community-based services. This vision is being realized through home and community-based services and dollars awarded to Indiana for a demonstration grant, "Money Follows the Person".

Describe how the amount of reserved capacity was determined:

The State reviewed the number of patients currently receiving institutional care and determined, based upon the number of waiver slots, the realistic number of individuals that could be transitioned in year 1 through 3. It was determined that we could move a total of 1035 individuals over the course of the first 3 years of this waiver renewal.

Money Follows the Person is sun setting in 2020 with the last transitions to be pipelined in 2019. Indiana plans to continue transitioning persons from the nursing facility to HCBS settings.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved		
Year 1		345	
Year 2		345	
Year 3		345	
Year 4		345	
Year 5		345	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Applicants will enter the waiver on the following basis:

1. Eligible individuals transitioning off 100% state funded budgets to the waiver, transitioning from nursing facilities to the waiver, or discharging from in-patient hospital settings to the waiver, by date of application; followed by

2. Other eligible individuals applying to the waiver on a first come first serve basis by date of application.

Individuals being served under any other 1915(c) home and community-based services waiver shall not be concurrently served under the Aged & Disabled Waiver.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

- (●) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.
Indicate whether the state is a Miller Trust State *(select one)*:

- ( ) **No**
- (●) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional state supplement recipients**
- [x] **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - (●) **100% of the Federal poverty level (FPL)**
  - ( ) **% of FPL, which is lower than 100% of FPL.**

  Specify percentage: [ ]

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

42 CFR 435.110 Parents and other caretaker relatives

42 CFR 435.118 Infants and children under age 19

42 CFR 435.145 Children for whom adoption assistance or foster care maintenance payments are made (under title IV-E of the Act)

42 CFR 435.150 Former Foster Care Children; Sec. 1902(a)(10)(A)(i)(IX)

42 CFR 435.226 Independent Foster Care Adolescents; Sec. 1902(a)(10)(A)(ii)(VII)

42 CFR 435.227 Individuals under age 21 who are under State adoption assistance agreements

42 CFR 435.116 - Pregnant Women

Sec 1925 of the Act --Transitional Medical Assistance

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: ☐

○ **A dollar amount which is lower than 300%.**

Specify dollar amount: ☐

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- (●) **The following standard included under the state plan**

  Select one:

  - ( ) **SSI standard**
  - ( ) **Optional state supplement standard**
  - ( ) **Medically needy income standard**
  - (●) **The special income level for institutionalized persons**

    (*select one*):

    - (●) **300% of the SSI Federal Benefit Rate (FBR)**
    - ( ) **A percentage of the FBR, which is less than 300%**

      Specify the percentage:
    - ( ) **A dollar amount which is less than 300%.**

      Specify dollar amount:
  - ( ) **A percentage of the Federal poverty level**

    Specify percentage:
  - ( ) **Other standard included under the state Plan**

    Specify:

- ( ) **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.
- ( ) **The following formula is used to determine the needs allowance:**

  Specify:
- ( ) **Other**

  Specify:

ii. Allowance for the spouse only (*select one*):

- (●) **Not Applicable**
- ( ) **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

- ( ) **SSI standard**
- ( ) **Optional state supplement standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

Specify dollar amount: [ ] If this amount changes, this item will be revised.

- ( ) **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

- ( ) **Not Applicable (see instructions)**
- (●) **AFDC need standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

Specify dollar amount: [ ] The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- ( ) **The amount is determined using the following formula:**

Specify:

- ( ) **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The state does not establish reasonable limits.**
- ○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ◉ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

Specify percentage:

○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised

○ **The following formula is used to determine the needs allowance:**

Specify formula:

○ **Other**

Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

◉ **Allowance is the same**

○ **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

◉ **The state does not establish reasonable limits.**

○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The state requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**

○ **By a government agency under contract with the Medicaid agency.**

Specify the entity:

◉ **Other**

Specify:

All initial evaluations are completed by an ADRC Options Counselor and determinations are rendered by the care manager supervisor, unless the participant has been in a nursing facility for at least ninety (90) days. In that instance, if a participant has already received a long term level of care designation for a nursing facility stay, then that determination will serve as the initial evaluation.

All initial level of care approvals are reviewed and verified by the operating DA staff prior to service implementation. Service provision can begin at the time the initial level of care has been completed by the care manager's supervisor; however, there will be no reimbursement made until, and only if, the DA has approved the level of care and service plan.
Re-evaluations completed by the AAA care managers are approved or denied by AAA management staff. Re-evaluations completed by non-AAA care managers are approved or denied by DA Staff.
Re-evaluations completed by AAA care managers are initially approved or denied by AAA management staff, however DA staff make the final decision.

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

All initial evaluations are completed by the ADRC options counselor and determinations are rendered by the care manager supervisor.

Care managers performing level of care evaluations and care management supervisors must meet all case management qualifications as detailed in Appendix C and have received training in the nursing facility level of care process by the DA or designee.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

All applicants to the A&D Waiver are screened for nursing facility level of care (NFLOC).

NFLOC
Indiana has established the Eligibility Screen (E-Screen), a tool that is used to determine basic level of care criteria that identifies NFLOC (405 IAC 1-3). The E-Screen is required to be completed by the care manager as part of the Level of Care packet. An E-Screen will not be accepted by the computer system if not all of the pages of the E- Screen have been addressed. Care managers complete an interRAI-HC assessment tool that aids in the discovery of the information needed for completion of the E-Screen.

The final level of care determination is documented in the section of the Transmittal for Medicaid Level of Care Eligibility form (State Form 46018 HCBS7).

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the**

state Plan.

○ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

INITIAL EVALUATIONS
All applicants for the Waiver are evaluated to assure NFLOC is met prior to receiving services. All initial evaluations are completed by the ADRC care manager and determinations are rendered by the care manager supervisor unless the participant has been in a nursing facility for at least ninety (90) days. In that instance, if a participant has already received a long-term level of care designation for a nursing facility stay, initially completed by a DA contractor, then that determination will serve as the initial evaluation. Indiana has established the E-Screen, a tool that is used to determine basic level of care criteria that identifies NFLOC (455 IAC 2-3-1).

RE-EVALUATIONS
NFLOC evaluations are completed annually or when a participant is discharging 60 days after a nursing facility admission.

NFLOC re-evaluations for participants care managed by the AAA are completed by the AAA care manager and

determinations are rendered by the AAA care manager supervisor. All care management supervisors must meet all qualifications as detailed in Appendix C and have received training in the NFLOC process by the DA or designee.

For those participants who have chosen to be care managed by non-AAA care managers the NFLOC re-evaluation decisions are required to be reviewed and a decision rendered by designated staff members within the DA.

The care manager maintains copies of all written notices and electronically filed documents related to a participant's level of care determination and the participant's right to a Medicaid Fair Hearing. The care manager must ensure that the Level of Care Review Form is sent to the applicant or participant within 10 working days of the issue date and must document in the electronic case management database system the date the Level of Care Review Form was sent to the participant or their guardian or the participant circle of support.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

○ **Every three months**

○ **Every six months**

○ **Every twelve months**

◉ **Other schedule**

Specify the other schedule:

Every twelve months or more often as needed.

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**

○ **The qualifications are different.**
Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

The DA is using a reporting tool that generates a report at least sixty (60) days prior to the annual level of care (LOC) reevaluation to advise a care manager that reviews are due. The report was designed to establish trends and needed education regarding annual level of care. The reports are monitored by the Supervisor of the Waiver Operations Unit and coordinated with the Assistant Director of the Waiver Operations Unit.

Notifying the care managers at least sixty (60) days prior to the annual LOC reevaluation due date will assist care managers in returning the annual LOC reevaluation within the required timeframe. The DA is able to monitor which care managers submit a late annual reevaluation and therefore will be able to provide educational training and assistance to those care managers who are consistently late in their submissions.

The DA runs a monthly report that identifies participants whose reevaluation are due within sixty (60) days and sends the listing to care managers. After the due date, the DA re-runs the report that identifies the care managers who are late in submitting the annual LOC reevaluation and notifies the care managers that the reevaluation is due within fifteen (15) days. If the reevaluation is not received by the DA within fifteen (15) days of notification, the DA submits the listing of delinquent care managers to the unit within the DA for corrective action.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The evaluation and reevaluation documentation is maintained for a minimum of three years within the electronic care management database within the DA.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
B.1 Number and percent of new enrollees who received a Nursing Facility Level of Care (NFLOC) evaluation prior to enrollment. Numerator: Number of new enrollees who received a NFLOC evaluation prior to enrollment. Denominator: Number of new enrollees.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Case Management Database System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
B.2 Number and percent of active waiver participants compared to the approved waiver capacity. Numerator: Total number of active waiver participants. Denominator: total number of CMS approved waiver slots.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid**	☐ **Weekly**	☒ **100% Review**

Agency		
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
B.3 Number of percent of waiver participants enrolled by the Division of Aging in accordance to state established criteria. Numerator: Total number of waiver participants enrolled by the Division of Aging in accordance to state established criteria. Denominator: Total number of waiver participants enrolled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver enrollment report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information

regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

NFLOC determinations are facilitated through the electronic case management application referred to as the E-Screen. This tool is structured to assure that NFLOC criteria is consistently applied and other automated features prevent service plan approval prior to NFLOC approval. The DA monitors and identifies NFLOC program non-compliance, which is identified in the performance measures. All documentation of resolution activities will be maintained within the electronic case management database or other electronic tracking system.

If the DA, or any other entity, identifies any instance of a new applicant not having received a level of care evaluation prior to enrollment the DA will ascertain any related claims had been made and deny these. The waiver care manager will be required to immediately conduct a proper evaluation and enter this into the electronic system. If it is identified that the applicant does not meet the criteria the care manager is required to explore other community or public funded services that may be available to the individual. The DA will report any finding of evidence of malfeasance to FSSA Program Integrity for review. All NFLOC decisions are subject to the applicant's rights to appeal and have a Medicaid Fair Hearing. All initial evaluations are completed by the ADRC care manager and determinations are rendered by the case manager supervisor. All initial level of care approvals are reviewed and verified by the operating Agency- DA staff prior to service implementation.

Re-evaluations completed by AAA care managers are approved or denied by AAA care management staff. Re-evaluations completed by non-AAA care managers are approved or denied by DA Staff.

DA and OMPP continuously monitor slots both assigned and utilized to ensure members are utilizing the programs they selected. If a case where slots appear to be potentially exhausted for a waiver year based on targeting efforts of the operating agency, the State discusses amendments to slots to increase the waiver capacity.

In any discovery finding where a participant received an evaluation where NFLOC criteria was not accurately applied, the DA will require that a reevaluation be conducted with findings verified by a supervisor or the DA Care Management Director. If there is any evidence that the evaluation was intentionally inaccurate, the DA will handle this as a formal complaint with potential sanctions up to and including termination as a waiver provider.

If redetermination reveals that the participant does not meet the approved NFLOC category, any claims submitted will be denied back to the date of expiration of the prior NFLOC period. The care manager will be advised to refer the participant for any other services which may be available and the participant will be informed in writing that they have the right to request a formal Appeal and are entitled to a Medicaid Fair Hearing to dispute any NFLOC determination decision.

If an issue were discovered in which a member was enrolled who did not meet State criteria for the waiver, OMPP and DA would work together to remediate the issue on an individual basis.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The care manager is responsible for explaining all HCBS waiver service options available to the participant. The care manager assesses the participant and completes a service plan. On the service plan there is a section regarding freedom of choice. The freedom of choice language is as follows and is required to be signed by the participant.

"A Medicaid Waiver Services care manager has explained the array of services available to meet my needs through the Medicaid Home and Community-Based Services Waiver. I have been fully informed of the services available to me in an institutional care setting. I understand the alternatives and have been given the opportunity to choose between waiver services in a home and community-based setting and institutional care. As long as I remain eligible for waiver services, I will continue to have the opportunity to choose between waiver services in a home and community-based setting and institutional care."

In addition, the applicant/participant is informed that participants in the waiver cannot receive traditional Medicaid services through Medicaid's risk-based managed care system.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Forms will be maintained by the care management entity and within the electronic case management database within the DA.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

FSSA's OMPP and the DA address the needs of participants with limited English in a variety of ways:
Public informational materials regarding waiver services will be available in Spanish and English.
- The care manager identifies the participant's preferred language of communication.
- Care managers and service providers are expected to have oral interpretation available for most common languages in their service areas. Bilingual providers are preferred.

Oral interpretation is achieved either through:
- Bilingual staff, contractual interpreters, telephone interpreters; or
- The use of family/friends as interpreters only when/if the person needing service is aware of the option of one provided at no cost. A participant needing services will not be required to use a family member as an interpreter.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	**Adult Day Service**		
Statutory Service	**Attendant Care**		
Statutory Service	**Care Management**		
Statutory Service	**Home and Community Assistance Service**		
Statutory Service	**Respite**		
Other Service	**Adult Family Care**		
Other Service	**Assisted Living**		
Other Service	**Community Transition**		
Other Service	**Home Delivered Meals**		
Other Service	**Home Modification Assessment**		
Other Service	**Home Modifications**		
Other Service	**Integrated Health Care Coordination**		
Other Service	**Nutritional Supplements**		
Other Service	**Participant Directed Home Care Service**		
Other Service	**Personal Emergency Response System**		
Other Service	**Pest Control**		
Other Service	**Specialized Medical Equipment and Supplies**		
Other Service	**Structured Family Caregiving**		
Other Service	**Transportation**		
Other Service	**Vehicle Modifications**		
Other Service	**Caregiver Coaching & Behavior Management**		
Other Service	**Goal Engagement**		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04050 adult day health
Category 2:	**Sub-Category 2:**
04 Day Services	04060 adult day services (social model)
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Adult Day Service (ADS) are community-based group programs designed to meet the needs of individuals who need structured, social integration through a comprehensive and non-residential program. The service plan will identify the need through the person centered assessment (PCA) process and evident through the assessment tool. The purpose for ADS is to provide health, social, recreational, supervision, support services, and personal care. Meals, specifically, and as appropriate, breakfast, lunch, and nutritious snacks are required.

Participants attend Adult Day Services on a planned basis. The three levels of Adult Day Services are Basic, Enhanced, and Intensive.

ALLOWABLE ACTIVITIES

BASIC ADULT DAY SERVICES (Level 1) includes:

- Monitor all activities of daily living (ADLs) defined as dressing, bathing, grooming, eating, walking, and toileting with hands-on assistance provided as needed
- Comprehensive, therapeutic activities for those with cognitive impairment in a safe environment
- Initial Health assessment conducted by RN consultant prior to beginning services at the adult day, and intermittent monitoring of health status
- Monitor medication or medication administration
- Minimum staff ratio: One staff for each eight individuals
- RN Consultant available

ENHANCED ADULT DAY SERVICES (Level 2) includes: Level 1 service requirements must be met. Additional services include:
- Hands-on assistance with two or more ADLs or hands-on assistance with bathing or other personal care
- Initial health assessment conducted by RN consultant prior to beginning services as well as regular monitoring or intervention with health status
- Medication assistance
- Psychosocial needs assessed and addressed, including counseling as needed for individuals and caregivers
- Therapeutic structure and intervention for participants with mild to moderate cognitive impairments in a safe environment
- Minimum staff ratio: One staff for each six individuals
- RN Consultant available
- Minimum of one full-time LPN staff person with monthly RN supervision

INTENSIVE ADULT DAY SERVICES (Level 3) includes: Level 1 and Level 2 service requirements must be met. Additional services include:

- Hands-on assistance or monitoring with all ADLs and personal care
- One or more direct health intervention(s) required
- Rehabilitation and restorative services, including physical therapy, speech therapy, and occupational therapy coordinated or available
- Therapeutic intervention to address dynamic psychosocial needs such as depression or family issues affecting care
- Therapeutic interventions for those with moderate to severe cognitive impairments
- Minimum staff ratio: One staff for each four individuals
- RN Consultant available
- Minimum of one full-time LPN staff person with monthly RN supervision
- Minimum of one qualified full-time staff person to address participants' psycho-social needs

DOCUMENTATION STANDARDS

Care Managers:

- Justification for the service is documented
- The documented need for the service is to describe, but not limited to the following: Describe the structure needed for the participant (medical, social, recreational) Types of ADL care the participant may require and level of assistance needed

- Level of service is determined in the person centered assessment (PCA), which is given to provider

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Adult Day Services are allowed for a maximum of ten (10) hours per day.

ACTIVITIES NOT ALLOWED:

- Services to participants receiving Assisted Living waiver service

NOTE: Therapies provided through this service will not duplicate therapies provided under any other service

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/ DA approved Adult Day Service Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Service

Provider Category:
Agency
Provider Type:

FSSA/ DA approved Adult Day Service Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must comply with the Adult Day Services Provision and Certification Standards, as follows:

DA approved
455 IAC 2 Provider Qualifications: Becoming an approved provider; maintaining approval
455 IAC 2 Provider Qualifications: General requirements
455 IAC 2 Provider Qualifications: General requirements for direct care staff
455 IAC 2 Procedures for Protecting Individuals
455 IAC 2 Unusual occurrence; reporting
455 IAC 2 Transfer of individuals record upon change of provider
455 IAC 2 Notice of termination of services
455 IAC 2 Provider organizational chart
455 IAC 2 Collaboration and quality control
455 IAC 2 Data collection and reporting standards
455 IAC 2 Quality assurance and quality improvement system
455 IAC 2 Financial information
455 IAC 2 Liability insurance
455 IAC 2 Maintenance of personnel records
455 IAC 2 Adoption of personnel policies
455 IAC 2 Operations manual
455 IAC 2 Maintenance of records of services provided
455 IAC 2 Individuals personal file; site of service delivery

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Attendant Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Attendant Care services (ATTC) are provided to participants with nursing facility level of care needs. ATTC provides direct, hands-on care to participants for the functional needs with ADLs. The participant is the employer for Participant Directed ATTC, or appoints a representative to be the employer on their behalf.

ALLOWABLE ACTIVITIES

All non-skilled ADL care as identified in the PCA that includes but is not limited to the following:

Provides assistance with personal care, which includes:
- Bathing, partial bathing
- Oral hygiene
- Hair care including clipping of hair
- Shaving
- Hand and foot care
- Intact skin care
- Application of cosmetics
- Dressing

Provides assistance with mobility, which includes:
- Proper body mechanics
- Transfers
- Ambulation
- Use of assistive devices

Provides assistance with elimination, which includes:
- Assists with bedpan, bedside commode, toilet
- Incontinent or involuntary care
- Emptying urine collection and colostomy bags

Provides assistance with nutrition, which includes:
- Meal planning, preparation, clean-up

Provides assistance with safety, which includes:
- Use of the principles of health and safety in relation to self and individual
- Identify and eliminate safety hazards
- Practice health protection and cleanliness by appropriate techniques of hand washing
- Waste disposal, and household tasks
- Reminds individual to self-administer medications

Provides assistance with correspondence and bill paying
- Transportation of individuals to non-medical community activities. Out of State transportation is limited to 50 miles of State geographic limits. Escorting of participants does not include mileage or other costs that are not associated with the provision of personal care.
- Accompanying and transporting the individual to medical appointments. ATTC services to accompany members to medical appointments includes assistance to ensure individual has a complete understanding of information shared by physician or medical personnel. This activity is offered in addition to medical transportation available under the State Plan and does not replace it. Whenever possible, other sources will be utilized.

SERVICE STANDARDS

ATTC may be provided from the following:
- Agency—an agency enrolled in the program is responsible to hire and render services or

Non-Agency/Solo Provider- The solo provider classification refers to an individual (as opposed to an agency) operating under their SSN and operating without employees.
- Participant Directed—the participant is the employer and acts as the agency directing their care.

If direct care or monitoring of care is not provided to the client and the documentation of services rendered for the

units billed reflects Home and Community Assistance duties, an entry must be made to indicate why the direct care was not provided for that day. If direct care or supervision of care is not provided for more than 30 days and the documentation of services rendered for the units billed reflects Home and Community Assistance duties, the care manager must be contacted to amend the service plan to

a) add Home and Community Assistance Services and eliminate Attendant Care Services or

b) reduce attendant care hours and replace with the appropriate number of hours of Home and Community Assistance services

DOCUMENTATION STANDARDS

Care Managers:
• Responsible to document the medical need for ATTC and types of ADL care the participant may require.
• Responsible to document the type of (ATTC or participant-directed) ATTC determined to meet the needs of the individual or caregiver through the PCA
• Document the ATTC activity that will meet the participant's needs and assure it is accurately documented in the level of care E-screen
• If the participant is SK-LOC, the CM must document how the skilled need is being met and by whom. If ATTC is being requested for an individual with skilled care documentation must describe who will be providing ATTC, the frequency of care and activities being performed.

• Participant Directed ATTC. The CM must document who is the employer, who is the employee/direct worker and their relationship to the participant (include POA, guardian status as well).

ATTC Providers:
In addition to Electronic Visit Verification, providers will record services provided, including:
• complete date and time of service (in and out)
• specific services/tasks provided
• signature of participant verifying the service was provided by agency
• signature of employee providing the service (minimally the last name and first initial) If the person providing the service is required to be a professional, the title must also be included
• Each staff member providing direct care or supervision of care to the participant must make at least one entry on each day of service.
• Documentation of service delivery is to be signed by the participant or designated participant representative.

• Notification to the participant's care manager within forty-eight hours of any changes in the participant's person centered service plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

ACTIVITIES NOT ALLOWED
Attendant Care services will not be provided to people with unstable medical needs as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician, or other health professional ATTC services will not be reimbursed to a provider for a participant, with the following but not limited to items, regarding specialized feeding, (such as difficulty swallowing, refuses to eat, or does not eat enough); unless permitted under law and not duplication of State Plan services.
Hoyer lift; and weight bearing transfers assistance should be considered for State Plan HOHE or respite home health aide under the supervision of a registered nurse.

ATTC services will not be reimbursed to a provider for a participant requiring management of uncontrolled seizures, infusion therapy; venipuncture; injection; wound care for, decubitus, incision; ostomy care; and tube feedings must be considered for respite nursing services unless permitted under law and not duplication of State Plan services.

• The ATTC will not be a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician, or other health professional.
• ATTC will not set up and administer medications. ATTC may not assist with catheter and ostomy care,
• Attendant Care services will not be provided to household members other than to the participant.
• Attendant Care services will not be reimbursed when the owner of the agency is a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, the health care representative (HCR) of a participant, or the legal guardian of a participant.
• Attendant Care services to participants receiving Adult Family Care waiver service, Structured Family Caregiving waiver service, or Assisted Living waiver service.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	FSSA/DA approved Attendant Care Individual
Agency	Licensed Personal Services Agency
Agency	Licensed Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Attendant Care

Provider Category:

Individual

Provider Type:

FSSA/DA approved Attendant Care Individual

Provider Qualifications

License *(specify):*

IC 16-27-4

Certificate *(specify):*

Other Standard *(specify):*

DA approved
455 IAC 2 Provider Qualifications; General requirements
455 IAC 2 General requirements for direct care staff
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements
455 IAC 2 Personnel Records
455 IAC 2-6-1 Provider qualifications: becoming an approved provider; maintaining approval
455 IAC 2-6-2 (a)(1)(B) Provider qualifications: general requirements
455 IAC 2-11-1 Property and personal liability insurance
IC 12-10-17.1-10 Registration; prohibition
IC 12-10-17.1-11 Registration requirement
IC 12-10-17.1-12 Registration by the division; duties of the division
The division may reject any applicant with a conviction of a crime against persons or property, a conviction for fraud or abuse in any federal, state, or local government program, (42 USC §1320a-7) or a conviction for illegal drug possession. The division may reject an applicant convicted of the use, manufacture, or distribution of illegal drugs (42 USC §1320a-7). The division may reject an applicant who lacks the character and fitness to render services to the dependent population or whose criminal background check shows that the applicant may pose a danger to the dependent population. The division may limit an applicant with a criminal background to caring for a family member only if the family member has been informed of the criminal background.

Compliance with IC 16-27-4, if applicable.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Attendant Care

Provider Category:

Agency

Provider Type:

Licensed Personal Services Agency

Provider Qualifications

License *(specify):*

IC 16-27-4

Certificate *(specify):*

Other Standard *(specify):*

DA approved

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Attendant Care

Provider Category:

Agency

Provider Type:

Licensed Home Health Agency

Provider Qualifications

License *(specify):*

IC 16-27-1
IC 16-27-4

Certificate *(specify):*

Other Standard *(specify):*

DA approved

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Care Management

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Care Management is a process of assessment, discovery, planning, facilitation, advocacy, collaboration, and monitoring of the holistic needs of each individual, regardless of funding sources.

ALLOWABLE ACTIVITIES

Person Centered Assessment and Planning. This activity includes but not limited to discovering the participants strengths, needs, goals, and preferences. The Care Manager will appropriately facilitate the assessment process through utility of person centered discovery tools and practice to engage the individual and their circle of support. The assessment and planning phase can include but not limited to, brokering community resources, action and/or service planning, and eligibility for funded services.

Development and implementation of a Person Centered Support Plan, including action and/or service plans. Action Planning is a process to determine community resources to meet the individual's functional and social needs. Service Planning is a process to determine funded services and eligibility to appropriately meet the individual's needs.

Monitoring and evaluating all action and/or service plans.
Care managers are responsible to monitor progress for all services displayed on the action and/or service plans.

The care manager will provide and coordinate high quality services to the individual, while promoting seamless, integrated, coordinated care.

Monitoring person centered support plans will be completed by the care manager in a face to face contact every 90 days from the initial service plan activation. When the initial care plan is activated, the care manager will either call or visit the individual within 30 days and no more than 40 days from initial service plan activation to ensure implementation of services.

The care manager is responsible to complete annual person centered assessments including eligibility and service planning.

The care manager is responsible to coordinate changes in the service plan that include but are not limited to notifying all providers about the change and when they are to begin or end services. , and notifying all providers when a care plan is in a terminated or re-start status.

The care manager will be responsible to evaluate the effectiveness of all services. Evaluation is demonstrated through but not limited to:
- Monitoring the progress from identifying need to meeting goals/preferences identified by the individual.
- Direct collaboration and coordination with providers to ensure services are within the individual's preferences
- Adjusting action and service plans appropriately to identify changing needs that meet the participant's needs

Termination of plans

The care manager will follow the Medicaid Nursing Facility level of Care Home and Community- Based Services Waivers termination Procedures when a participant is no longer to receive services under the waiver program. This includes providing a thirty (30) day notice to any participant the care manager is terminating.

SERVICE STANDARDS

- Care Management Services must be reflected in the service plan of the participant.
- Care managers enhance the individual's functional and social well-being.
- Broker community resources that align with the participant's unique needs.
- Care manager's will engage the participant and their circle of support in all aspects of the care management process and tailor the person centered support plan to the participant's needs, preferences, goals, and strengths.
- Care manager is expected to coordinate and collaborate with other care managers, other organizations, community partners, and DA staff to ensure quality care management is being delivered and options are being discovered and presented to the individual to optimize his/her overall functioning capability.
- Care manager maximum Medicaid Waiver caseload is not to exceed 65 participants at any time.
- Care managers are responsible for identifying when a participant is residing in a provider owned or controlled

setting, monitoring HCBS characteristics, monitoring person centered modifications to HCBS characteristics, and documented in the PCMT as such.

DOCUMENTATION STANDARDS

Person Centered Assessment and Planning. This activity includes but not limited to discovering the participants strengths, needs, goals, and preferences. The care manager will appropriately facilitate the assessment process to engage the individual and their circle of support. The assessment and planning phase can include but not limited to, brokering community resources, action and/or service planning, and eligibility for funded services.

Development and implementation of a Person Centered Support Plan, including action and/or service plans. Action Planning is a process to determine community resources to meet the individual's functional and social needs.

Service Planning is a process to determine funded services and eligibility to appropriately meet the individual's needs.

Monitoring and evaluating all action and/or service plans.

Care managers are responsible to monitor progress for all services displayed on the action and/or service plans.

The care manager will provide and coordinate high quality services to the individual, while promoting seamless, integrated, coordinated care.

Monitoring person centered support plans will be completed by the care manager in a face-to-face contact every 90 days from the initial service plan activation. When the initial care plan is activated, the care manager will either call or visit the individual within 30 days and no more than 40 days from initial service plan activation to ensure implementation of services.

The care manager is responsible to complete Annual person centered assessments including eligibility and service planning.

The care manager is responsible to complete all assessment tools including but not limited to incident reports timely.

The care manager will be responsible to evaluate the effectiveness of all services. Evaluation is demonstrated through but not limited to:

1. Monitoring the progress from identified need to meeting goals/preferences identified by the individual.

2. Direct collaboration and coordination with providers to ensure services are within the individual's preferences

3. Adjusting action and service plans appropriately to identify changing needs that meet the participant's needs

Termination of plans

The care manager will follow the Medicaid Nursing Facility level of Care Home and Community-Based Services Waivers termination Procedures when a participant is no longer to receive services under the waiver program.

Transition follow up

It is the responsibility of the care manager to assure the individual fully understands their ability to make choices concerning all services they receive. This includes care management services. In the event the individual chooses another CM agency the current CM agency is to fully assist the individual in their transition, to the new agency or individual CM of choice. The goal is to assure a seamless transition for the individual.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

ACTIVITIES NOT ALLOWED

Care Management may not be conducted by any organization, entity, or participant that also delivers other in- home and community-based services, or by any organization, entity, or participant related by common ownership or control to any other organization, entity, or participant who also delivers other in-home and community-based services, unless the organization is an AAA that has been granted permission by the FSSA's DA to provide direct services to participants.

Prior to billing, a care manager must have completed the care management curriculum to become a Medicaid certified care manager.

Note: Common ownership exists when a participant, or any legal entity possess ownership or equity of at least five percent in the provider as well as the institution or organization serving the provider. Control exists where a participant or organization has the power or the ability, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not actually exercised. Related means associated or affiliated with, or having the ability to control, or be controlled by.

Independent care managers and independent case management companies may not provide initial applications for Medicaid Waiver services.

Reimbursement of care management under Medicaid Waivers may not be made unless and until the participant becomes eligible for Medicaid Waiver services. Care management provided to participants who are not eligible for Medicaid Waiver services will not be reimbursed as a Medicaid Waiver service

Care Management Services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, the health care representative (HCR) of a participant, or the legal guardian of a participant

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	FSSA/ DA approved Case Management Individual
Agency	FSSA/DA approved Case Management Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Care Management

Provider Category:
Individual
Provider Type:

FSSA/ DA approved Case Management Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

455 IAC 2 Documentation of qualifications
455 IAC 2 Case Management Liability Insurance

Training in the nursing facility level of care process by the DA or designee Education and work experience
Must be a registered nurse or licensed practical nurse, Bachelor's degree or associate's degree with one year of experience delivering healthcare/social services or case management, or at least 2 or more years in care planning, care management, or delivering healthcare or social services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Care Management

Provider Category:

Agency

Provider Type:

FSSA/DA approved Case Management Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

DA, or its designee, approved
455 IAC 2 Provider Qualifications; General requirements 455 IAC 2 Procedures for protecting individuals
455 IAC 2 Unusual occurrence; reporting
455 IAC 2 Transfer of individual's record upon change of provider 455 IAC 2 Notice of termination of services
455 IAC 2 Provider organizational chart 455 IAC 2 Collaboration and quality control
455 IAC 2 Data collection and reporting standards
455 IAC 2 Quality assurance and quality improvement system 455 IAC 2 Financial information
455 IAC 2 Liability insurance
455 IAC 2 Documentation of qualifications 455 IAC 2 Maintenance of personnel records 455 IAC 2 Adoption of personnel policies
455 IAC 2 Operations manual
455 IAC 2 Maintenance of records of services provided 455 IAC 2 Case Management

Training in the nursing facility level of care process by the DA or designee Education and work experience
Must be a registered nurse or licensed practical nurse, Bachelor's degree or associate's degree with one year of experience delivering healthcare/social services or case management, or at least 2 or more years in care planning, care management, or delivering healthcare or social services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

Home and Community Assistance Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08050 homemaker
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Home and Community Assistance services provide instrumental activities of daily living (IADL) for the participant in their home. The services are provided when the individual is unable to meet their needs or when the informal caregiver/helper is unable to perform these needs for the participant.

ALLOWABLE ACTIVITIES. Provides IADL care that may include but are not limited to the following:

- Dusting and straightening furniture
- Cleaning floors and rugs by wet or dry mop and vacuum sweeping
- Cleaning the kitchen, including washing dishes, pots, and pans; cleaning the outside of appliances and counters and cupboards; cleaning ovens and defrosting and cleaning refrigerators
- Maintaining a clean bathroom, including cleaning the tub, shower, sink, toilet bowl, and medicine cabinet; emptying and cleaning commode chair or urinal
- Laundering clothes in the home or laundromat, including washing, drying, folding, putting away, ironing, and basic mending and repair
- Changing linen and making beds
- Washing insides of windows
- Removing trash from the home
- Provides assistance with meal planning and preparation, including special diets under the supervision of a registered dietitian or health professional
- Completing essential errands and/or unassisted transportation for non-medical, community activities,
- Provides assistance with correspondence and bill paying
- Minor pet care may be allowed at the discretion of the agency
- Assistance with outdoor tasks including raking leaves, snow removal, lawn mowing, and weeding

SERVICE STANDARDS

Care Manager Standards

Care manager will document through the Person Centered Assessment (PCA) the need for HMK, the frequency of need, the required type of HMK activities

DOCUMENTATION STANDARDS

Care Manager Documentation Standards

Care manager will document through the PCA the need for HMK, the frequency of need, the required type of HMK activities.

Home and Community Assistance Providers

Data record of services provided, including:

- Complete date and time of service (in and out)
- Specific services/tasks provided
- Notification to the participant’s care manager, within forty-eight hours, upon any changes in the participant’s person centered service plan.
- For errands such as utilizing a laundromat due to there not being a washer or dryer in the participant’ home, then the time spent traveling and completing the errand shall be recorded as well as the specific tasks and necessity of the task being completed.
- If Home and Community Assistance services take place outside the participant’s home (such as errands being required due to no washer/dryer in home, or travel for other allowable tasks) travel expenses beyond the time spent on the errand are the responsibility of the agency providing Home and Community Assistance services
- signature of employee providing the service (minimally the last name and first initial). If the person providing the service is required to be a professional, then that title must also be included.
- Each staff member providing direct care or supervision of care to the participant must make at least one entry on each day of service. All entries should describe an issue or circumstance concerning the participant.
- Documentation of service delivery is to be signed by the participant or designated participant representative.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

ACTIVITIES NOT ALLOWED
- Assistance with ADL hands on care. Specifically Home and Community Assistance may not provide any ADL assistance such as eating, bathing, dressing, personal hygiene, medication set up and administration.
- Hands on and/or assisted transportation of participants to community activities or errands
- Home and Community Assistance services provided to household members other than to the participant
- Home and Community Assistance services will not be reimbursed when the owner of the organization is the parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, the health care representative (HCR) of a participant, the legal guardian of the participant, or by any member of the participant's household
- Services to participants receiving Adult Family Care waiver service, Structured Family Caregiving waiver service, or Assisted Living waiver service

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☒ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Home Health Agency
Individual	FSSA/DA approved Homemaker Individual
Agency	Licensed Personal Services Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home and Community Assistance Service

Provider Category:
Agency
Provider Type:

Licensed Home Health Agency

Provider Qualifications

License *(specify)*:

IC 16-27-1
IC 16-27-4

Certificate *(specify)*:

Other Standard *(specify)*:

DA approved

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home and Community Assistance Service

Provider Category:

Individual

Provider Type:

FSSA/DA approved Homemaker Individual

Provider Qualifications

License *(specify):*

IC 16-27-4

Certificate *(specify):*

Other Standard *(specify):*

DA approved
455 IAC 2 Provider qualifications: becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: general requirements
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements
455 IAC 2 Personnel Records

Compliance with IC 16-27-4, if applicable.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home and Community Assistance Service

Provider Category:

Agency

Provider Type:

Licensed Personal Services Agency

Provider Qualifications

License *(specify):*

IC 16-27-4

Certificate *(specify):*

Other Standard *(specify):*

DA approved

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**
05 Nursing	05020 skilled nursing
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Respite services are those services that are provided temporarily or periodically in the place of the usual caregiver. Respite can occur in home and community based settings.

ALLOWABLE ACTIVITIES

- Home health aide services (RHHA)
- Skilled nursing services (RSKNU)

SERVICE STANDARDS

If respite occurs in a HCBS certified facility targeting children and young adults twenty-two (22) and younger, staff to participant ratio cannot be greater than 1 staff per 2 participants. When respite is provided in this environment, the intent is to provide support to families in an effort to avoid institutionalization of their children.

The level of professional care provided under respite services depends on the needs of the participant and caregiver determined in the Person Centered Assessment (PCA).

RHHA: A participant who is eligible for State Plan Home Health Services (HOHE) should be considered for respite home health aide under the supervision of a registered nurse

RHHA authorized hours will roll over month-to-month through the duration of the Annual Service Plan. If a request for an increase in RHHA during the annual care plan is needed the care manager must coordinate with the agency to verify unused hours before requesting the additional hours. If there are unused hours they must first be used before requesting additional hours.

Agency providing respite service is responsible for tracking participant's respite hours and notifying participant and care manager of hours used as well as hours remaining.

RSKNU: A participant who is eligible for State Plan Nursing Services (SKNU) must be considered for respite nursing services

RSKNU authorized hours will roll over month to month through the duration of the Annual Service Plan. If a request for an increase in RHHA during the annual care plan is needed the care manager must coordinate with the agency to verify unused hours before requesting the additional hours. If there are unused hours they must first be used before requesting additional

DOCUMENTATION STANDARDS

Care Manager Documentation Standards:

The care manager must identify the primary caregiver being relieved. The care manager needs to identify the primary caregiver is not being paid by the agency to respite themselves during this time

The care manager must document needs and activities that require respite.

- Provider Documentation Standards
- Data Record of staff to participant service documenting the complete date and time in and time out, and the number of units of service delivered that day
- Each staff member providing direct care or supervision of care to the participant makes at least one entry on each day of service describing an issue or circumstance concerning the participant
- Documentation should include date and time, and at least the last name and first initial of the staff person making the entry. If the person providing the service is required to be a professional, that title must also be included (example: if a nurse is required to perform the service then the RN title would be included with the name)
- Any significant issues involving the participant requiring intervention by a health care professional, or care manager that involved the participant also needs to be documented
- Specify applicable (if any) limits on the amount, frequency, or duration of this service
- Documentation must include the following elements: the reason for the respite and the type of respite rendered
- Notification to the participant's care manager and other un-skilled provider, within forty-eight hours, upon and

changes to the participant's person-centered service plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

ACTIVITIES NOT ALLOWED

- Respite may not be used to replace services that should be provided under the Medicaid State Plan
- Respite will not be reimbursed when the owner of the organization is the parent of a minor child t, the spouse of a participant, the attorney-in-fact (POA) of a participant, the health care representative (HCR) of a participant, or the legal guardian of a participant
- Respite must not duplicate any other service being provided under the participant's service plan.
- Respite service to participants receiving Adult Family Care waiver service, or Assisted Living waiver service.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Licensed Home Health Agency

Provider Qualifications

License *(specify):*

IC 16-27-1

Certificate *(specify):*

Other Standard *(specify):*

DA approved

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adult Family Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02023 shared living, other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Adult Family Care (AFC) is a comprehensive service in which a participant resides with an unrelated caregiver. The participant and up to three (3) other participants who have physical and/or cognitive disabilities, and who are not members of the provider's or primary caregiver's family, and/or reside in a home that is owned, rented, or managed by the AFC provider.

ALLOWABLE ACTIVITIES:

The following are included in the daily per Diem for Adult Family Care:

- Attendant care related to ADL's
- Home and Community Assistance care related to IADL's
- Medication oversight (to the extent permitted under State law)

SERVICE STANDARDS

- Adult Family Care services must follow a written service plan addressing specific needs determined by the participant's Person Centered Assessment.
- Services must address the participant's level of service needs
- Provider must live in the AFC home, unless another provider-contracted primary caregiver, who meets all provider qualifications, lives in the provider's home
- Backup services must be provided by a qualified participant familiar with the participant's needs for those times when the primary caregiver is absent from the home or otherwise cannot provide the necessary level of care.
- AFC provides an environment that has the qualities of a home, including privacy, safe place that is free of environmental hazards such as pests, habitable environment, comfortable surroundings, and the opportunity to modify one's living area to suit one's participant preferences.
- Rules managing or organizing the home activities in the AFC home that are developed by the provider or provider-contracted primary caregiver, or both and approved by the Medicaid waiver program must be provided to the participant prior to the start of AFC services and may not be so restrictive as to interfere with a participant's rights under state and federal law.
- Participant-focused activity plans are developed by the provider with the participant or their representative
- Providers or provider's employees who provide medication oversight as addressed under allowed activities must receive necessary instruction from a doctor, nurse, or pharmacist on the administration of controlled substances prescribed to the participant

DOCUMENTATION STANDARDS:
Level of service is determined in the person centered assessment (PCA).
Care Manager Documentation standards:

- Responsible to document the medical need for AFC and types of ADL and IADL care the participant may require.
- Document the expected AFC activity to meet the individual's needs and is accurately shown in the level of care E-screen
- If the participant requires skilled care, the CM must justify how the skilled need will be met and by whom. The documentation must describe the reason to use ATTC, who will be providing this service, the activities that are expected to be performed and frequency
- Care manager must give the completed PCA to the provider

Provider Documentation Standards:

Daily documentation to support services rendered by the AFC to address needs identified in the PCA:

- Participant's status, including health, mental health, medication, diet, sleep patterns, social activity
- Updates, including health, mental health, medication, diet, sleep patterns, social activity
- Participation in consumer focused activities
- Medication management records, if applicable

Monthly updated service plans provided to the participant's care manager from the AFC caregiver.

Notification to the participant's care manager, within forty-eight hours, of any changes in participants care plan.

Maintenance of participant's personal records to include:

- Social security number
- Medical insurance number
- Birth date
- Emergency Contact(s)
- All medical information available including all current prescription and non-prescription drug medication
- Most recent prior residence
- Hospital preference
- Primary care physician
- Mortuary (if known)
- Religious affiliation and place of worship, if applicable

Participant's personal records must include copies of all applicable documents, which the AFC caregiver will also provide to the participant's care manager on an ongoing basis if there are changes to these documents:

- Advance Directive
- Living Will
- Power of Attorney
- Health Care Representative
- Do Not Resuscitate (DNR) Order
- Letters of Guardianship

NOTE: if applicable, copies of personal record must be:

Placed in a prominent place in the consumer file; and
Sent with the consumer when transferred for medical care or upon moving from the residence

Notification to the participant's care manager, within forty-eight hours, of any changes in participants care plan.

Maintenance of participant's personal records to include:

- Social security number
- Medical insurance number
- Birth date
- Emergency Contact(s)
- All medical information available including all current prescription and non-prescription drug medication
- Most recent prior residence
- Hospital preference
- Primary care physician
- Mortuary (if known)
- Religious affiliation and place of worship, if applicable

Participant's personal records must include copies of all applicable documents, which the AFC caregiver will also provide to the participant's care manager on an ongoing basis if there are changes to these documents:

- Advance Directive
- Living Will
- Power of Attorney
- Health Care Representative
- Do Not Resuscitate (DNR) Order
- Letters of Guardianship

NOTE: if applicable, copies of personal record must be:

Placed in a prominent place in the consumer file; and
Sent with the consumer when transferred for medical care or upon moving from the residence

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

ACTIVITIES NOT ALLOWED:

- Services provided in the home of a caregiver who is related by blood or related legally to the participant
- Adult Family Care services will not be reimbursed when the owner of the organization is a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, the health care representative (HCR) of a participant, or the legal guardian of a participant
- Payments for room and board or the costs of facility maintenance, upkeep or improvement
- Personal care services provided to medically unstable or medically complex participants as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician or other health professional
- The Adult Family Care service per diem does not include room and board.
- Separate payment will not be made for Home and Community Assistance, Respite, Home Modifications, Attendant Care, Home Delivered Meals, Pest Control, Community Transition, or Structured Family Caregiving services furnished to a participant selecting Adult Family Care services as these activities are integral to and inherent in the provision of Adult Family Care Services.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DA approved Adult Family Care Agency
Individual	FSSA/DA approved Adult Family Care Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Family Care

Provider Category:
Agency
Provider Type:

FSSA/DA approved Adult Family Care Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Provider and home must meet the requirements of the Indiana Adult Family Care Service Provision and Certification Standards.

DA approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider Qualifications: General Requirements
455 IAC 2 General requirements for direct care staff
455 IAC 2 Procedures for protecting individuals
455 IAC 2 Unusual occurrence; reporting
455 IAC 2 Transfer of individual's record upon change of provider
455 IAC 2 Notice of termination of services
455 IAC 2 Provider organizational chart
455 IAC 2 Collaboration and quality control
455 IAC 2 Data collection and reporting standards
455 IAC 2 Quality assurance and quality improvement system
455 IAC 2 Financial information
455 IAC 2 Liability insurance
455 IAC 2 Transportation of an individual
455 IAC 2 Documentation of qualifications
455 IAC 2 Maintenance of personnel records
455 IAC 2 Adoption of personnel policies
455 IAC 2 Operations manual
455 IAC 2 Maintenance of records of services provided
455 IAC 2 Individual's personal file; site of service delivery

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Family Care

Provider Category:

Individual

Provider Type:

FSSA/DA approved Adult Family Care Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Provider and home must meet the requirements of the Indiana Adult Family Care Service Provision and Certification Standards.

DA approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider Qualifications; General requirements
455 IAC 2 General requirements for direct care staff
455 IAC 2 Procedures for protecting individuals
455 IAC 2 Unusual occurrence; reporting
455 IAC 2 Transfer of individual's record upon change of provider
455 IAC 2 Notice of termination of services
455 IAC 2 Provider organizational chart
455 IAC 2 Collaboration and quality control
455 IAC 2 Data collection and reporting standards
455 IAC 2 Quality assurance and quality improvement system
455 IAC 2 Financial information
455 IAC 2 Liability insurance
455 IAC 2 Transportation of an individual
455 IAC 2 Documentation of qualifications
455 IAC 2 Maintenance of personnel records
455 IAC 2 Adoption of personnel policies
455 IAC 2 Operations manual
455 IAC 2 Maintenance of records of services provided
455 IAC 2 Individual's personal file; site of service delivery

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assisted Living

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02013 group living, other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Assisted living service is defined as personal care and services, home and community assistance, chore, attendant care and companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a congregate residential setting in conjunction with the provision of participant paid room and board. This service includes 24 hour on-site response staff to meet scheduled and unpredictable needs. The participant retains the right to assume risk.

ALLOWABLE ACTIVITIES

The following are included in the daily per Diem for Assisted Living Services: Attendant care related to ADL's
Home and Community Assistance care related to IADL's
Medication oversight (to the extent permitted under State law).
Non-emergency non-medical transportation
Therapeutic social and recreational programming

SERVICE STANDARDS
Assisted Living services must follow a written service plan addressing specific needs determined by the participant's Person Centered Assessment (PCA).

If the participant requires skilled care, the care manager must justify how the skilled need will be met and by whom. The documentation must describe the reason to use AL, who will be providing this service, the activities that are expected to be performed and frequency.

DOCUMENTATION STANDARDS

Care Manager Documentation Standards:

Responsible to document the need, types, and frequency of ADL and/or IADL care the participant may require, which is identified in the PCA.

If the participant requires skilled care, the care manager must justify how the skilled need will be met and by whom. The documentation must describe the reason to use AL, who will be providing this service, the activities that are expected to be performed and frequency.

Care manager must give the completed PCA Assisted Living to the provider.
Provider Documentation Standards:
Complete and accurate documentation to support daily services rendered by the AL to address needs identified in the Person Centered Care Plan:

- Participant's status, including health, mental health, medication, diet, sleep patterns, social activity
- Updates, including health, mental health, medication, diet, sleep patterns, social activity
- Participation in consumer focused activities
- Medication management records, if applicable
- Quarterly updated service plans provided to the participant's care manager from the AL.
- Notification to the participant's care manager, within forty-eight hours, of any changes in participants care plan.

Maintenance of participant's personal records to include:

- Social security number
- Medical insurance number
- Birth date
- Emergency Contact(s)
- Available medical information including known current prescription and non-prescription drug medication
- Hospital preference
- Primary care physician
- Mortuary (if known)

Participant's personal records must include copies of below documents, if available, which the assisted living caregiver will also provide to the participant's care manager on an ongoing basis if there are changes to these

documents:

- Advance directive
- Living will
- Power of attorney
- Health care representative
- Do not resuscitate (DNR) order
- Letters of guardianship
- Fully executed lease agreement with the AL

NOTE: if applicable, copies of personal record must be:

- Placed in a prominent place in the consumer file; and
- Sent with the consumer when transferred for medical care or upon moving from the residence and in accordance with state law.

Services outlined in the service plan
Documentation to support service rendered

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

ACTIVITIES NOT ALLOWED:

The Assisted Living service per diem or monthly rate does not include room and board.

Personal care services provided to medically unstable or medically complex participants as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician or other health professional

Separate payment will not be made for Home and Community Assistance, Respite, Environmental Modifications, Transportation, Personal Emergency Response System, Attendant Care, Adult Family Care, Adult Day Services, Home Delivered Meals, Pest Control, or Structured Family caregiving services furnished to a participant selecting Assisted Living Services as these activities are integral to and inherent in the provision of the Assisted Living Service.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Assisted Living Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assisted Living

Provider Category:

Agency

Provider Type:

Licensed Assisted Living Agencies

Provider Qualifications

License *(specify):*

IC 16-28-2

Certificate *(specify):*

Other Standard *(specify):*

DA approved
410 IAC 16.2-5

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Transition

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Community Transition Services (CTS) include reasonable, set-up expenses for participants who make the transition from an institution to their own home where the person is directly responsible for his or her own living expenses in the community and will not be reimbursable on any subsequent move.

Note: Own Home is defined as any dwelling, including a house, an apartment, a condominium, a trailer, or other lodging that is owned, leased, or rented by the participant.

Items purchased through Community Transition are the property of the participant receiving the service, and the participant takes the property with him or her in the event of a move to another residence. For those receiving this service under the waiver, reimbursement for approved Community Transition expenditures are reimbursed through the local AAA or DA approved provider who maintains all applicable receipts and verifies the delivery of services.

ALLOWABLE ACTIVITIES

1. Security deposits and application fees that are required to obtain a lease on an apartment or a home
2. Essential, not luxury, furnishings and moving expenses required to occupy and use a community domicile including a bed, table or chairs, assembly of flat-packed furniture when it is not included as part of the furniture purchase cost, window coverings, (1) land line telephone, eating utensils, housekeeping supplies, food preparation items, microwave, bed or bath linens
3. Set-up fees or deposits for utility or service access including telephone, electricity, heating, internet and water
4. Health and safety assurances including pest eradication; allergen control that would be used in instances where the participant is allergic to certain things that need to be removed from the residence (like animal hair); or one-time cleaning prior to occupancy.

SERVICE STANDARDS

Community Transition services must follow a written service plan addressing specific needs determined by the Person Centered Assessment (PCA).

DOCUMENTATION STANDARDS

Care Managers Documentation Standards:

- Responsible to document the need for CTS and reasonable furnishings or set up expenses being requested by the participant. Determined through the PCA.
- Documentation requirements include maintaining receipts for all expenditures, showing the amount and what item or deposit was covered

*If care manager requests full $1,500 and not all funds are used, then the care manager is responsible to complete a service plan update to reduce the amount to ensure Medicaid is not over-reimbursing for these services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Reimbursement for Community Transition is limited to a lifetime cap for set up expenses, up to $1,500

•Community Transition Services are furnished only to the extent that they are reasonable and necessary as determining through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

Allergen control will not be used to fund the mitigating or removal of items that would be the responsibility of the landlord or homeowner.

*The state will not bill for FFP until after the individuals depart the institution and enter the waiver.

Reimbursement for Community Transition is limited to a lifetime cap for set up expenses, up to $1,500.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DA approved Community Transition Service Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Transition

Provider Category:

Agency

Provider Type:

FSSA/DA approved Community Transition Service Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

DA approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: General requirements
455 IAC 2 Transfer of individual's record upon change of provider
455 IAC 2 Financial information
455 IAC 2 Liability insurance
455 IAC 2 Transportation of an individual
455 IAC 2 Professional qualifications and requirements; documentation of qualifications
455 IAC 2 Maintenance of personnel records
455 IAC 2 Adoption of personnel policies
455 IAC 2 Operations manual
455 IAC 2 Maintenance of records of services provided
455 IAC 2 Individual's personal file; site of service delivery

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1:	Sub-Category 1:
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition (Scope):

A Home Delivered Meal is a nutritionally balanced meal.
ALLOWABLE ACTIVITIES
Home delivered meals may include but are not limited to:

- No more than two meals per day will be reimbursed under the waiver
- Diet/ nutrition counseling provided by a registered dietician
- Nutritional education based on needs of each participant
- Diet modification according to a physician's order as required meeting the individual's medical and nutritional needs

SERVICE STANDARDS

Home Delivered Meals services must follow a written service plan addressing specific needs determined by the participant's Person Centered Assessment (PCA).

Home Delivered Meals will be provided to persons who are unable to prepare their own meals and for whom there are no other persons available to do so or where the provision of a home delivered meal is the most cost effective method of delivering a nutritionally adequate meal and it is not otherwise available through other funding sources.

All meals must meet state, local, and federal laws and regulations regarding the safe handling of food. The provider must also hold adequate and current servsafe certification.

All home delivered meals provided must contain at least 1/3 of the current recommended dietary allowance (RDA) as established by the Food and Nutrition Board of the National Academy of Sciences, National Research council, including but not limited to:

A variety of vegetables; dark green, red and orange, legumes (beans and peas), starchy and other vegetables

Fruits, especially whole fruit

Grains, at least half of which are whole grain

Fat-free or low-fat dairy, including milk, yogurt, cheese, and/or fortified soy beverages

A variety of protein foods, including seafood, lean meats and poultry, eggs, legumes (beans and peas), soy products, and nuts and seeds

Oils, including those from plants: canola, corn, olive, peanut, safflower, soybean, and sunflower. Oils also are naturally present in nuts, seeds, seafood, olives, and avocados.

Meals shall contain less than 10% daily calories from added sugars unless prior DA or Registered Dietitian approval.

Meals shall contain less than 10% of daily calories from saturated fats unless prior DA or Registered Dietitian approval.

Meals shall contain less than 2,300 mg of sodium per day unless prior DA or Registered Dietitian approval.

DOCUMENTATION STANDARDS

Care Manager Documentation Standards:

Responsible to document the need for HDM and amount being requested

Provider Standards:

Date of delivery, how many meals included in care professional, or care manager that involved the participant also needs to be documented

Document any food allergies, food preferences, gluten sensitivity for waiver participants.

Date of expiration included on all meals

Written or oral instruction for appropriate storage of meal

Written or oral instruction for preparing meal

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

ACTIVITIES NOT ALLOWED

No more than two meals per day will be reimbursed under the waiver
Services to participants receiving Adult Family Care waiver service
Services to participants receiving Assisted Living waiver service

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DA approved Home Delivered Meals Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:
Agency
Provider Type:

FSSA/DA approved Home Delivered Meals Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

DA approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: General requirements
455 IAC 2 Maintenance of Records of services provided
455 IAC 2 Liability insurance
455 IAC 2 Maintenance of records of services provided

Must comply with all State and local health laws and ordinances concerning preparation, handling, and serving of food.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Modification Assessment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17030 housing consultation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

The service will be used to objectively determine the specifications for a home modification that is safe, appropriate and feasible in order to ensure accurate bids and workmanship. All participants must receive a home modification assessment if a provider is available in that county, with a certified waiver provider selected by the participant prior to any subsequent home modifications as well as a home modification inspection upon completion of the work. A home modification will not be reimbursed until the final inspection has been completed.

The home modification assessment will assess the home for physical adaptations to the home, including incidental structural repairs to facilitate modifications, which as indicated by individual's service plan, are necessary to ensure the health, welfare and safety of the individual and enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

The assessor will be responsible for writing the specifications, review of feasibility and the post-project inspection. Upon completion of the specifications, and review of feasibility, the Assessor will prepare and submit the project specifications to the care manager and individual for the bidding process and be paid first installment for completion of home specifications. Once the project is complete, the assessor, consumer and care manager will each be present on an agreed upon date and time to inspect the work and sign- off indicating that it was completed per the agreed upon bid and be paid the final installment of the home modification work. In the event the participant, provider, assessor and/or care manager become aware of discrepancies for complaints about the work being completed, the provider shall stop work immediately, and contact the care manager and Division of Aging for further instruction. The DA also has the ability to request additional assessment visits to help resolve a disagreement between the home modification provider and the participant. This payment is not included in the actual home modification cost category and shall not be subtracted from the participant's lifetime cap for home modifications. The care management provider entity will be responsible for maintaining related records that can be accessed by the state.

ALLOWABLE ACTIVITIES

- Evaluation of the current environment, including the identification of barriers, underneath the home, electrical and plumbing, which may prevent the completion of desired modifications.
- Reimbursement for non-feasible assessments.
- Drafting of specifications
- Preparation/submission of specifications
- Examination of the modification (inspection/approve)
- Contact county code enforcement

SERVICE STANDARDS
Need for home modification must be indicated in the participant's plan of care
Modification must address the participant's level of service needs
Proposed specifications for modification must conform to the requirements and limitations of the current approved service definition for home modification services
Assessment should be conducted by an approved, qualified individual who is independent of the entity providing the home modifications.
Contact appropriate authority regarding potential code violations.

DOCUMENTATION STANDARDS

Need for home modification must be indicated in the participant's plan of care

Modification must address the participant's level of service needs

Any discrepancy noted by the provider, care manager and/or participant shall be detailed in the final inspection, and addressed by the assessor.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

An annual cap of $500 is available for home modification assessment services, unless the DA requests an additional assessment in order to help mediate disagreements between the home modification provider and the participant.

ACTIVITIES NOT ALLOWED

Home modification assessment services will not be reimbursed when the owner of the organization is a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, the Health care representative (HCR) of a participant, or the legal guardian of a participant.

Payment will not be made for home modifications under this service.

Payment will not be made for a home modification assessment for the maintenance, repair or service of an existing home modification that was funded by a home and community based services (HCBS) waiver

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	FSSA/DA approved Home Modification Assessment Individual
Individual	Architect

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Modification Assessment

Provider Category:
Individual
Provider Type:

FSSA/DA approved Home Modification Assessment Individual

Provider Qualifications

License *(specify):*

IC 25-20.2 Home Inspector

Certificate *(specify):*

In addition to the licensure standard, either a Certified Aging-In-Place Specialist (CAPS Certification – National Association of Home Builders) OR
a Executive Certificate in Home Modifications (University of Southern California)

Other Standard *(specify):*

DA Approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: General requirements
455 IAC 2 Financial information
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements; documentation of qualifications
455 IAC 2 Warranty required
Compliance with applicable building codes and permits

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Modification Assessment

Provider Category:

Individual

Provider Type:

Architect

Provider Qualifications

License *(specify):*

IC 25-4

Certificate *(specify):*

Other Standard *(specify):*

DA Approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: General requirements
455 IAC 2 Financial information
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements; documentation of qualifications
455 IAC 2 Warranty required
Compliance with applicable building codes and perm

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Modifications

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Home modifications are physical adaptations to the home, as required by the participant's service plan, which are necessary to ensure the health, welfare and safety of the participant, and which enable the participant to function with greater independence in his/her home, and without which the individual would require institutionalization. Incidental structural repairs to facilitate modifications may be included in this service

Home Ownership

Home modifications will be for when the participant owns a home. Rented homes or apartments or family owned homes are allowed to be modified only when a signed agreement from the property owner is obtained. The signed agreement must be submitted along with all other required documentation. Disputes between different parties may not be within the scope of, the Division of Aging to be able to intervene in a resolution.

Choice of Provider

The participant chooses the certified providers to submit bids for the home modifications. If the participant chooses to continue with the home modification after receiving the bids, then the lowest bid that meets the minimum requirements shall be chosen, such as, timeframe to start service. There is a minimum requirement to gather 2 bids for any expected amount over $5,000.00.

ALLOWABLE ACTIVITIES

Home modifications may include but are not limited to the following:

Adaptive door openers and locks

Bathroom Modification—including but not limited to:
Removal of existing bathtub, toilet and/or sink; and/or
Installation of roll in shower, grab bars, toilet and sink; and/or
Installation of replacement incidental items such as flooring, storage space, cabinets that are necessary due to the bath modification.

Home Control Units—Adaptive switches and buttons to operate medical equipment, communication devices, heat and air conditioning, and lights for an individual living alone or who is alone without a caregiver for a substantial portion of the day.

Kitchen modification—including but not limited to:
Removal of existing cabinets, sink; and/or
Installation of sink, cabinet; and/or
Installation of replacement incidental items such as flooring, storage space, and cabinets if necessary due to kitchen modification.

Home safety devices such as:
Door alarms; and/or
Anti-scald devices;
Hand held shower head;
Grab bars for the bathroom.

Ramp—including but not limited to:
Permanent or Portable—only considered for renters

Vertical lift and/or Stair lift

Single room air or portable conditioner(s) / single room air purifier(s)

Widen doorways—such as:
Exterior or Interior bedroom, bathroom, kitchen door or any internal doorway as needed to allow for access. Pocket doors may be requested.

Windows—replacement of glass with Plexi-glass or other shatterproof material when there is a documented medical/behavioral reason (s);

Upon the completion of the modification, the room being modified will be matched to the degree possible with the same paint, wall texture, wall coverings, doors, trim, flooring etc. to the previous color/style/design;

Home Modification Maintenance (HOMM) - limited to $1,000.00 annually for the repair and service of home modifications that have been provided through a HCBS waiver. Requests for HOMM service must detail parts cost and labor cost. If the need for HOMM exceeds $1000.00, the care manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor funded through a non-waiver funding source.

Items requested which are not listed above, must be reviewed and decision rendered by the State DA director or State agency designee.

Requests for modifications at two or more locations may only be approved at the discretion of the DA director or designee.

Requests for modifications may be denied if the State division director or State agency designee determines the documentation does not support residential stability and/or the service requested.

SERVICE STANDARDS

Care Manager Standards:

- Responsible to document the need for home modification assessment
- Share expected modification requests identified by the participant determined through the Person Centered Assessment to the assessor.
- All home modifications must be approved by the waiver program prior to services being rendered.
- Collect 2 bids if over $5,000.00. If 1 bid is obtained the CM must document the date of contact, the provider name, and why the bid was not obtained from that provider.
- Notification to the Division of Aging of any discrepancies or complaints about the work while it is being completed. Notice provided to the Division of Aging within forty-eight hours upon learning of the issues.
- Before and after drawings are required for bathroom, kitchen and ramps
- Bid must contain warranty information
- If a home assessor is available in the county where the participant lives, then all participants must receive a home modification assessment if a provider is available in that county, with a certified waiver provider selected by the participant prior to any subsequent home modifications as well as a home modification inspection upon completion of the work

Provider Standards:

- Need for home modification must be indicated in the participant’s service plan
- Proposed specifications for modification must conform to the requirements and limitations of the current approved service definition for home Modification Services.
- Providers are required to provide a written warranty for a new product or service in the form of a binding document stating that, for a period of not less than one (1) year, the service provider shall replace or repair any product or installation.
- If the State agency determines the provider is at fault for poor and/or incorrect work during the home modification, then the provider is responsible for correcting work at the cost of the provider
- Bid must contain warranty information
- Before and after drawings are required for bathroom, kitchen and ramps
- Bid must be itemized with cost for each major component of the modification
- Prohibited from placing residential liens
- All home modifications must be approved by the waiver program prior to services being rendered.
- Home modification requests must be provided in accordance with applicable State and/or local building codes. Home Modifications must be compliant with applicable building codes.

- Land survey may be required when exterior modification(s) approach property line.
- Provider of services must maintain receipts for all incurred expenses related to the modification; must be in compliance with FSSA and Division specific guidelines and/or policies.
- Notification to the participant's care manager and Division of Aging of any discrepancies or complaints about the work while it is being completed. Notice provided to the Division of Aging within forty-eight hours upon learning of the issues.

DOCUMENTATION STANDARDS

Documentation/explanation of the service within the Request for Approval to Authorize Services (RFA) including the following:

- Property owner of the residence where the requested modification is proposed;
- Property owner's relationship to the participant;
- What, if any, relationship the property owner has to the waiver program;
- Written agreement of landlord or home owner for modification including agreement about items purchased during the modification, such as a bathtub, upon participant moving from the property or eviction.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A lifetime cap of $20,000 is available for home modifications, however, the cap on any single project is $15,000. The cap represents a cost for basic modification of a participant's home for accessibility and safety and accommodates the participant's needs for housing modifications. The cost of an home modification includes all materials, equipment, labor, and permits to complete the project. No parts of a home modification may be billed separately as part of any other service category (e.g. Specialized Medical Equipment). In addition to the $20,000 lifetime cap, $1,000.00 is allowable annually for the repair, replacement, or an adjustment to an existing home modification that was funded by a Home and Community Based Services (HCBS) waiver.

ACTIVITIES NOT ALLOWED

Examples/descriptions of activities not allowed include, but are not limited to the following, such as:
A. Adaptations or improvements which are not of direct medical or remedial benefit to the participant such as:
1. central heating and air conditioning;
2. routine home maintenance;
3. roof repair;
5. structural repair that is not incidental to the original modification;
6. driveways, decks, patios, publicly owned sidewalks, household furnishings;
7. swimming pools, spas or hot tubs;
8. outside storage spaces;
9. home security systems.

B. Modifications that create living space or facilities where they did not previously exist (e.g. installation of a bathroom in a garage/basement, etc.);

C. Modifications that will add non-incidental square footage to the home;

D. Participants living in foster homes, group homes, assisted living facilities, or homes for special services (any licensed residential facility) are not eligible to receive this service. (Note: The responsibility for home modifications rests with the facility owner or operator);

E. Participants living in a provider owned or controlled residence are not eligible to receive this service. (Note: The responsibility for home modifications rests with the facility owner or operator);

F. Completion of, or modifications to, new construction or significant remodeling/reconstruction are excluded unless there is documented evidence of a significant change in the participant's medical or remedial needs that now require the requested modification.

G. Home Modification services will not be reimbursed when the owner of the organization is a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, the health care representative (HCR) of a participant, or the legal guardian of a participant

H. The services under home modification are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/ DA approved Home Modification Agency/ Contractor
Individual	FSSA/ DA approved Home Modification Individual
Individual	Architect
Individual	Plumber

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Modifications

Provider Category:

Agency

Provider Type:

FSSA/ DA approved Home Modification Agency/ Contractor

Provider Qualifications

License *(specify):*

Any applicable licensure
IC 25-20.2 Home inspector
IC 25-28.5 Plumber

Certificate *(specify):*

IC 25-4 Architect

Other Standard *(specify):*

DA approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: General requirements
455 IAC 2 Maintenance of Records of services provided
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements; documentation of qualifications
455 IAC 2 Warranty required
Compliance with applicable building codes and permits

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Modifications

Provider Category:

Individual

Provider Type:

FSSA/ DA approved Home Modification Individual

Provider Qualifications

License *(specify):*

Any applicable licensure must be in place

Certificate *(specify):*

Other Standard *(specify):*

DA approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: General requirements
455 IAC 2 Maintenance of Records of services provided
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements; documentation of qualifications
455 IAC 2 Warranty required
Compliance with applicable building codes/ permits.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Modifications

Provider Category:

Individual

Provider Type:

Architect

Provider Qualifications

License *(specify):*

Certificate *(specify):*

IC 25-4

Other Standard *(specify):*

DA Approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: General requirements
455 IAC 2 Financial information
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements; documentation of qualifications
455 IAC 2 Warranty required
Compliance with applicable building codes and perm

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Modifications

Provider Category:

Individual

Provider Type:

Plumber

Provider Qualifications

License *(specify):*

IC 25-28.5

Certificate *(specify):*

Other Standard *(specify):*

DA approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: General requirements
455 IAC 2 Financial information
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements; documentation of qualifications
455 IAC 2 Warranty required
Compliance with applicable building codes and permits

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Integrated Health Care Coordination

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11010 health monitoring
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Integrated Health Care Coordination is to promote improved health status and quality of life, delay/prevent deterioration of health status, manage chronic conditions in collaboration with physicians, and integrate medical and social services.

ALLOWABLE ACTIVITIES

Development and oversight of a healthcare support plan which includes coordination of medical care and proactive care management of both chronic diseases and complex conditions such as falls, depression and dementia.

Skilled nursing services are provided within the scope of the Indiana State Nurse Practice Act.

Physician collaboration

Medication review

Transitional Care from hospital or nursing facility to home/assisted living.

Advance care planning

PROVIDER STANDARDS

Weekly consultations or reviews.

Face-to-face visits with the participant; including a minimum of one (1) face to face visit per month.

Not to exceed sixteen (16) hours of Health Care Coordination per month, including travel time.

Health care coordination services will not duplicate services provided under the Medicaid State Plan or any other waiver service.

Services must address needs in the plan of care.

CARE MANAGEMENT STANDARDS

Care manager is expected to coordinate and collaborate with other care managers, other organizations, community partners, healthcare professionals, and DA staff to ensure quality care management is being delivered and options are being discovered and presented to the individual to optimize his/her overall functioning capability.

DOCUMENTATION STANDARDS

Current Indiana RN license for each nurse.

Current Indiana license for LPN.

Current Indiana license for social worker (LSW) with master’s degree in social work with additional documentation of at least two (2) years of experience providing health care coordination.

Evidence of a consultation including complete date and signature; consultation can be with the participant, informal caregivers, other staff, other professionals, as well as health care professionals.

Weekly consultations or reviews.

Minimum of one (1) face to face visit/month. IHCC is not to exceed sixteen (16) hours per month.

Services must address needs identified in the plan of care/PCA.

The provider of will provide a written report to pertinent parties at least quarterly. Pertinent parties include the participant, guardian, waiver care manager, all waiver service providers including mental health providers, State

Plan services, and physicians.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Health care coordination services will not duplicate services provided under the Medicaid State Plan or any other waiver service.

ACTIVITIES NOT ALLOWED

Skilled nursing services available under the Medicaid State Plan.
Any other service otherwise provided by the waiver.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Facility
Agency	Assisted Living Facility
Agency	Home Health Agency
Agency	FSSA/DA approved physician practice

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Integrated Health Care Coordination

Provider Category:

Agency

Provider Type:

Adult Day Facility

Provider Qualifications

License *(specify):*

IC 25-23-1 RN
IC 25-23-1 LPN
IC 25.23.6 LSW

Certificate *(specify):*

Other Standard *(specify):*

DA approved

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Integrated Health Care Coordination

Provider Category:

Agency

Provider Type:

Assisted Living Facility

Provider Qualifications

License *(specify):*

IC 25-23-1 RN
IC 25-23-1 LPN
IC 25.23.6 LSW

Certificate *(specify):*

Other Standard *(specify):*

DA approved

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Integrated Health Care Coordination

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

IC 25-23-1 RN
IC 25-23-1 LPN
IC 25.23.6 LSW

Certificate *(specify):*

Other Standard *(specify):*

DA approved

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Integrated Health Care Coordination

Provider Category:

Agency

Provider Type:

FSSA/DA approved physician practice

Provider Qualifications

License *(specify):*

IC 25-23-1 RN
IC 25-23-1 LPN
IC 25.23.6 LSW

Certificate *(specify):*

Other Standard *(specify):*

DA approved

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Nutritional Supplements

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14032 supplies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Nutritional (Dietary) supplements include liquid supplements, such as "Boost" or "Ensure" to support people in maintaining their health in order to remain in the community.

Supplements must be ordered by a physician, physician assistant, or nurse practitioner.

Reimbursement for approved Nutritional Supplement expenditures are reimbursed through the local AAA or an approved DA provider, who maintains all applicable receipts and verifies the delivery of services. Providers can directly relate to the State Medicaid Agency at their election.

ALLOWABLE ACTIVITIES

Enteral Formula, category 1 such as "Boost" or “Ensure”
SERVICE STANDARDS
Nutritional Supplement services must follow a written service plan addressing specific needs determined by the individual’s Person Centered Assessment

DOCUMENTATION STANDARDS
Care Manager Documentation Standards:

Responsible to document the need for nutritional supplements and amount being requested
Identify the amount requesting from the Annual Cap of $1200 for nutritional supplemental services.

Provider Standards:

Date of delivery, how many meals included in care professional, or care manager that involved the participant also needs to be documented

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services available through the Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before this service may be requested by waiver.

The services under Nutritional Supplements are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. The meals provided as part of these services shall not constitute a full nutritional regimen.

An annual cap of $1200 is available for nutritional supplement services.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DA approved Nutritional Supplements Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Nutritional Supplements

Provider Category:

Agency

Provider Type:

FSSA/DA approved Nutritional Supplements Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

DA approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: General requirements
455 IAC 2 Transfer of individual's record upon change of provider
455 IAC 2 Maintenance of Records of services provided
455 IAC 2 Liability insurance

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Participant Directed Home Care Service

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Participant-Directed Home Care Service (PDHCS) is a health-related service that can be performed by either licensed medical personnel or trained non-medical personnel and is provided for the primary purpose of meeting the chronic personal needs of the participant to maintain a level of function that will allow for a participant to avoid unnecessary institutionalization. This service can provide skilled or attendant care activities or both. In conjunction with State Plan, PDHCS may be provided twenty-four (24) hours per day, seven (7) days a week.

Service Requirements:
• A participant shall hire either a licensed professional through a home health agency, an independent, licensed professional, or a non-clinical competency-trained unlicensed professional.
• Home Care Service requires individual and continuous services when there is no person available outside of these services to assume the role of caregiver.
• PDHCS requires a participant to be diagnosed with a chronic medical condition that may require up to twenty-four (24) of continuous hours of care, as evidenced through a physician's order that can be safely provided outside of an institution. The participant must also receive home health State Plan services.
• Home Care Service must be ordered by a physician (MD/DO) and/or nurse practitioner as part of the participant's plan of care.
• Home Care Attendant Service is provided according to the participant's service plan/plan of care which documents the member's specific health-related need for individual and continuous care.
• Participant must be willing to accept risks and responsibilities associated with employing his/her caregiver and directing his/her own care.

Limitations:
• PDHCS is offered to Aged and Disabled Waiver participants.
• PDHCS is offered to participants who receive State Plan Home Health Skilled Care.
• PDHCS is offered to individuals in a non-congregate setting.
• PDHCS is offered to individuals living alone without family or other informal supports willing and able to be trained to care for the participant and assume a portion of the participant's care.
• PDHCS is offered to individuals able to direct his/her own care.
• PDHCS is offered to individuals with a stable and chronic medical condition as diagnosed by a physician (MD/DO) or nurse practitioner, evidenced by a physician's or nurse practitioner's order.
• PDHCS is offered to individuals twenty-one (21) years or older.
• PDHCS is offered to individuals residing in select postal codes.
• PDHCS does not include administration of level II, III, IV, and V medications.

Documentation Standards: Care Manager Standards
• To provide a current assessment, including scope, frequency, duration and activities of PDHCS to be provided, that documents the participant's needs.
• The care manager is required to assess the needs of the participant through a person-centered planning process. The care manager is required to develop a person-centered plan to meet those needs and create a service request (expressed in service units and cost reimbursement services); the care manager must document the budget process and review with the participant.
• Responsible for documenting the medical need for a skilled service and types of skilled care the participant may require.
• Responsible for documenting the frequency, duration and types of appropriate skilled activities.
• Responsible for documenting the skilled activity that will meet the participant's needs and assuring it is accurately documented in the skilled level of care E-screen.
• Responsible for monitoring the service delivery every month. The care manager shall coordinate service delivery (frequency, activities) with the employee/direct worker and also contact the fiscal intermediary agency to verify.
• Responsible for conducting monthly face-to-face visits with participants.
• Responsible for completing face-to-face assessments, including the Person Centered Monitoring tool every quarter and annually.
• Responsible for documenting the back-up plan for the participant for when the direct worker is unavailable to deliver skilled care.
• Responsible for having participant sign a waiver liability form.
• Responsible for documenting who is the employer, who is the employee/direct worker and his/her relationship to the participant.
• Responsible for completing the participant-directed checklist before the service may be added to the service plan and at the initial, quarter review, annual and re-entry assessments.

• Responsible for monitoring the enrollment process for the participant and their employee/direct worker.
• Care Manager is responsible for collecting all training paperwork containing signatures for the file.

Provider Standards: The caregiver applicant must enter into the IHCP agreement in order to become a paid caregiver the caregiver authorized to provide home care attendant services to consumers if the individual must
(1) Either meet the personnel qualifications specified in IC.16-27-1 or successfully completed, as applicable, the following, as verified by the fiscal intermediary:
(a) If applicable, a competency evaluation program or training and competency evaluation program approved or conducted under section of 10.2.2 the
American Association of Respiratory Care (AARC) Clinical Practice Guideline; and/or
(b) A program that includes CPR, basic first aid, and any applicable DME training. (2) The paid caregiver must identify and document participant need in
the provider service plan.
(2)The paid caregiver must identify and document participant need in the provider service plan.
• Services must be outlined in the provider service plan.
• Data record of services must be provided and maintained, including: – Complete date and time of service (in and out). – Specific services or tasks provided. – Signature of paid caregiver providing the service (minimally the last name and first initial).
• Each paid caregiver providing direct care or supervision of care to the participant must make at least one entry on each day of service. All entries must describe an issue or circumstance offered to the individual.
• Daily documentation of service delivery is to be signed by the participant. If the participant cannot sign, then the paid caregiver must self-attest and sign in lieu of the participant. The paid caregiver is required to coordinate information about the participant's care, including backup plan, with any and all other providers and care manager rendering services to the participant. Provider coordination shall occur among providers/paid caregivers during shift changes for the participant and at any other time where the participant experiences a healthcare change.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Activities Not Allowed: Home Care Service shall not be reimbursed when provided by the attorney-in-fact (POA) of a participant, the health care representative (HCR) of a participant, or the legal guardian of a participant.
• Participant must be able to direct his/her own care.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Aide/Paid Caregiver
Agency	Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Participant Directed Home Care Service

Provider Category:
Individual

Provider Type:

Aide/Paid Caregiver

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

DA Approved

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

No more than every three years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Participant Directed Home Care Service

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

IC 16-27-1

Certificate *(specify):*

Other Standard *(specify):*

DA Approved Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

No longer than every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response System

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Personal Emergency Response System (PERS) is an electronic device which enables certain participants at high risk of institutionalization to secure help in an emergency. The participant may also wear a portable help button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a button is activated. The response center is staffed 24 hours daily/ 7 days per week by trained professionals.

ALLOWABLE ACTIVITIES

Device Installation service

Ongoing monthly maintenance of device Electronic service that is usually a portal help button; however, it can also be an electronic device that includes, but is not limited to GPS or video monitoring service. Remote monitoring will not be placed in participant bedrooms or bathrooms.

SERVICE STANDARDS
Personal Emergency Response services must follow a written service plan addressing specific needs determined by the individual's assessment.
Care manager is required to contact the waiver participant if contacted by the PERS provider that waiver participant experienced a fall.
DOCUMENTATION STANDARDS
Care Manager Documentation Standards:

Responsible to document the need for PERS
Describe the person residing alone or alone for significant parts of the day without a caregiver present

Provider Standards:

Date of installation.

Documentation of expense for installation.

Documentation of monthly rental fee.

Ongoing monthly maintenance of device.

Monthly written notification to care managers of any participant who experienced a fall within a one month timeframe.

The monitor positions would be determined during the person centered service planning process.

Persons responsible for monitoring would be determined during the person centered service planning process including the provider.

The mainframe location would be determined by the provider.

The State confirms there is a back-up plan in the event of equipment failure.

The care manager is the central vehicle for the state to provide information to the participant, their family, and their entire circle of support. This is part of the person centered planning process, which would include the provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

ACTIVITIES NOT ALLOWED
The replacement cost of lost or damaged equipment

Services to participants receiving Assisted Living waiver service

Services to participants receiving Adult Family Care Services

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/ DA approved Personal Emergency Response Sytem Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:

Agency

Provider Type:

FSSA/ DA approved Personal Emergency Response Sytem Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

DA approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: General requirements
455 IAC 2 Maintenance of Records of services provided
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements; documentation of qualifications
455 IAC 2 Warranty required
Compliance with applicable building codes and permits

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Pest Control

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Pest Control services are designed to prevent, suppress, or eradicate anything that competes with humans for food and water, injures humans, spreads disease to humans and/ or annoys humans and is causing or is expected to cause, more harm than is reasonable to accept. Pests include but are not limited to, insects such as roaches, mosquitoes, fleas; bed bugs insect-like organisms, such as mites and ticks; and vertebrates, such as rats and mice.

Services to control pests are services that prevent, suppress, or eradicate pest infestation.
Reimbursement for approved Pest Control expenditures is reimbursed through the local AAA or other approved DA provider, who maintain all applicable receipts and verifies the delivery of services. Providers can directly relate to the State Medicaid Agency at their election.

ALLOWABLE ACTIVITIES

Pest Control services are added to the service plan when the care manager determines-either through direct observation or by participant report that a pest is present that is causing or is expected to cause more harm than is reasonable to accept.

Services to control pests are services that prevent, suppress, or eradicate pest infestation
SERVICE STANDARDS
Pest control services must follow a written service plan addressing specific needs determined by the individual's Person Centered Assessment (PCA)

DOCUMENTATION STANDARDS

Care Manager Standards:

Responsible to document the need for Pest Control and the types of pests to eradicate through the PCA

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

ACTIVITIES NOT ALLOWED

Pest Control services may not be used solely as a preventative measure. There must be documentation of a need for this service either through care manager direct observation or participant report that a pest is causing or is expected to cause more harm than is reasonable to accept.

Services to participants receiving Adult Family Care waiver service or Assisted Living waiver service. Preventive measures or on-going need for service, or Eradication or prevention of mold or mold like substances.

An annual cap of $4,000 is available for pest control services

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DA approved Pest Control Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Pest Control

Provider Category:

Agency

Provider Type:

FSSA/DA approved Pest Control Agency

Provider Qualifications

License *(specify):*

IC 15-3-3.6

Certificate *(specify):*

Other Standard *(specify):*

DA approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: General requirements
455 IAC 2 Maintenance of Records of services provided
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements; documentation of qualifications
455 IAC 2 Warranty required

Pesticide applicators must be certified or licensed through the Purdue University Extension Service and the Office of the Indiana State Chemist.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Specialized Medical Equipment and Supplies are medically prescribed items required by the participant's service plan, which assist the participant in maintaining his/her health, welfare and safety, and enable the participant to function with greater independence in the home. Specialized Medical Equipment provides therapeutic benefits to a participant in need, because of certain medical conditions and/or illnesses. Specialized Medical Equipment primarily and customarily are used to serve a medical purpose and are not useful to a person in the absence of illness or injury. All Specialized Medical Equipment and Supplies must be approved by the waiver program prior to the service being rendered.

A. Participants requesting authorization for this service through utilization of Home and Community Based Services (HCBS) waivers must first exhaust eligibility of the desired equipment or supplies through Indiana Medicaid State Plan, which may require Prior Authorization (PA). The Division of Aging will deny any provider claim that did not follow the correct Medicaid billing practices.

- There should be no duplication of services between HCBS waiver and Medicaid State Plan; or
- The refusal of a Medicaid vendor to accept the Medicaid reimbursement through the Medicaid State Plan is not a justification for waiver purchase; or
- Preference for a specific brand name is not a medically necessary justification for waiver purchase; or
- Medicaid State Plan often covers like equipment but may not cover the specific brand requested. When this occurs, the participant is limited to the Medicaid State Plan covered service/brand; or
- Reimbursement is limited to the Medicaid State Plan fee schedule, if the requested item is covered under Medicaid State Plan; or
- All requests for items to be purchased through a Medicaid waiver must be accompanied by documentation of Medicaid State Plan PA request and decision, if requested item is covered under State Plan.

B. Requests will be denied if the DA director or designee determines the documentation does not support the service requested.

ALLOWABLE ACTIVITIES

Justification and documentation is required to demonstrate that the request is necessary in order to meet the participant's identified need(s).

- Lift chairs-The HCBS program will cover the chair. State Plan should be pursued first for prior approval of the lift mechanism.

- Medication Dispensers.

- Toileting and/or incontinence supplies that do not duplicate State Plan Services.

- Slip resistant socks.

- Self-help devices - including over the bed tables, reachers, adaptive plates, bowls, cups, drinking glasses and eating utensils.

- Strollers - when needed because participant’s primary mobility device does not fit into the participant's vehicle/mode of transportation, or when the participant does not require the full time use of a mobility device, but a stroller is needed to meet the mobility needs of the participant outside of the home setting.

- Voice active smart devices.
- Maintenance - limited to $1,000.00 annually for the repair and service of items that have been provided through a HCBS waiver:
  - Requests for service must detail parts cost and labor cost;
  - If the need for maintenance exceeds $500.00, the care manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a non-waiver funding source.

Items requested which are not listed above, will be submitted in the service plan and will be reviewed by the State

DA Director.

Interpreter service - provided in circumstances where the interpreter assists the individual in communication during specified scheduled meetings for service planning (e.g. waiver case conferences, team meetings) and is not available to facilitate communication for other service provision."

SERVICE STANDARDS

Specialized Medical Equipment and Supplies must be of direct medical or remedial benefit to the participant;

All items shall meet applicable standards of manufacture, design and service specifications

DOCUMENTATION STANDARDS
Care Manager Documentation Standards:

Responsible to document the need for medical specialized equipment.
Describe the how the equipment is expected to improve the participants quality of ADL.
Collect 2 bids if over $1,000.00. If 1 bid is obtained the CM must document the date of contact, the provider name, and why the bid was not obtained from that provider.
Bid must contain warranty information
Picture of the equipment
State plan denial for the equipment and/or supplies.

Provider Standards:

Date of installation,

Documentation of expense for installation

All Documentation standards include the following:

A. The identified direct benefit or need must be documented within:
- POC/SERVICE PLAN; and
- Physician prescription and/or clinical evaluation as deemed appropriate.

B. Medicaid State Plan Prior Authorization request and the decision rendered, if applicable;

C. Signed and approved Request for Approval to Authorize Services (RFA);

D. Signed and approved POC/SERVICE PLAN;

E. Provider of services must maintain receipts for all incurred expenses related to this service;

F. Must be in compliance with FSSA and Division specific guidelines and/or policies.

At the time of renewal or when this section of the waiver is opened/edited in an amendment prior to the renewal, the state will create a separate, standalone Interpreter service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Maintenance - limited to $1,000.00 annually for the repair and service of items that have been provided through a HCBS waiver:

- Requests for service must detail parts cost and labor cost; and
- If the need for maintenance exceeds $500.00, the care manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a non-waiver funding source.

ACTIVITIES NOT ALLOWED

A. Unallowable items include, but are not limited to the following:
1. hospital beds, air fluidized suspension mattresses/beds;
2. therapy mats;
3. parallel bars;
4. scales;
5. paraffin machines or baths;
7. therapy balls;
8. books, games, toys;
9. electronics - such as CD players, radios, cassette players, tape recorders, television, VCR/DVDs, cameras or film, videotapes and other similar items;
10. computers and software;
11. exercise equipment such as treadmills or exercise bikes;
12. furniture;
13. appliances - such as refrigerator, stove, hot water heater;
14. indoor and outdoor play equipment such as swing sets, swings, slides, bicycles adaptive tricycles, trampolines, play houses, merry-go-rounds;
15. swimming pools, spas, hot tubs, portable whirlpool pumps;
16. adjustable mattresses (such as, but not limited to, Tempur-Pedic), positioning devices, pillows;
17. motorized scooters;
18. barrier creams, lotions, personal cleaning cloths;
19. essential oils
20. totally enclosed cribs and barred enclosures used for restraint purposes;
21. manual wheelchairs'
22. vehicle modifications.

B. Any equipment or items that can be authorized through Medicaid State Plan;

C. Any equipment or items purchased or obtained by the participant, his/her family members, or other non- waiver providers.

D. The services under specialized medical equipment and supplies are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Home Health Agency
Agency	FSSA/ DA approved Specialized Medical Equipment and Supplies Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Agency
Provider Type:

Licensed Home Health Agency
Provider Qualifications
License *(specify):*

IC 16-27-1
Certificate *(specify):*

Other Standard *(specify):*

DA approved
455 IAC 2-18 Warranty required
Verification of Provider Qualifications
Entity Responsible for Verification:

Division of Aging
Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Agency
Provider Type:

FSSA/ DA approved Specialized Medical Equipment and Supplies Agency
Provider Qualifications
License *(specify):*

IC 25-26-21
Certificate *(specify):*

IC 6-2.5-8-1

Other Standard *(specify):*

DA approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: General requirements
455 IAC 2 Maintenance of Records of services provided
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements; documentation of qualifications
455 IAC 2 Warranty required

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Structured Family Caregiving

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02023 shared living, other
Category 2:	**Sub-Category 2:**
02 Round-the-Clock Services	02033 in-home round-the-clock services, other
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Structured Family Caregiving means a caregiving arrangement in which a participant lives with a principal caregiver who provides daily care and support to the participant based on the participant's daily care needs. The principal caregiver may be a non-family member or a family member who lives with the participant in the private home of the participant or the principal caregiver.

Necessary support services are provided by the principal caregiver (family caregiver) as part of Structured Family Caregiving. Caregivers must be qualified to meet all Federal and State regulatory guidelines, and be able to provide care and support to a participant based on the participant's assessed needs. Caregivers receive training based on their assessed needs and are paid a per diem stipend for the care and support they provide to participants.

Structured Family Caregiving preserves the dignity, self-respect and privacy of the participant by ensuring high-quality care in a non-institutional setting. The goal of this service is to provide necessary care while fostering and emphasizing the participant's independence in a home environment that will provide the participant with a range of care options as the needs of the participant change. The goal is reached through a cooperative relationship between the participant (or the participant's legal guardian), the caregiver, HCBS Medicaid Waiver care manager and the Structured Family Caregiving provider. Participant needs shall be addressed in a manner that support and enable the individual to maximize abilities to function at the highest level of independence possible while caregivers receive initial and ongoing support in order to provide high quality care. The service is designed to provide options for alternative long-term care to persons who meet Nursing Facility level of care and whose needs can be met in Structured Family Caregiving.

Only agencies may be Structured Family Caregiving providers, with the home settings being assessed and accessible, and caregivers being qualified as able to meet the participant's needs. The provider agency must conduct at a minimum of two quarterly y home visits. Additional home visits and ongoing communication with the caregiver is based on the assessed needs of the participant and the caregiver. Home visits are conducted by a registered nurse and/or a caregiver coach as determined by a person-centered plan of care. The provider agency must capture daily notes that are completed by the family caregiver in an electronic format, and use the information collected to monitor participant health and caregiver support needs. The agency provider must make such notes available to waiver care managers and the State, upon request.

ALLOWABLE ACTIVITIES

Structured Family Caregiving includes (Levels 1-3)

Home and Community Assistance care services related needed IADLs.

Attendant care services related to needed ADLs.

Medication oversight (to the extent permitted under State law).

Escorting for necessary appointments, whenever possible, such as transporting individuals to doctor.

Appointments and community activities that are therapeutic in nature or assist with maintaining natural supports.

Other appropriate supports as described in the individual's service plan.

Caregivers not living in the home of the participant is allowable if this arrangement began prior to February 1, 2020.

Unskilled Respite for the family caregiver for a maximum of fifteen (15) days per calendar year (funding for this respite is included in the per diem paid to the service provider, the actual service of Respite Care may not be billed in addition to the per diem).

Other appropriate supports as described in the individual's service plan

SERVICE STANDARDS

- Agency providers must demonstrate 3 years of delivering services to elders and adults with disabilities and their caregivers in Indiana or as a Medicaid participating provider in another State or have a national accreditation.
- Structured family caregiving must be reflected in the participant's service plan and address specific needs

determined by the participant's PCA.
• Agency providers develop, implement and provide ongoing management and support of a person-centered service plan that addresses the participant's level of service needs.
• The supports provided within the home are managed and completed throughout the day based on the participant's daily needs.
• Structured Family Caregiving is provided in a private residence and affords all of the rights, dignity and qualities of living in a private residence including privacy, comfortable surroundings, and the opportunity to modify one's living area to suit one's individual preferences.
• Provider agencies must conduct, at a minimum, two quarterly home visits based on the participant's assessed needs and caregiver coaching needs, but the actual frequency of visits should be based on the participant's assessed needs and caregiver coaching needs.
• Caregivers receive a minimum of 8 hours in person annual training that reflects the participant's and caregiver's assessed needs. Training may be delivered during quarterly home visits, or in another manner that is flexible and meaningful for the caregiver.
• Agency providers must work with participants and caregivers to establish backup plans for emergencies and other times when the principal caregiver is unable to provide care.
• Paid unskilled respite services must be provided by a qualified caregiver familiar with the participant's needs during those times when the primary caregiver is absent from the home or otherwise cannot provide the necessary level of care.
• Structured Family Caregiving emphasizes the participant's independence in a setting that protects and encourages the participant's dignity, choice, and decision-making while preserving self-respect.
• Employees of Agency providers who provide medication oversight, as addressed under Allowable Activities, must receive necessary instruction from a doctor, nurse, or pharmacist regarding medications prescribed to the participant.

DOCUMENTATION STANDARDS

Identified need in the service plan,
Services outlined in the service plan,
Care manager must give the completed Person Centered Assessment to the provider.

Documentation to support service rendered include:
• Electronic caregiver notes that record and track the participant's status, and updates or significant changes in his/her health status or behaviors and participation in community based activities and other notable or reportable events,
• Medication management records, if applicable,
Regular review of caregiver notes by agency provider in order to:
• Understand and respond to changes in the participant's health status and identify potential new issues in an effort to better communicate changes with the participant's doctors or healthcare providers and avoid unnecessary hospitalizations or emergency room use.
• Document and investigate and refer reportable events to the Waiver Care manager.
• Documentation of home visits conducted by the registered nurse and caregiver coach.
• Education, skills training and coaching conducted with the caregiver.
• Documentation demonstrating collaboration and communication with other service providers and healthcare professionals (as appropriate), waiver care managers and other caregivers or individuals important to the participant regarding changes in the participant's health status and reportable events.
• Documentation of all qualified caregivers (including paid respite caregivers).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

ACTIVITIES NOT ALLOWED

• Structured Family Caregiving service will not be reimbursed when provided by a parent of a minor child participant,
• Personal care services provided to medically unstable or medically complex participants as a substitute for care provided by a registered nurse, licensed practical nurse, licensed nurse or other health professional.
• Separate payment will not be made for Home and Community Assistance, Transportation, Attendant Care, Assisted Living, or Adult Family Care.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DA approved Structured Family Caregiving Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Structured Family Caregiving

Provider Category:

Agency

Provider Type:

FSSA/DA approved Structured Family Caregiving Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Provider and home must meet the requirements of the Indiana Adult Foster Care Service Provision and Certification Standards.

DA approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider Qualifications: General Requirements
455 IAC 2 General requirements for direct care staff
455 IAC 2 Procedures for protecting individuals
455 IAC 2 Unusual occurrence; reporting
455 IAC 2 Transfer of individual's record upon change of provider
455 IAC 2 Notice of termination of services
455 IAC 2 Provider organizational chart
455 IAC 2 Collaboration and quality control
455 IAC 2 Data collection and reporting standards
455 IAC 2 Quality assurance and quality improvement system
455 IAC 2 Financial information
455 IAC 2 Liability insurance
455 IAC 2 Transportation of an individual
455 IAC 2 Documentation of qualifications
455 IAC 2 Maintenance of personnel records
455 IAC 2 Adoption of personnel policies
455 IAC 2 Operations manual
455 IAC 2 Maintenance of records of services provided
455 IAC 2 Individual's personal file; site of service delivery

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transportation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
15 Non-Medical Transportation	15010 non-medical transportation

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Services offered in order to enable participants served under the waiver to gain access to waiver and other non-medical community services, activities and resources, specified by the service plan

SERVICE STANDARDS

Transportation services must follow a written service plan addressing specific needs determined by the participant's Person Centered Assessment.

This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them.

Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

Transportation services are reimbursed at three (3) types of service:

Level 1 Transportation - the participant does not require mechanical assistance to transfer in and out of the vehicle.
Level 2 Transportation - the participant requires mechanical assistance to transfer into and out of the vehicle.
Adult Day Service Transportation - the participant requires round trip transportation to access adult day services.

DOCUMENTATION STANDARDS

Identified need in the service plan.
Services outlined in the service plan.
A provider or its agent shall maintain documentation that the provider meets and maintains the requirements for providing services under 455 IAC 2.
Specify applicable (if any) limits on the amount, frequency, or duration of this service.
Services provided under Transportation service will not duplicate services provided under the Medicaid .State Plan or any other waiver service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

ACTIVITIES NOT ALLOWED

Services available through the Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before reimbursement is available through the Medicaid waiver for this service).
Services to participants receiving Adult Family Care waiver service, or Assisted Living waiver service.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Home Health Agency
Agency	FSSA/DA approved Transportation Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Licensed Home Health Agency

Provider Qualifications

License *(specify):*

IC 16-27-1

Certificate *(specify):*

Other Standard *(specify):*

DA approved
Compliance with applicable vehicle/driver licensure for vehicle being utilized

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

FSSA/DA approved Transportation Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

DA approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider Qualifications: General Requirements
455 IAC 2 Procedures for protecting individuals
455 IAC 2 Unusual occurrence; reporting
455 IAC 2 Transfer of individual's record upon change of provider
455 IAC 2 Notice of termination of services
455 IAC 2 Provider organizational chart
455 IAC 2 Collaboration and quality control
455 IAC 2 Data collection and reporting standards
455 IAC 2 Quality assurance and quality improvement system
455 IAC 2 Financial information
455 IAC 2 Liability insurance
455 IAC 2 Transportation of an individual
455 IAC 2 Documentation of qualifications
455 IAC 2 Maintenance of personnel records
455 IAC 2 Adoption of personnel policies
455 IAC 2 Operations manual
455 IAC 2 Maintenance of records of services provided

Compliance with applicable vehicle/driver licensure for vehicle being utilized

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Vehicle Modifications

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Vehicle Modifications (VMOD) are the addition of adaptive equipment or structural changes to a motor vehicle that will empower a participant to safely transport in a motor vehicle.

ALLOWABLE ACTIVITIES

Justification and documentation is required to demonstrate that the modification is necessary in order to meet the participant's identified need(s).

A. Wheelchair lifts;

B. Wheelchair tie-downs (if not included with lift);

C. Wheelchair/scooter hoist;

D. Wheelchair/scooter carrier for roof or back of vehicle;

E. Raised roof and raised door openings;

F. Power transfer seat base;

G. Maintenance is limited to $1,000.00 annually for repair and service of items that have been funded through a HCBS waiver:
1. Requests for service must differentiate between parts and labor costs;
2. If the need for maintenance exceeds $500.00, the care manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a non-waiver funding source.

H. Items requested which are not listed above, must be reviewed and decision rendered by the State division director or State agency designee.

SERVICE STANDARDS

A. The vehicle to be modified must meet all of the following:
1. The participant or primary caregiver is the titled owner;
2. The vehicle is registered and/or licensed under state law;
3. The vehicle has appropriate insurance as required by state law;
4. The vehicle is the participant's sole or primary means of transportation;
5. The vehicle is not registered to or titled by a Family and Social Services Administration (FSSA) approved provider.
6. Only one vehicle per a participant's household may be modified;

B. Many automobile manufacturers offer a rebate of up to $1,000.00 for participants purchasing a new vehicle requiring modifications for accessibility. To obtain the rebate the participant is required to submit to the manufacturer documented expenditures of modifications. If the rebate is available it must be applied to the cost of the modifications.

C. Requests for modifications may be denied if the DA director or designee determines the documentation does not support the service requested.

D. All vehicle modifications must be approved by the waiver program prior to services being rendered.

DOCUMENTATION STANDARDS

Care Manager Documentation Standards:
Responsible to document the medical need for VMOD determined to meet the needs of the participant through the person centered assessment (PCA)

Responsible to describe the specific modification being requested to the vehicle
Collect 2 bids if over $1,000.00. If 1 bid is obtained the CM must document the date of contact, the provider name, and why the bid was not obtained from that provider.

Warranty information.

Picture of vehicle modification is included with the bid.

Provider Standards:

Provider of services must maintain receipts for all incurred expenses related to the modification;

All bids must be itemized.

Must be in compliance with FSSA and Division specific guidelines and/or policies.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A lifetime cap of $15,000.00 is available for one (1) vehicles per every ten (10) year period for a participant's household. In addition to the applicable lifetime cap, $500.00 will be allowable annually for repair, replacement, or an adjustment to an existing modification that was funded by a Home and Community Based Services (HCBS) waiver.

ACTIVITIES NOT ALLOWED

Examples/descriptions of modifications/items Not Covered include, but are not limited to the following:

A. Repair or replacement of modified equipment damaged or destroyed in an accident;
B. Alarm systems;
C. Auto loan payments;
D. Insurance coverage;
E. Driver's license, title registration, or license plates;
F. Emergency road service;
G. Routine maintenance and repairs related to the vehicle itself.
H. Specialized Medical Equipment or Home Modification items are not allowed.
I. Leased vehicles

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/ DA approved Vehicle Modification Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Vehicle Modifications

Provider Category:

Agency

Provider Type:

FSSA/ DA approved Vehicle Modification Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

DA approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: General requirements
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements; documentation of qualifications
455 IAC 2 Maintenance of records of services provided
455 IAC 2 Warranty required

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Caregiver Coaching and Behavior Management Support

Service Definition

The purpose of Caregiver Coaching and Behavior Management is to enable the stabilization and continued community tenure of a Waiver participant by equipping the participant's lay caregiver(s) with the necessary skills to manage the participant's chronic medical conditions and associated behavioral health needs related to a cognitive impairment and/or dementia. This service allows family caregivers who are not eligible to participate in Structured Family Caregiving (i.e.) to access support.

Covered Services

- **Initial consultation for assessment of the caregiver to determine initial coaching needs, and understand the caregiver's goals, values, needs and strengths.**
- **Caregiver Coaching and Behavior Management provided in the home of the participant, virtually or telephonically and through HIPAA secure communication platforms that allow for real-time and asynchronous communication between caregivers and caregiver coaches and collaboration with Waiver case managers.**

Service Standards

- **Caregiver Coaching and Behavior Management services are family-centered, individualized to the needs of the participant and caregiver, and informed by an assessment of each caregiver's goals, values, needs, and strengths.**
- **A caregiver coach with expertise working with lay caregivers will conduct a structured caregiver assessment and deliver ongoing education and coaching that is informed by the assessment.**
- **Caregiver Coaching and Behavior Management services may be delivered telephonically and through HIPAA secure electronic communication platforms that enable a caregiver coach and a caregiver to communicate efficiently and, in**

a manner, convenient to the caregiver. Provider agencies must capture any caregiver communications received through an electronic communication platform to facilitate the sharing of relevant information with Waiver case managers.

- **A caregiver coach engages with a caregiver on a bi-weekly basis to understand the evolving needs of the participant and caregiver and deliver content, strategies and tools related to the management of the participant's needs and behaviors and the caregiver's self-care needs.**
- **Caregiver training will include how to address necessary precautions to prevent COVID-19 infection/spread in the home and address anxiety that consumers may experiencing related to the crisis; behaviors and triggering events; effective verbal and non-verbal communication strategies; strategies for managing challenging behaviors; and how to address home safety concerns. Coaching will also support a caregiver to apply stress reduction techniques and reduce caregiver isolation.**
- **Caregiver coach will assist the caregiver and client in creation of a crisis management/emergency plan to address the person and environment. Plan will be reviewed and updated (as needed) on a monthly basis and provided to waiver care manager and waiver/State Plan/Hospice providers as well as emergency contacts and backup caregiver. Plan shall include but is not limited to the following:**
    - **Health conditions**
    - **Advanced directives, will planning, physician orders for life sustaining treatment.**
    - **Medications and medication management/assistance to prevent medication errors.**
    - **Fall prevention interventions**
    - **Healthcare providers including contact information**
    - **Emergency contacts**
    - **Identification and contact information for back-up caregiver**
    - **Contact Information for Caregiver coach and waiver care manager.**
    - **Caregiver resources available within the caregiver's/participant's community of choice.**

Caregiver Coach and Behavior Management Support Service Limitations

- **Medicaid- participating Structured Family Caregiving agencies may be service providers; agencies must employ caregiver coaches with the experience and qualifications appropriate to the needs of each family. Educational content delivered by provider agencies to caregivers and delivery methods must be appropriate to the needs of lay caregivers.**
- **Caregiver coaching services will not duplicate services provided under the Medicaid State Plan or any other waiver service.**
- **Separate payment will not be made for Structured Family Caregiving.**
- **Caregiving coaching and behavior management service will not be reimbursed when provided by a parent of a minor child participant.**

Provider Certification Requirements:

Any agency certified to be a structured family caregiving provider.

Goal Engagement Program

The Goal Engagement program is a set of highly individualized, person-centered services that use the strengths of the waiver participant to improve her/his safety and independence. Goal Engagement Program services engage participants to identify and address their goals related to increasing functional independence, improving safety, decreasing depression and improving motivation, including addressing barriers to achieve and maintain maximum functional independence in their daily lives. Participants receive a structured set of home visits conducted by a multidisciplinary team consisting of an Occupational Therapist (OT), a Registered Nurse (RN), and a home repair specialist. The participant and OT work together to identify areas of concern using a standardized assessment tool. Areas evaluated include ADLs, IADLs, maintaining health and community engagement. Based on the assessment, the OT may recommend strategies that can be implemented by the home repair specialist to increase home safety and mitigate conditions that pose a risk or barrier to safe, independent daily functioning, such as changes necessary for fall prevention. Using a motivational interviewing approach, the OT engages the participant to develop goals based on difficulties found in the self-report, observations during the assessment, and what the participant identifies is meaningful activity for them in order to preserve their independence and prevent institutionalization. The participant and OT develop an action plan for addressing these goals. At each visit, the participant reviews their goals, refines them as desired, and practices the action plan with the assessor. Each visit includes training the participant to harness their motivation to work toward their goals. Complementing the OT work, the RN addresses medical issues that inhibit daily function, such as pain, mood, medication adherence and side effects, strength and balance, and communication with healthcare providers. RN visits focus on goals set by the participant rather than on adherence to medical regimens unless this is the participant's goal. Each member of the multidisciplinary Goal Engagement Program team focuses on the participant's identified goals to customize the service according to the action plan. Accordingly, this service includes coordination between the OT, RN and home repair specialist to ensure services are targeted to meet the goals identified by the participant.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Goal Engagement Program services include up to 10 in-home visits by the OT or RN. Purchases related to home safety, minor home repairs, and related items and services are limited to $1,800 per participant, per year, when reimbursed on a fee-for-service basis. Participants are limited to one set of Goal Engagement services per calendar year.

Provider Qualifications

Occupational Therapy elements of the service must be performed by an Occupational Therapist with a valid Indiana license

or by either a certified occupational therapy assistant or an occupational therapy student under the direct supervision of a licensed Occupational Therapist. Skilled nursing elements of the service must be performed by a Registered Nurse or a Licensed Practical Nurse with a valid Massachusetts license. If the scope of work involves minor home repairs, agencies and individuals employed by the agencies must possess any licenses/ certifications required by the state (e.g., Home Improvement Contractor, Construction Supervisor License, Plumber's license, etc.)

Staff providing OT and nursing must be CAPABLE certified.

Provider Qualifications
Occupational Therapy elements of the service must be performed by an Occupational Therapist with a valid Indiana license or by either a certified occupational therapy assistant or an occupational therapy student under the direct supervision of a licensed Occupational Therapist. Skilled nursing elements of the service must be performed by a Registered Nurse or a Licensed Practical Nurse with a valid Massachusetts license. If the scope of work involves minor home repairs, agencies and individuals employed by the agencies must possess any licenses/ certifications required by the state (e.g., Home Improvement Contractor, Construction Supervisor License, Plumber's license, etc.)

Staff providing OT and nursing must be CAPABLE certified.

Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists. Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate. Responsiveness: Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; and all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements). In addition, providers shall ensure that individual workers employed by the agency have been CORI checked, and are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
Check each that applies:

☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☐ **As an administrative activity.** *Complete item C-1-c.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete*

item C-1-c.

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

○ **No. Criminal history and/or background investigations are not required.**

◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

All direct care providers must submit a criminal background check as required by 455 IAC 2-15-2. The criminal background check must not show any evidence of acts, offenses, or crimes affecting the applicant's character or fitness to care for waiver consumers in their homes or other locations. Additionally, licensed professionals are checked for findings through the Indiana Professional Licensing Agency. The DA also requires that a current limited criminal history be obtained from the Indiana State Police central repository as prescribed in 455 IAC 2-15-2. Adoption of personnel policies, for each employee or agent involved in the direct management, administration, or provision of services in order to qualify to provide direct care to participants receiving services at the time of provider certification. Direct care staff is also checked against the nurse aide registry at the Indiana Professional Licensing Agency verifying that each unlicensed employee or agent involved in the direct provision of services has no finding entered into the registry in order to qualify to provide direct care to participants receiving services. The DA provider relations waiver specialist verifies receipt of documentation as a part of provider enrollment.
DA providers are required to submit a policy regarding OIG checks at certification and compliance review.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

○ **No. The state does not conduct abuse registry screening.**

◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Indiana Professional Licensing Agency is responsible for maintaining the nurse aide registry. Pursuant to Indiana Administrative Code 455 IAC 2.6.2 General Requirements: the provider must obtain and submit a current document from the nurse aide registry of the Indiana Professional Licensing Agency verifying that each unlicensed employee involved in the direct provision of services has no finding entered into the registry before providing direct care to participants receiving services. The DA provider relations waiver specialist verifies receipt of documentation as a part of provider enrollment.

Nurse aide registry documents are maintained in agency files and are available upon request.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Indiana State Licensed Residential Care Facilities	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

To maintain the integrity of a community based setting, personalized care is furnished to participants who reside in their own living units (which may include dually occupied units when both occupants request the arrangement) which include kitchenette, toilet facilities, and a sleeping area, not necessarily designated as a separate bedroom from the living area. Participants may choose to utilize their own furnishings. The participant has a right to privacy. Living units may be locked at the discretion of the participant, except when a physician or mental health professional has certified in writing that the participant is sufficiently impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The participant retains the right to assume risk, tempered only by the participant's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each participant to facilitate aging in place. Routines of care provision and service delivery must be participant-driven to the maximum extent possible, and treat each person with dignity and respect. While some assisted living facilities are located on the campus of or adjacent to a nursing facility, they are not located on the grounds of or immediately adjacent to a public institution.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Indiana State Licensed Residential Care Facilities

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Specialized Medical Equipment and Supplies	☒
Transportation	☐
Attendant Care	☐
Care Management	☒
Participant Directed Home Care Service	☐
Personal Emergency Response System	☐
Community Transition	☐
Nutritional Supplements	☐
Respite	☐
Home Modifications	☐
Home Modification Assessment	☐
Pest Control	☐
Adult Day Service	☐
Assisted Living	☒
Structured Family Caregiving	☐
Integrated Health Care Coordination	☐
Vehicle Modifications	☐
Home Delivered Meals	☐
Adult Family Care	☐
Home and Community Assistance Service	☐

Facility Capacity Limit:

no limit

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒

Standard	Topic Addressed
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

◉ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

○ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

☐ **Self-directed**

☐ **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

○ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom

payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

◉ **Other policy.**

Specify:

Relatives who receive payment for waiver services will be subject to post-payment review as described in Appendix D-1-g and service plan monitoring as described in Appendix D-2-a. These practices will ensure that services delivered will continue to meet the needs and goals as well as the best interest of the participant. These practices will ensure that services delivered will continue to meet the needs and goals as well as the best interest of the participant.

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The State Medicaid Agency's OMPP and the DA are dedicated to increasing HCBS providers for the waiver. The DA is promoting HCBS services by using new marketing tools and personal visits to potential providers. The DA is dedicated to focusing on recruitment, certification, and timely enrollment of providers by the fiscal agent contractor, and retention of waiver providers. Information regarding HCBS services is posted on the FSSA website. The DA has open enrollment meaning any provider can apply at any time.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
C.2 Number and percent of existing enrolled licensed providers that continue to meet provider qualifications. Numerator: Number of existing enrolled licensed providers continuing to meet provider qualifications. Denominator: Number of existing enrolled licensed enrolled waiver providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Indiana State Department of Health (ISDH) Notice

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
C.1 Number and percent of newly enrolled licensed providers that met the provider qualifications prior to providing waiver services. Numerator: Number of newly enrolled licensed providers that met the provider qualifications prior to providing waiver services. Denominator: Number of newly enrolled licensed providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DA's Provider Relations Tracking Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
C.3 Number and percent of newly enrolled non-licensed / non-certified providers that met the provider qualifications prior to providing waiver services. Numerator: Number of newly enrolled non-licensed / non-certified providers that met the provider qualifications prior to providing waiver services. Denominator: Number of newly enrolled non-licensed / non-certified providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DA's Provider Relations Tracking Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
C.4 Number and percent of non-licensed/non-certified providers that continue to meet waiver requirements. Numerator: Number of existing non-licensed/non-certified providers reviewed that continue to meet waiver requirements. Denominator: Number of existing non-licensed/non-certified providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DA's Provider Compliance Tool

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: 100% over a 3 year period
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
C.8 Number and percent of provider reviews completed by the Division of Aging within specified timeframe outlined in the waiver. Numerator: Total number of provider reviews completed by the Division of Aging within specified timeframe. Denominator: Total number of provider reviews due.

Data Source (Select one):

Other
If 'Other' is selected, specify:
DA Provider Review Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
C.9 Number and percent of cited providers successfully completing a corrective action plan. Numerator: The number of provider corrective action plans successfully completed. Denominator: The total number of corrective action plans issued.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Compliance Review tracking tool

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

C.5 Number and percent of newly enrolled care managers who completed initial care management training. Numerator: Number of newly enrolled care managers who completed initial care management training. Denominator: Number of newly enrolled care managers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Relations Training Record

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
C.6 Number and percent of case management providers who continue to meet training requirements. Numerator: Number of case management providers who meet training requirements. Denominator: Number case management providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DA's Provider Compliance Tool

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: 100% review over a 3 year period
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
C.7 Number and percent of providers who meet staff training requirements.
Numerator: Number of providers who meet staff training requirements.
Denominator: Total number of providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:

DA's Provider Compliance Review Tool

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: 100% review over a 3 year period
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The DA reviews daily incident reports, complaints, and other data sources, such as Adult Protective Services records, to determine on an on-going basis if specific provider trends exist. Additionally, the DA utilizes various electronic reports, generated on a monthly basis, which directly relate to the performance measures identified in the approved waiver. Each negative finding is individually researched by the DA to determine if the problem or issue has been resolved.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The DA has means to monitor program compliance for providers that aligns with the waiver provider agreement. The DA utilizes various electronic reports, generated on a monthly basis, or as needed, which directly relate to the performance measures identified in the approved waiver. Each negative finding is investigated by the appropriate team within DA to intervene and monitor the issue through resolution. If existing documentation does not indicate resolution, the appropriate DA team will initiate consequences to the provider that may include but are not limited to informal actions, formal warning, corrective action plan, or decertification.

Any provider decertified as a result of non-compliance with the provider agreement, and/or failing to complete corrective actions, will be notified of the decision, and of his/her right to appeal. Documentation of all corrective actions taken with providers will be maintained in the operating agency's Provider Database. Prior to taking action to suspend or terminate a provider alternative service options will be provided to any affected participants through their care manager.

C.1 and C.3: Indiana requires all new waiver provider-applicants to submit documentation verifying that they meet the criteria and qualifications to provide services prior to allowing them to enroll with the fiscal intermediary (FI). The process in place effectively prevents provider-applicants from providing waiver services prior to approval and enrollment. In the event a provider became enrolled and initiated delivery of waiver services prior to approval by the DA, the DA would instruct the fiscal intermediary (FI) to deny any claim relating to waiver service provision, and dis-enroll the provider-applicant until such time as provider- applicant fully documents they meet all qualifications. The DA will initiate an investigation of both internal and FI processes to identify deficiencies or vulnerabilities within the enrollment and approval processes and undertake appropriate improvements.

C.2 and C.4: To assure existing providers continue to meet provider qualifications, providers undergo a formal service review at least every three (3) years. For licensed providers, this review is conducted by the

Indiana State Department of Health (ISDH). Non-licensed providers are reviewed by the operating agency. Both ISDH and the operating agency have formal review and remediation procedures which utilize CAPs submitted by the provider with approval or denial by the reviewing entity. If denied, the provider is required to re-submit the CAP. Once approved, the reviewing entity verifies successful implementation of the CAP. Any provider not successfully completing the remediation process to document qualifications is decertified as a provider.

C.5: The DA requires all new waiver care managers to undergo orientation training prior to being entered into the electronic case management database system as an approved provider of case management services. In the event a care manager (CM) is identified as providing services prior to completing the required training, the operating agency will instruct the FI to deny any claim for services and dis-enroll that CM as a provider. The DA will appropriately initiate formal complaint proceedings against the care manager's sponsoring provider agency, if applicable, with possible formal sanctions up to and including termination as a waiver provider.

C.6: To assure a high level of service delivery by care managers (CMs), the DA completes provider compliance service plan and NFLOC reviews on all case management entities. The DA will initiate the appropriate consequence to the provider that may include but not limited to informal actions, formal warning, corrective action plan, or decertification.

C. 7: To assure service delivery standards are met by provider personnel, the DA completes provider compliance service reviews are conducted on all providers (non CM) entities every three years. The DA will initiate the appropriate consequence to the provider that may include but is not limited to informal actions, formal warning, corrective action plan, or decertification.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The State has a HCBS Waiver Transition Plan for settings that do not meet requirements at time of submission available in Module 1, Attachment 2.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Service Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the

development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:
- ☐ **Social Worker**
  Specify qualifications:
- ☐ **Other**
  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- ◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The care manager facilitates the service plan development process with the participant, or the participant's legal guardian, and the participant's chosen supports identified in his/her circle of support. The participant and his/her circle of support are educated on all HCBS program service options for consideration in developing a service plan. A "pick- list" of all approved service providers in his or her area is provided to the participant and the participant has freedom of choice to select among these providers for each service addressed in the service plan. The care manager empowers the participant to actively self-advocate by communicating needs and preferences to potential and selected providers and other plan development participants.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The care manager facilitates the service plan development process with the participant, or the participant's legal guardian, and the participant's chosen supports identified in his/her circle of support. The participant and his/her circle of support are educated on all HCBS program service options for consideration in developing a service plan. The care manager, in collaboration with the participant, develops the service plan. During this development when service types have been identified to appropriately meet his/her service needs, then the participant with his/her circle of support will select providers. When providers are selected the participant or guardian will appropriately sign the pick list for all services. When the service plan is ready for review the care manager will follow their internal process to submit to the DA.

The care manager in collaboration with the participant, the participant circle of support, and providers will engage with the initial, ninety (90) day, mid-reviews, and annual re-determination assessments to evaluate the participant's holistic well-being that includes but is not limited to, strengths, capacities, needs, preferences and desired outcomes, health status, and risk factors. Assessments can be conducted more often depending on the participant's changing needs. Based on the outcomes of the assessments, a comprehensive service plan is developed.

The care manager is responsible for the coordination of all services and to assure that needs are met. The care manager is responsible for the implementation and monitoring of the service plan.

The DA is updating its policy to require the person centered plan be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation. The DA is updating the person centered plan to include signature lines for all individuals and providers responsible for its implementation.

The participant receives a copy of the service plan so they are aware of the services that are being provided and the frequency of the services by the service providers. The service plan development process affords a checks and balance approach regarding the assignment of responsibilities to implement and monitor the service plan by input from the participant, care manager, physician, provider of service, and the DA.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs

and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Risks are assessed both during the NFLOC and service planning processes. During the initial and renewal NFLOC processes, the Eligibility Screen tool is used to identify potential risks and vulnerabilities. Service plan development takes into account risks identified from the 90 Day Review that is captured in the person-centered monitoring tool (assessment). Appropriate interventions may be initiated immediately to address emergent needs as they are identified.

Formal and informal back-up supports are identified early in the service planning process to address contingencies which could pose a threat to the participant's health, safety, or welfare. These contingency plans may address medical emergencies, failure of a support worker to appear when scheduled, or any other potential risk which can be identified by assessment tools, the participant, or any members of his/her support system. Informal supports including friends, family, and neighbors may be used to assist in providing services in a crisis situation. The State also requires that all participants have easy access to emergency contact information and monitors for this in provider compliance reviews.

The State recognizes that risk tolerance varies greatly from participant to participant and encourages care managers to recognize and respect the participant's participant desires and preferences when formulating risk mitigation strategies.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

As a service is identified, participant or guardian with the circle of support are encouraged to call and interview potential service providers and make their own choice. If the participant or parent/guardian with the circle of supports wishes to select a provider that is not an approved waiver service provider, FSSA's OMPP and the DA will assist in reviewing and processing applications from potential providers. Once providers are identified the participant or guardian will be provided a pick list for each service to demonstrate his/her choice of providers

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

FSSA has designated the OMPP as the division under the single state agency that will retain responsibility for service plan approvals made by the DA.

As part of its routine operations, DA will review service plans submitted to ensure the plan addresses all service requirements identified through the Person Centered Assessment.

The OMPP will review and approve the policies, processes and standards for developing and approving waiver service plans. Based on the terms and conditions of this waiver, the Medicaid agency may review and overrule the approval or disapproval of any specific service plan acted upon by the DA serving in its capacity as the operating agency for this waiver.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review

and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ○ **Every twelve months or more frequently when necessary**
- ◉ **Other schedule**

Specify the other schedule:

Every ninety days or more frequently when necessary.

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☒ **Operating agency**
- ☒ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The waiver care manager is the entity responsible for monitoring implementation of the service plan as well as the general health and welfare of the participant. The state requires the care manager to meet face-to-face with the participant at a minimum of every ninety (90) days. At this 90 Day Review, the care manager completes the 90 Day assessments to assure that approved services continue to meet the medical needs and goals of the participant. The 90- Day assessments are comprehensive assessment tools which addresses the following domains via responses from both the care manager and the participant: service plan implementation and applicability, behavior, rights, medical issues, medication issues, seizures, nutrition and dining, health and safety, critical incident reporting and resolution, staffing, and financial issues. This review tool also provides a means of assessing the potential for suspected abuse, neglect or exploitation and forms the basis for any needed revision to the service plan.

All providers rendering services to the participant are required to coordinate efforts and to share documentation regarding the participant's well-being with the care manager. Providers of waiver services are required to have back- up plans to provide staffing for waiver participant's needs. At the ninety (90) Day Review, the care manager verifies with the participant the appropriateness and effectiveness of back up plans and adjusts the plan accordingly.

As part of the monitoring of the participant's health and welfare, the provider is required to send all incident reports to both the DA and the care manager. If follow-up is required for an incident, the State requires the care manager to provide follow-up every seven (7) days until the incident is deemed resolved. Similarly, the State may require the care manager to address any provider complaints filed by the participant, or on his/her behalf.

If changes to the service plan are warranted in order to meet the medical needs and goals of the participant, the care manager submits additional information and an updated service plan to the DA. The DA determines if the additional services are appropriate based on the assessment and documentation provided.

The care manager serves as the primary contact for the participant and family and is expected to coordinate needs with the participant's providers.

The DA reviews service plan delivery and the supporting documentation through the use of the Person-Centered Management Tool (PCMT).

Additional methods for systemic collection of information about monitoring results are detailed in Appendix H.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.1 Number and percent of participants' service plans found to address participants' assessed needs and personal goals. Numerator: Number of participants' service plans that address participants' assessed needs and personal goals. Denominator: Total number of participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
D.1 Electronic Case Management Database System - 90 Day Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.5 Number and percent of active participants with 90 Day Reviews indicating primary care is being provided. Numerator: Number of participants indicating primary care was received in the previous 12 months as reflected in the 90 day review. Denominator: Number of active participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Case management Database System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100%**

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
D.6 Number and percent of participants indicating their health care needs are being addressed. Numerator: Number of participants indicating their current health care needs are being addressed as reflected in the 90 Day Review. Denominator: Number of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Case Management Database System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.7 Number and percent of participants whose acute health needs are addressed in a timely manner. Numerator: Number of participants whose acute health needs are addressed in a timely manner. Denominator: Number of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Person Centered Compliance Tool (PCCT)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.2 Number and percent of participant's service plans which were updated/revised within 12 months of the previous annual service plan. Numerator: Number of participant's service plans which were updated/revised within 12 months of the previous annual service plan. Denominator: Number of annual service plans due within the previous 12 month period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Case Management Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.3 Number and percent of participant's service plans which were updated/revised when warranted by changes in the waiver participant's needs. Numerator: Number of participant's service plans which were updated/revised when warranted by

changes in the waiver participant's needs. Denominator: Number of service plans that identify a change in need.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Case Management Database System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.8 Number and percent of services delivered in the type outlined in the service plan. Numerator: Total number of sampled participants who received services in the type outline in their service plan. Denominator: Total number of participants sampled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Service plan notations and Provider service notes and/or claims.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = representative sample with a 95% confidence interval
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
D.9 Number and percent of services delivered in the amount outlined in the service plan. Numerator: Total number of sampled participants who received services in the amount outlined in their service plan. Denominator: Total number of participants sampled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Service plan notations and Provider service notes and/or claims.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = representative sample with a 95% confidence interval
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.10 Number and percent of services delivered in the frequency outlined in the service plan. Numerator: Total number of sampled participants who received services in the frequency outlined in their service plan. Denominator: Total number of participants sampled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Service plans and Provider notes and/or claims.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = representative sample with a 95% confidence interval
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.4 Number and percent of participants that are afforded choice between/among waiver services and providers. Numerator: Number of participant's service plans with a signed Freedom of Choice form indicating the choice between/among waiver services and providers. Denominator: Number of service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
D.7a Electronic Case Management Database System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: QA Contractor	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information

regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Discovery activities specific to each performance measure are carried out on an on-going basis by the DA using electronic reports which gather data from each participant's electronic care management record, including the Service Plan and all required assessment reviews. Each negative finding is investigated by the appropriate team within DA to intervene and monitor the issue through resolution. If existing documentation does not indicate resolution, the appropriate DA team will initiate consequences to the provider that may include but not limited to informal actions, formal warning, corrective action plan, or decertification.

D.1: Identification of a participant service plan which does not meet a participant's assessed needs and personal goals will result in a review of the full record contained in the electronic database to identify the circumstances surrounding the reported issues. If resolution activities have not already been initiated, the DA will contact the waiver care manager and require action steps that may include but are not limited to an updated assessment or development of compliant service plan, as appropriate, recognizing the participant's choice of services and providers, and who to include in service planning. Failure by the care manager to address the unmet need(s) may result in referral to the DA for handling as a formal complaint.

D.2, D.3, D.4, D.6 and D.7: Identification of a service plan for which evidence indicates that the plan was not developed in accordance with State policies and procedures will result in a review of the full record contained in the electronic database to identify the circumstances surrounding the reported issues. If resolution activities have not already been initiated, the DA will contact the care manager to determine steps needed to restore compliance. Potential areas of non-compliance for these measures include: timeliness; signatures indicating Freedom of Choice of providers and institution/waiver not in place; overdue 90 Day Review at time of plan submission; signatures of participant or legal guardian, or care manager missing; and not updating or revising the service plan to reflect a change in need. The required resolution will be completion of a revised or new service plan by the participant's care manager. Findings of late service plan submission will be tracked to identify area or care manager-specific trends, or other systemic issues. A care manager who does not adequately address a non-compliant issue, or who is found to have recurrent negative findings, will be referred to the DA for appropriate consequence action.

D.5: Identification of a participant for whom services are not being delivered in accordance with the service plan will result in a review of the full record contained in the electronic database to identify the circumstances surrounding the reported issues.. If resolution activities have not already been initiated, the DA will contact the waiver care manager to determine steps needed to ensure compliance. Findings and remediation for this measure vary greatly as participant choice, medical conditions or interventions, and innumerable life circumstances, such as a vacation or a change in residence, can prompt a negative response on the tool used for this measure. Remediation may involve interruption or termination of the waiver program if the participant is unable to benefit from, or chooses not to receive, services. A negative finding may also reflect a provider service delivery or quality issue. If attempts to remediate a provider issue have not been successful, the care manager will be directed to discuss alternative providers with the participant, respecting the participant's right of choice in selecting or maintaining a provider. If evidence indicates that billing has occurred when services have not been delivered, the provider will be referred to FSSA Program Integrity for review. The DA will investigate and take appropriate consequence action toward the non-care manager provider related in the issue.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify:	☐ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
QA Contractor	
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Participants residing in Indiana and receiving attendant care on the A&D Medicaid Waiver are offered the PARTICIPANT DIRECTED ATTENDANT CARE SERVICE. Additionally, participants may also elect to receive the PARTICIPANT DIRECTED HOME CARE SERVICE. The two options are described below.

1) PARTICIPANT DIRECTED ATTENDANT CARE SERVICE

In PARTICIPANT DIRECTED ATTENDANT CARE SERVICE, participants are empowered to choose his/her own personal attendants. This program allows participants receiving care, or his/her representatives on their behalf, to select, schedule, train, supervise, and (if necessary) terminate their own personal attendants. The participant directing care or his/her representative takes on all of the responsibilities of being an employer except for payroll management, which is handled by the fiscal intermediary.

Some of the opportunities afforded to the participant receiving PARTICIPANT DIRECTED ATTENDANT CARE SERVICE include:
- An opportunity to exercise more self-control, to arrange the care more conveniently for the participant, and to work with attendants who are chosen by the participant.
- An alternative to agency-based care or care provided by independent care providers.
- Allows the participant the opportunity to arrange for services from more than one personal attendant or from a combination of agency-based care and self-directed attendant care, depending on the participant's service plan.

Attendant care providers shall be recruited, hired, trained, paid, and supervised under the authority of the participant, participant's parent(s), other person acting on the participant's behalf, or the (emancipated) participant, if the participant, parent, or participant circle of support, chooses to self-direct the attendant care providers. The participant or their representative assumes the responsibility to initiate self-directed attendant care service and exercise judgment regarding the manner in which those services are delivered, including the decision to employ, train, and dismiss an attendant care provider.

Attendant Care services are defined in Appendix C1/C3 Service Specifications.

PARTICIPANT DIRECTED ATTENDANT CARE offers participants employer authority only.

Care managers are an integral part of the success of the PARTICIPANT DIRECTED ATTENDANT CARE Program. The care manager is responsible for oversight and monitoring of the Service Plan of the participant; assess the participant for participation in the self-directed attendant care service; assist the participant in directing care in evaluating whether the PARTICIPANT DIRECTED ATTENDANT CARE SERVICE is appropriate for meeting the participant’s needs and whether the participant or the participant's representative is interested in taking on the responsibilities associated with the PARTICIPANT DIRECTED ATTENDANT CARE Program.

For the PARTICIPANT DIRECTED ATTENDANT CARE Program, the care manager is required to have face-to-face contact with the participant at a minimum of at least every ninety (90) days, or more often as the needs of the participant change. The care manager is also required to reauthorize the participant in the PARTICIPANT DIRECTED ATTENDANT CARE Service every ninety (90) days. The care manager shall evaluate for quality and ask the participant to verify whether they are satisfied with the services they are receiving. The participant will be asked to sign the Participant Directed 90 Day Review Checklist facilitated by the care manager. For PARTICIPANT DIRECTED ATTENDANT CARE, representatives directing care on behalf of the participant will be required to sign the 90 Day Participant Directed Review Checklist, and-verify weekly face-to-face visits between the caregiver and the participant.

The DA contracts with a fiscal intermediary whose responsibilities include serving as the payroll department; obtaining limited criminal background history checks on providers; issuing paychecks per submitted timesheets; withholding all necessary taxes; filing monthly, quarterly, and annual tax and labor reports; issuing annual W-2 wage statements; managing service units; providing participants, employers and care managers with monthly reports of spending on participant’s behalf; and responding to all questions posed by the participant and the provider and state officials. Participant directed care providers are required to document the activities performed. Appendix C contains the service definition for attendant care and must be followed for Participation Direction of Care.

2) PARTICIPANT DIRECTED HOME CARE SERVICE

The PARTICIPANT DIRECTED HOME CARE SERVICE (PDHCS) is a health-related service that can be performed by either licensed or trained non-medical personnel, and is provided for the primary purpose of meeting chronic medical needs, and maintaining, as opposed to improving, a level of function, to an extent that allows for a participant to avoid unnecessary institutionalization. In conjunction with State Plan services, PDHCS can be provided twenty-four (24) hours per day, seven (7) days a week.

PARTICIPANT DIRECTED HOME CARE SERVICE is defined in Appendix C1/C3 Service Specifications.

The PARTICIPANT DIRECTED HOME CARE SERVICE offers both employer and budget authority.

This program expects participants receiving care to select, schedule, train, supervise, and (if necessary) terminate their own provider. The participant directing his/her provider takes on all of the responsibilities of being an employer except for payroll management, which is handled by a fiscal intermediary.

Some of the opportunities afforded to the participant receiving PARTICIPANT DIRECTED HOME CARE SERVICE include:
-An opportunity to exercise self-control, to arrange the care conveniently for the participant, and to work with provider(s) who are chosen by the participant.
-An alternative to agency-based care or care provided by independent care providers.
-Allows the participant the opportunity to arrange for services from more than one provider or from a combination of agency-based care and self-directed skilled care, depending on the participant's service plan.

Providers shall be recruited, hired, trained, paid, and supervised under the authority of the participant.

Care managers are an integral part of the success of the PARTICIPANT DIRECTED HOME CARE SERVICE. The care manager is required to:
Provide oversight and monitoring of the Service Plan of the participant;
-Assess the participant for participation in the PARTICIPANT DIRECTED HOME CARE SERVICE;
-Assist the participant in directing care in evaluating whether the PARTICIPANT DIRECTED HOME CARE SERVICE is appropriate for meeting the participant's needs.
-Assess the needs of the participant through a person-centered planning process, and establish an annual cost limit based on the authorized plan of care. For waiver participants, annual cost per participant is determined by an algorithm established by the Division of Aging. The care manager will develop a person-centered plan to meet those needs and service requests, and a dollar amount will be assigned to the plan using the Division of Aging’s algorithm.

If a participant selects an un-skilled provider as PARTICIPANT DIRECTED HOME CARE ATTENDANT, the rate will be reimbursed at the A&D Waiver Attendant Care rate. If a participant selects a PARTICIPANT DIRECTED SKILLED CARE ATTENDANT, the rate will be reimbursed per the rate methodology developed by the Division of Aging for the skilled Home Healthcare Aide.

-For Participant Directed Home Care Service, have face-to-face contact with the participant at a minimum of at least every thirty-one (31) days, or more often as the needs of the participant change.
-To reauthorize the participant in the PARTICIPANT DIRECTED HOME CARE SERVICE every ninety (90) days. The care manager shall evaluate for quality and ask the participant to verify whether they are satisfied with the services they are receiving. The participant shall be asked to sign the 90 Day Participant -Directed Review Checklist facilitated by the care manager.

The DA also contracts with a fiscal intermediary whose responsibilities include:
-Serving as the payroll department, and;
-Obtaining limited criminal background history checks, and;
-Obtaining professional licensing documentation if applicable; issuing paychecks per submitted timesheets; withholding all necessary taxes; filing monthly, quarterly, and annual tax and labor reports; issuing annual W-2 wage statements; managing service units; providing participants, employers and care managers with monthly reports of spending on participant's behalf; and responding to all questions posed by the participant and the provider and State officials, and;

PARTICIPANT DIRECTED HOME CARE SERVICE providers are required to document the activities performed.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

☐ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☒ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

The participant directed attendant care service is available to participants who do not live in a congregate setting. The participant directed home care service is only available to participants who live alone in their own private residence.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

○ **Waiver is designed to support only individuals who want to direct their services.**

○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

PARTICIPANT DIRECTED ATTENDANT CARE SERVICE and PARTICIPANT DIRECTED HOME CARE SERVICE are the only services that can be self-directed by the participant.

The option to self-direct care is presented to the participant by care manager. Once Participant Directed Attendant Care and/or Participant Directed Home Care Service is determined to be the appropriate service, this list is generated by the care manager and then reviewed with the participant. The participant signs off on their selection of a provider for PARTICIPANT DIRECTED ATTENDANT CARE and/or PARTICIPANT DIRECTED HOME CARE SERVICE. If he or she is interested in self-direction, the care manager then evaluates the ability of the participant to self-direct, or for the PARTICIPANT DIRECTED ATTENDANT CARE SERVICE only if there is a representative that can direct their care on his/her behalf. The 90 Day Participant Directed checklist is to be completed for PARTICIPANT DIRECTED ATTENDANT CARE or PARTICIPANT DIRECTED HOME CARE, and is used to determine if a participant is able to self-direct his/her own attendant care and/or skilled care.

The following questions are asked by the care manager and answered by the participant for the Participant Directed Attendant Care and Home Care Service Enrollment Checklist: Participant accepts full responsibility for direction of his personal care and managing the hours that have been approved in the plan of care. Participant is prepared to hire, train, supervise, and dismiss (if needed) an employee who will perform the duties of his personal paid caregiver. Participant understands he will be receiving an enrollment packet from the Fiscal intermediary and will need to complete all necessary paperwork required to become an employer. Participant understands his employee(s) will need to complete the necessary paperwork provided by the Fiscal Intermediary before starting work. Participant understands the process of reporting the time his personal attendant has worked and understands the program's timekeeping procedures. Participant is aware that each paid caregiver cannot provide more than 40 hours of service in one-week, and the participant will arrange for service from another provider if she requires additional services. Participant is aware he/she must inform the Fiscal Intermediary of any changes of employment. Participant has developed a written back-up plan for a situation in which a provider is unavailable. Participant has identified emergency information which will be available to the personal attendant and/or nursing staff Participant understands he is responsible for addressing any quality of care issues directly with his provider. Participant is aware of how to report abuse or neglect promptly to the specified authorities and to the care manager.

For PARTICIPANT DIRECTED ATTENDANT CARE, participant understands that the care manager will be checking in at a minimum of 90-day intervals and will file an incident report to the State to report any quality-of-care issues or lapses in participant/employer responsibilities.

For PARTICIPANT DIRECTED HOME CARE, participant understands that the care manager will be checking in at a minimum of 31-day intervals and will file an incident report to the State to report any quality-of-care issues or lapses in participant/employer responsibilities. Participant understands that if these issues are not resolved that the care manager can revoke eligibility for the self-directed care program. Participant understands she will be required to address Incident Report Issues when investigated by the State. Participant further understands that failure to do so may result in termination from the self-directed care program. Participant is aware of the customer Service Hotline and how to contact it.

For PARTICIPANT DIRECTED ATTENDANT CARE and PARTICIPANT DIRECTED HOME CARE, the following questions are asked for the 90 Day Participant Directed 90 Day Review Checklist: Participant continues to be capable of performing the duties required of an employer. The number of hours of care the paid caregiver has delivered is in line with the participant's plan of care. No paid caregiver has provided more than 40 hours of service in any given one-week period within the plan of care. Participant has submitted timesheets and completed all necessary paperwork as requested by the fiscal intermediary. Participant has hired, trained and is actively supervising the paid caregiver. Participant is able to address quality of care and or performance issues with the paid caregiver. Paid caregiver is delivering all services appropriately as stated in the participant's plan of care and as described in the responsibilities worksheet. Participant has a written back-up plan for care when provider is unavailable. Back-up provider is still available to provide care. Emergency information is up to date and available to paid caregivers. There are no issues of abuse, exploitation or neglect.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the

benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Participants residing in Indiana and receiving participant-directed care on the A&D Medicaid Waiver are offered the attendant care and/or the home care service option by care managers. This option is offered initially and ongoing basis during the normal quarterly visits by the care manager. Participants are empowered to choose their own personal care attendant. This program enables participants receiving care or their representatives to select, schedule, train, supervise, and (if necessary) dismiss their own personal attendants and/or homecare staff. The participant, or the participant's representative (for participant-directed attendant care only), directing care takes on all of the responsibilities of being an employer, except for payroll management, which is handled by the fiscal intermediary.

For the participant-directed home care service only, the participant and the care manager will create a caregiver reimbursement budget based on an algorithm determined by the Division of Aging. Participant will receive monthly financial budget reports detailing the funds spent and remaining for the year.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Participant Directed Attendant Care Providers shall be recruited, hired, trained, paid, and supervised under the authority of the participant, participant's parent(s), other person acting on the participant's behalf, or the emancipated participant, if the participant, parent, or representative acting on the participant's behalf, chooses to self-direct the attendant care providers and assumes the responsibility to initiate self-directed service and exercise judgment regarding the manner in which those services are delivered, including the decision to employ, train, and dismiss an attendant care/skilled care provider. Participant Directed Home care service providers shall be recruited, hired, trained, paid, and supervised under the authority of the participant. If the participant chooses to self-direct home care providers they assume the responsibility to direct the home care service, and exercise judgement regarding the manner in which those services are delivered, including the decision to employ, train, and dismiss a home care provider. PARTICIPANT DIRECTED ATTENDANT CARE shall not be reimbursed when provided by a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, the health care representative (HCR) of a participant, or the legal guardian of a participant. PARTICIPANT DIRECTED HOME CARE SERVICE shall not be reimbursed when provided by the attorney-in-fact (POA) of a participant, the health care representative (HCR) of a participant, or the legal guardian of a participant.

Care managers are an integral part of the success of the self-directed services as the care manager is responsible for oversight and monitoring of the Service Plan of the participant; assessing the participant for participation in the self-directed services; assisting the participant in directing care in evaluating whether the self-directed skilled care service is appropriate for meeting the participant's needs and whether the participant or the participant's representative (if applicable) is interested in taking on the responsibilities associated with the self-directed skilled care service. The care manager will assess the needs of the participant through a person-centered planning process, and establish an annual cost limit based on the authorized plan of care. For waiver participants, annual cost per participant is determined by an algorithm established by the Division of Aging. The care manager will develop a person-centered plan to meet those needs and service request and a dollar amount will be assigned to the plan using the Division of Aging's algorithm. The care manager and fiscal intermediary are responsible for monitoring the allocation of funds to the participant's caregiver. The care manager is required to have face-to-face contact with the participant at a minimum of at least every ninety (90) days and every thirty-one (31) days for the home care service, or more often as the needs of the participant change. The care manager is also required to reauthorize the participant in the participant-directed services every ninety (90) days. The care manager will evaluate the service plan for quality and ask the participant to verify whether he/she is satisfied with the services he/she is receiving. The participant will be asked to sign the 90 Day Self-Directed 90 Day Review Checklist facilitated by the care manager. Representatives directing care on behalf of the participant for the participant-directed attendant care service, will be required to sign the 90 Day Self-Directed Skilled Care 90 Day Review Checklist, and verify weekly face-to-face visits between the caregiver and the participant.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Attendant Care	☒	☐
Participant Directed Home Care Service	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. **Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

As the operating agency, the DA through the procurement process, contracted with a fiscal intermediary for the self-directed attendant care/home care services whose job responsibilities include serving as the payroll department; including administering limited criminal history background checks; professional licensure checks; issuing paychecks per submitted timesheets; filing monthly, quarterly and annual tax and labor reports; issuing annual W-2 wage statements; managing service units; providing participants, employers, and care managers with monthly reports of fiscal intermediary spending on participant's behalf; and responding to questions and issues concerning the self-directed attendant care/home care service.

ii. **Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

The PARTICIPANT DIRECTED ATTENDANT CARE and PARTICIPANT DIRECTED HOME CARE SERVICE fiscal intermediary is compensated for administrative activities which include compensation for performing payroll and related functions for participants who are self-directing their care. The administrative activity costs are divided equally per month throughout the length of the contract. The fiscal intermediary is also reimbursed based upon an established fee-for-service basis for each quarter hour of attendant care services provided by the participant's provider of service on the approved service plan. The ratio between the administrative activities and the fee-for-service activities is 1-4 or 25% to 75%. Therefore, the administrative activities equal 25% percent of the total cost of the self-directed care program and the fee for service equals 75% of the cost of the self-directed attendant care service.

iii. **Scope of FMS.** Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☒ **Other**

Specify:

Administers limited criminal history background check.

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [ ] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The DA is responsible for monitoring the performance of the fiscal intermediary (detailed in Appendix E-1) through weekly telephonic conference calls and weekly written reports on payments to providers. The reports include the number of participants, the number of providers, dollar amounts, and which participants have service plans but are not receiving services.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. **Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Care managers are an integral part of the success of the participant-directed services as the care manager is responsible for oversight and monitoring of the service plan for the participant. One of the care manager's responsibilities is to have face-to-face contact with the participant at a minimum of at least every ninety (90) days or every thirty-one (31) days for the home care service, or more often as the needs of the participant change. The role of the care manager is to empower the participant in directing care and in evaluating whether the participant-directed attendant/home care service is appropriate for meeting the participant's needs and whether the participant or the participant's representative (Participant-directed attendant care service only) is able to fulfill all the responsibilities to manage the participant-directed services. The participant will be asked to sign the 90 Day Review Checklist along with the care manager. Participants will be required to sign the 90 Day Participant Directed Attendant Care 90 Day Review Checklist and verify weekly face-to-face visits between the caregiver and the participant. The care manager also helps to provide administrative guidance to the participant, or the participant's representative participant-(directed attendant care service only), regarding the self-directed attendant services implementation process. This process includes: training on the program via manual study or one of the forms of electronic information; assisting with obtaining and/or completion of the employer and employee packets involved in hiring the participant-directed attendant/home care provider; direct the employer to the fiscal intermediary's help line if assistance is needed with the completion of the fiscal intermediary forms and paperwork; and monitoring the outcomes of the participant-directed services, to the extent as agency services are monitored.

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Specialized Medical Equipment and Supplies	☐
Transportation	☐
Attendant Care	☐
Care Management	☒
Participant Directed Home Care Service	☐
Personal Emergency Response System	☐
Community Transition	☐
Nutritional Supplements	☐
Respite	☐
Home Modifications	☐
Home Modification Assessment	☐
Pest Control	☐
Adult Day Service	☐
Assisted Living	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Structured Family Caregiving	☐
Integrated Health Care Coordination	☐
Vehicle Modifications	☐
Home Delivered Meals	☐
Adult Family Care	☐
Home and Community Assistance Service	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

If at any time the participant voluntarily chooses to terminate the participant directed attendant care service, the care manager will provide information regarding other service options and to assure selected services are able meet the participant's needs, according to service definitions. The participant will be asked to sign the 90 Day Self-Directed Attendant Care 90 Day Review Checklist along with the care manager.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Participants shall be involuntarily terminated from participant-direction and offered traditional waiver services when it has been determined by the Division of Aging that any of the following exist: (A) An immediate health and safety risks associated with participant-direction, such as, imminent risk of death or irreversible or serious bodily injury related to the provision of waiver services, has been identified; or (B) misuse of funds; or (C) participant utilized the entirety of self-directed funds allocated within their annual budget for the PDHCS prior to the end of the time period; or (D) failure to follow and implement Division of Agency policies and/or guidance; or (E) providing false information and/or documentation; or (G) participant has been convicted of illegal activity.

When action is taken to involuntarily terminate the participant from participant-directed services, the care manager assists the participant with accessing needed and appropriate services through the traditional waiver services option, ensuring that no lapse in necessary services occurs for which the participant is eligible. The care manager will provide the participant with other service options, which will be provided to meet the needs of the participant and to assure continuity of services to meet the participant's needs. The participant will be asked to sign the 90 Day Self-Directed Review Checklist along with the care manager. For PARTICIPANT DIRECTED ATTENDANT CARE SERVICE, the individuals directing care on behalf of the participant will be required to sign the 90 Day Review Checklist along with the care manager. This process will not circumvent the participant's right to a fair hearing as detailed in Appendix F-1.

Paid caregivers shall be involuntarily terminated from participant-direction when it has been determined by the Division of Aging that any of the following exist: (A) An immediate health and safety risks associated with the participant, such as, imminent risk of death or irreversible or serious bodily injury related to the provision of Waiver services, has been identified; or (B) misuse of funds following notification, assistance and support from Division of Aging; or (C) failure to follow and implement policies of participant-direction after receiving Division of Aging technical assistance and guidance; or (E) providing false information and/or documentation; or (G) paid caregiver is in violation of 455 IAC 2-15-2.

When a participant or paid caregiver are involuntarily terminated, they shall be ineligible to reapply for participant-directed services as either a participant or paid caregiver for twenty-four (24) months following the date of termination.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only			Budget Authority Only or Budget Authority in Combination with Employer Authority		
Waiver Year	**Number of Participants**			**Number of Participants**		
Year 1					375	
Year 2					375	
Year 3					375	
Year 4					375	
Year 5					375	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. **Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☒ **Hire staff common law employer**

☐ **Verify staff qualifications**

☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

All direct care providers must submit a criminal background check as required by 455 IAC 2-15-2. The criminal background check must not show any evidence of acts, offenses, or crimes affecting the applicant’s character or fitness to care for waiver consumers in their homes or other locations. The Fiscal Intermediary verifies receipt of documentation as a part of caregiver enrollment. DA providers are required to submit a policy regarding OIG checks at certification and compliance review. Criminal history checks are maintained in agency files and are available upon request.

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☐ **Determine staff wages and benefits subject to state limits**

- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. **Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [ ] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the state's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [x] **Authorize payment for waiver goods and services**
- [x] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. **Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how

the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Only the PARTICIPANT DIRECTED HOME CARE SERVICE has a budget. For the PARTICIPANT DIRECTED HOME CARE SERVICE, the care manager will assess the needs of the participant through a person-centered planning process. For waiver participants, annual cost per participant is determined by an algorithm established by the Division of Aging. The care manager will develop a person-centered plan to meet those needs and service request, and a dollar amount will be assigned to the plan using the Division of Aging's algorithm. The annual budget is determined by the number of hours assigned by the care manager for either or both the skilled and/or the attendant care activities during the person-centered planning process. Those hours are multiplied by the respective rate for home care skilled activities and/or attendant care activities. Even though the budget is determined during the person-centered care planning process, the participant is the one who decides what the actual rate and how many hours will actually be reimbursed within the total amount of the budget.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. **Informing Participant of Budget Amount.** Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The care manager will assess the needs of the participant through a person-centered planning process. The care manager will develop a person-centered plan to meet those needs and service request, and then a dollar amount will be assigned to the plan using the Division of Aging's algorithm. The care manager will explain how the budget is determined, the total amount of the budget, how a participant can request a change in the budget, and what the ramifications are if the participant exceeds the budget. The care manager and fiscal intermediary are responsible for monitoring the allocation of funds to the participant and the participant's paid caregiver. Participant will receive monthly financial statement detailing the funds spend and remaining for the year.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. **Participant Exercise of Budget Flexibility.** *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Care managers are an integral part of safeguarding participant's depletion of a self-directed budget and are responsible for the following prevention activities:
(A) discuss with participant or his/her representative the available amount in the budget;
(B) assist the participant or his/her representative with the development and modification of the participant-directed budget;
(C) submit request to Division of Aging for review and approval prior to the care manager's approval of the participant-directed budget;
(D) approve the participant-directed budget and modifications;
(E) assist the participant or his/her representative to develop or revise an emergency back-up plan;
(F) provide the fiscal intermediary a copy of the authorized participant budget and any modifications;
(G) monitor implementation of the plan;
(H) ensure services are initiated within required time frames;
(I) conduct ongoing monitoring of plan implementation and the participant's health and welfare;
(J) specify additional paid caregiver qualifications in the Plan based on the participant's needs and preferences when such qualifications are consistent with approved waiver qualifications.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The care manager's responsibilities include provision of both written and oral explanations of the participant's, or the guardian's- if appropriate, right to the Medicaid Fair Hearing process. This notification will occur at the time of initial assessment, reassessments and for any updates to the service plan related to participant's choice between institutional care and community based services, selection of services and service providers if community based care is chosen. This notification will include rights of appeal if services are suspended, denied, reduced or terminated.

The care manager maintains copies of all written notices and electronically filed documents related to a participant's level of care determination and the participant's right to a Medicaid Fair Hearing. The care manager must ensure that the Level of Care Review Form is sent to the applicant or participant within 10 working days of the issue date and must document in the electronic case management database system the date the Level of Care Review Form was sent to the applicant or participant.

Notice of Action (NOA)- State Form 46015 - HCBS5 - is used to notify each Medicaid applicant or participant of any action that affects the participant's Medicaid waiver benefits. An action may be a suspension, termination, reduction, or increase of all or any amount of covered services. This also includes actions taken to approve or deny new applicants. An explanation regarding a HCBS waiver service participant's appeal rights and the opportunity for a fair hearing is located on each Individual Service Authorization. Part 2, "Your Right to Appeal and Have a Fair Hearing" advises participants of their right to appeal and the timely actions which are required. Part 3, "How to Request an Appeal" provides instructions for participants regarding the procedures that are necessary in the appeal process.

The waiver Notice of Action (NOA) informs the participant (and the participant's guardian or advocate, as appropriate) of his/her right to an appeal. The Notice of Action (NOA) also advises the participant that services will be continued if he/she files the appeal in a timely manner, which is within 33 days of the decision date noted on the Notice of Action (NOA).
Written materials will be maintained in the participant's information folder kept in the home. Additionally, written materials detailing the service plan and service providers are mailed to the participant to allow for a right to appeal the service delivery plan and right to a Medicaid Fair Hearing. This formal notice occurs after the initial service plan is developed and at time of renewal or at any time there is a change in the service plan.

The care manager maintains copies of all written notices and electronically filed documents related to a participant's service plan and the participant's right to a Medicaid Fair Hearing. The care manager must ensure that the Notice of Action (NOA)is sent to the applicant or participant within 10 working days of the issue date and must document in the electronic case management database the date the Notice of Action (NOA)was sent to the applicant or participant.

If an applicant is denied waiver services, a written Notice of Action (NOA) is sent detailing the reasons for denial and explains the participant's right to appeal this decision and right to a Medicaid Fair Hearing. Written notice will be provided at least 10 days prior to a participant's waiver services being decreased, suspended or terminated. The written notice will detail the reasons for the decision and explain the participant's right to appeal this decision and right to a Medicaid Fair Hearing.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

The DA is responsible for managing complaints related to participants receiving services coordinated and administered by the DA.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DIVISION OF AGING GRIEVANCE/ COMPLAINT SYSTEM
The Grievance/Complaint System is not a pre-requisite or substitute for the Fair Hearing process.
A. TYPES OF GRIEVANCES/COMPLAINTS THAT PARTICIPANTS MAY REGISTER
DA accepts complaints from any person or entity, when such complaints are related to, participants receiving services that are coordinated and administered by the DA.
Complaints not specific to the DA are referred to the appropriate entity (agency/division/authority)
B. PROCESS AND TIMELINES FOR ADDRESSING GRIEVANCES/ COMPLAINTS
Complaints are acted upon by the DA in accordance with the nature of the complaint. Issues that immediately affect a participant's health and welfare are entered as incidents and classified as "Sentinel." This classification requires an immediate response and follow-up until the incident is resolved. A detailed description of resolution activities is provided in Appendix G-1d. An issue would be identified as a complaint only when there is not an immediate impact on the participant.
CRITICAL/Not Immediate - affecting participant's health and welfare; require a four (4) day response time. URGENT- serious problem, but not affecting participant's health and welfare; require a 7 day response time. STANDARD- general complaint with no critical or urgent impact; require a 21 day response time.
Complaints will be resolved through
- direct contact/ interviews with the complainant, service provider and other entities, as necessary
- documentation review, as necessary
- on-site visit, if indicated
- referral to the care manager for follow up -including the participant freedom of choice to select other providers

C. MECHANISMS THAT ARE USED TO RESOLVE GRIEVANCES/ COMPLAINTS
Complaints may require specific action by the DA as required by State and Federal law, regulation or policy depending on the type of complaint.
Complaints concerning licensed providers' quality of care issues will be referred to the State Department of Health as appropriate within four (4) business days.
Complaints alleging fraudulent billings or falsified time records will be researched through claims management and referred to the Surveillance and Utilization Review (SUR) Unit, as appropriate, for follow-up or action within four (4) Business days.
Systemic complaints may be referred to internal FSSA investigators or the Attorney General's office for consumer protection.
When there is not timely resolution; additional actions may be taken including:
- a request for a provider corrective action plan within two weeks
- a formal provider review within 30 days
- a hold (up to 60 days) on new referrals while corrective action/ formal review takes place
- termination of the provider agreement for non-compliance after 60 day notice CLOSING THE GRIEVANCE/ COMPLAINT

The complaint will be closed by the DA when the participant's needs have been addressed. The participant (or individual filing the complaint on participant's behalf) will be notified in writing (or e-mail when available) of the resolution and closure.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*
If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Indiana's 455 IAC 2 requires all providers of HCBS waiver services, including care managers, to submit incident reports to the DA when specific events occur. The nature of these events is defined as an unusual occurrence affecting the health and safety of an HCBS participant.

Events which must be reported include, but are not limited to:

- Alleged, suspected, reported or observed abuse/battery, neglect, or exploitation of a participant.
- The unexpected death of a participant
- Significant injuries to the participant requiring emergent medical intervention
- Any threat or attempt of suicide made by the participant
- Any unusual hospitalization due to a significant change in health and/or mental status may require a change in service provision
- Participant elopement or missing person
- Inadequate formal or informal support for a participant, including inadequate supervision, which endangers the participant
- Medication error occurring
- A residence that compromises the health and safety of a participant
- Suspected or observed criminal activity by a)provider's staff when it affects or has the potential to affect the participant's care;(b)a family member of a participant receiving services when it affects or has the potential to affect the participant's care or services; or (c) the participant receiving services;
- Police arrest of the participant or any person responsible for the care of the participant
- A major disturbance or threat to public safety created by the participant
- Any use of restraints

All service providers, including care managers, with knowledge of an incident event are required to submit an incident report through the DA web-based Incident Reporting system. If web access is unavailable, incidents can be reported to the DA by telephone, and e-mail. Recent changes to the incident reporting system allow for incident submission with less required information. This enhancement makes the system more accessible to participants, family members and direct caregivers.

Additionally, 455 IAC 2 requires reporting of known or suspected abuse, neglect, or exploitation (A-N-E) of an adult to Adult Protective Services. A twenty-four (24) hour hot-line connected to the statewide Adult Protective Services (APS) system is available for this reporting, or reports can be made to the local APS or County Prosecutor's office. A toll-free twenty-four (24) hour number is available through Indiana Department of Child Services (DCS) for reporting child abuse, neglect or exploitation.

Providers are required to suspend from duty any staff suspected, alleged, or involved in incidents of A-N-E of a participant, pending the provider's investigation of the incident. If needed, the care manager coordinates re- placement services for the participant. In the event that the care manager is the alleged perpetrator the participant will be given a new pick list from which a new care manager will be selected.

Providers of home and community-based services are required to submit an incident report for any reportable unusual occurrence within forty-eight (48) hours of the time of the incident or becoming aware of the incident. However, if an initial report involves a participant death, or an allegation or suspicion of A-N-E, it is required to be submitted within twenty-four (24) hours of "first knowledge" of the incident.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

As a part of the service plan process, participants, family members and/or legal guardians are advised by the care manager via written materials of the DA's abuse, neglect and exploitation reporting procedures. The care manager will discuss the information concerning who to contact, when to contact and how to report incidents with all persons involved in service plan development. The age appropriate toll-free hotline number is written inside of the participant's packet of service information. This information will be reviewed formally at 90 day face-to-face updates.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Incidents are received by the DA via a secure web-based reporting system which links to the electronic incident database. DA's Incident reporting staff process the A-N-E incidents within an average of one (1) work day of receipt of the reports, and for non A-N-E within an average three (3) work days of receipt of the reports. Processing each report includes coding the incident by Type, Apparent Cause, Resources Utilized and when applicable, Perpetrator, sub-type(s), and Outcome. Reviewers also determine what level of follow-up is required, if any, and send notifications to the care manager, DA, and provider of specific required actions.

Required actions may include:
- notification of APS or CPS if the incident involves A-N-E and notification is not documented in the report;
- additional follow-up by the care manager when the incident has not been resolved;
- follow-up by the DA when it appears the participant is at risk of further A-N-E or other substantial threat of harm (sentinel status). This follow-up is expected to be made by DA personnel within 48 hours of notification;
- submission of a new report when the first report was inadequate or incomplete.

The incident reviewer also sends notifications to the care manager when follow-up is not required and to the DA informing of all A-N-E reports. Additional notifications may be sent to reporting entities and the DA when incident reporting requirements for timeliness are not met, or when the report should have been submitted by another party.

All incidents which are not resolved require care manager follow-up and reporting every seven (7) days until the incident is determined by the incident reviewer to be resolved. Follow-up reports are also submitted via the web-based incident reporting system.

Aggregated incident data is reviewed by the DA to determine patterns which may result in required plan of corrections from providers, enhanced service provision for participants, or other modifications or enhancements to the waiver program.

The DA forwards geographic specific reports to each case management entity to aid them in tracking unresolved incident reports. Unresolved reports are monitored weekly by the DA.

All participants' deaths may be reported to the relevant APS unit or to the Department of Child Services (DCS) as applicable. APS units, DCS investigators and/or law enforcement conduct independent investigations of deaths and A-N-E reports at their discretion and following their departmental protocols.

Participant deaths are reviewed by the DA along with any previously filed incident reports involving the participant. Additional information, including provider's records of service delivery, may be collected for further review of any unexpected deaths. If additional review is indicated it is referred for review by the Mortality Review Committee.

The Mortality Review Committee will review all deaths that involve the participant when:
- death is due to alleged, suspected or known abuse or neglect
- death is from trauma or accident
- death is alleged or known suicide or homicide
- death occurs unexpectedly following transition from a Nursing facility
- death occurs when participant has gone missing from normal care setting

The Mortality Review Committee may:
- request additional information and review the case a second time when the requested information is in the file;
- close a case with recommendations for the provider(s) or a care manager, a referral to another entity, or a systemic recommendation; or
- close a case with no recommendation(s).

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Oversight of reporting and response to incidents is the direct responsibility of the DA. The web-based incident reporting system is augmented with e-mail tracking and "cc-ing" to appropriate DA staff. Appropriate DA staff are notified daily of all reports of A-N-E and death.

Additional reports track:
- "Non-resolved" Reports – generated weekly to appropriate DA staff with area-specific reports to the AAAs and independent care managers
- "Incidents by Type" report – reviewed by the DA staff.
- "Sentinel Status" report – Identifies "not-resolved" and "days-to-resolve" A-N-E and other critical incidents – reviewed by DA staff.
- Statewide and Area-specific Dashboard Reports identify number of total incidents, deaths, and A-N-E reports, with year-by-year comparisons. Reviewed at each Committee meeting.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The DA prohibits the use of restraints or seclusion in the provision of services regardless of the waiver setting. Reporting of prohibited restraint and/or seclusion usage by a provider is reported through the web-based incident reporting system.

The prohibition of use of seclusion and/or restraints including personal restraint, chemical restraint and/or mechanical restraint is included as a part of the required care manager training.

The DA has responsibility for oversight that these prohibitions are enforced. Care managers are responsible for initial oversight of participant's care, the thirty (30) day follow up and the ninety (90) day face-to-face review of the care plan. These reviews will be utilized as opportunities to monitor for any prohibited restraint usage or seclusion of the participant.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The DA prohibits the use of restrictive interventions by its service providers regardless of the waiver setting. Reporting of prohibited usage of restrictive interventions by a provider is reported through the web based incident reporting procedure.
The prohibition of the use of restrictive interventions is included as a part of the required care managers' training.

The DA has responsibility for oversight that these prohibitions are enforced. Care managers are responsible for initial oversight of participant's care, the thirty (30) day follow up by phone and the ninety (90) day face to face review of the care plan. These reviews will be utilized as opportunities to monitor for any prohibited usage of restrictive interventions of the participant to prevent reoccurrence

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this

oversight is conducted and its frequency:

The DA prohibits the use of seclusion by its service providers regardless of the waiver setting. Reporting of prohibited usage of seclusion by a provider is reported through the web based incident reporting procedure.

The prohibition of the use of seclusion is included as a part of the required care managers' training.

The DA has responsibility for oversight that these prohibitions are enforced. Care managers are responsible for initial oversight of participant's care, the thirty (30) day follow up by phone and the ninety (90) day face to face review of the care plan. These reviews will be utilized as opportunities to monitor for any prohibited usage of seclusion of the participant to prevent reoccurrence.
e.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*

◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The DA does not require Medication management and follow up responsibilities from providers other than Adult Day Service (ADS), which is not a round-the-clock provider. In Indiana, medication assistance may include reminders, cues, opening of medication containers or providing assistance to the participant who is competent, but otherwise unable to accomplish the task.

Providers must also adhere to the DA rules and policies as well as the specific waiver definition which include activities that are allowed and not allowed, service standards, and documentation standards for each service. All providers must adhere to the DA's Incident Reporting (IR) policies and procedures related to unusual occurrences. All approved waiver providers that are responsible for medication assistance are required to report specific medication errors as defined in DA's incident reporting policy to the DA. Additionally, AL providers licensed by the Indiana State Department of Health (ISDH) must also report medication errors to the ISDH. Please refer to Appendix G1-b for specific details regarding the IR process.

For approved service providers, medication assistance means the provision of reminders or cues, the opening of preset commercial medication containers or providing assistance in the handling of the medications (including prescription and over the counter medications).

The care manager conducts a face-to-face visit with the participant at least every ninety (90) days to assure all services, including medication assistance, are within the expectations of the waiver program. Additionally, non-licensed providers will be surveyed by the DA, or its designee, to assure compliance with all applicable rules and regulations.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The DA does not require Medication management and follow up responsibilities from providers other than Adult Day Service (ADS), which is not a round-the-clock provider.

DA and OMPP are responsible for monitoring and oversight of medication assistance practices and conduct analysis of medication errors and potentially harmful practices as discovered through incident reporting, provider compliance review process, mortality review, and the complaint process. Data is analyzed at the participant level, the provider level, and the state level. The data allows for implementation of corrective action plans and could lead to disciplinary measures up to and including provider de-certification.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. **Provider Administration of Medications.** *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. **State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

In Indiana, medication assistance means the provision of reminders or cues, the opening of preset commercial medication containers or providing assistance in the handling of the medications (including prescription and over the counter medications). Waiver providers that are not licensed by ISDH are restricted to medication assistance services. Waiver providers licensed by ISDH must follow State regulations concerning the administration of medications.

iii. **Medication Error Reporting.** *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

All approved waiver providers that are responsible for medication assistance are required to report specific medication errors as defined in DA's incident reporting policy to the DA. Licensed AL waiver service providers must also report medication errors to the Indiana State Department of Health (ISDH).

(b) Specify the types of medication errors that providers are required to *record:*

AL waiver service providers, by ISDH regulation, 410 IAC 16.2-5-4(e)(7), are required to record any error in medication shall be noted in the resident's record. All approved waiver providers that are responsible for medication assistance are required to record medication errors in the participants' record as per DA's IR policy.

(c) Specify the types of medication errors that providers must *report* to the state:

For licensed AL waiver providers, the facilities are required to report to ISDH any unusual occurrences if it directly threatens the welfare, safety or health of a resident as per 410 IAC 16.2-5-1.3(g)(1). The current ISDH policy on unusual occurrences includes the reporting of medication errors to ISDH that caused resident harm or require extensive monitoring for 24-48 hours. Waiver providers that are responsible for medication assistance must report medication errors in accordance with the DA's IR policy which includes errors of wrong medication, wrong dosage, missed dosage or wrong route.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

ISDH has responsibility for monitoring the licensed providers through survey and compliance review processes. Additionally, DA gathers data through incident reporting, complaints, provider surveys, and mortality review which is reviewed by the DA staff. Identified problems with medication administration involving licensed waiver providers are referred to ISDH. The DA staff reviews and reports medication administration error trends to the DA executive staff for further remedial action as deemed necessary.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G.2 Number and percent of participants that report they are free from abuse, neglect, and exploitation (A-N-E, and unexplained death. Numerator: Number of participants that report they are free from abuse, neglect, and exploitation(A-N-E), and unexplained death. Denominator: Number of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
G.2 Electronic Case Management Database System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.1 Number and percent of sentinel incidents, including abuse, neglect, and exploitation (A-N-E)and unexplained death, that are monitored to appropriate resolution. Numerator: Number of sentinel incidents, including abuse, neglect, and exploitation (A-N-E)and unexplained death, that are monitored to appropriate resolution. Denominator: Number of Sentinel Incidents reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Sentinel Resolution Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.3 Percent of waiver individuals (or families/legal guardians) who received information on how to report abuse, neglect, exploitation and unexplained death. Numerator: Total number of participants, family members, or legal guardians who received information on reporting abuse, neglect, exploitation, and unexplained death. Denominator: Total number of participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic case management system - 90 day review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☒ **Other** Specify: Statistically valid sample was proportional across AAAs to assure mixture of rural and urban populations. Distribution was based upon each geographic area's percentage of the total waiver population.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.4 Percent of critical incidents where root cause was identified. Numerator: Total number of critical incidents where the root cause was identified. Denominator: Total number of critical incidents reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident reporting system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Statistically valid sample was proportioned across AAAs to assure mixture of rural and urban populations. Distribution was based upon each geographic area's percentage of the total waiver population.

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.5 Number and percent of incidents of abuse, neglect and exploitation individually remediated in the stipulated time period. Numerator: Total number of incidents of abuse, neglect and exploitation remediated in the stipulated time period. Denominator: Total number of incidents of abuse, neglect and exploitation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident Reporting System.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100%**

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
HW B.1 Total number of incidents reported within the required time period.
Numerator: Total number of incidents reported within the required time period.
Denominator: Total number of incidents reported.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW B.2 Number and percent of incidents that were resolved within the stipulated time period. Numerator: Total number of incidents which were resolved within the stipulated time period. Denominator: Total number of incidents reported.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
HW C.1 Number and percent of reported uses of restraints or seclusion. Numerator: Total number of reported uses of restraints or seclusion. Denominator: Total number of reported incidents.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☒ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to

analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
HW D.1 Number and percent of sentinel events regarding medication errors that resulted in medical treatment. Numerator: Total number of medication errors that resulted in medical treatment. Denominator: Total number of medication errors.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

In addition to incident reporting, filed complaints are reviewed to determine if trends exist involving specific providers. Reported provider complaints and provider related incidents are compared to APS data bases to determine systemic issues affecting participants and/or community in general.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

DA staff becomes directly involved with any incident with sentinel status by following up with care managers, providers and participants as necessary. DA staff work directly with APS units to reach resolution and/or to determine next steps to safeguard participants at risk of abuse, neglect or exploitation.

DA staff person is responsible for coordination of response to high risk participants and/or settings throughout the state by working directly with local APS units, local LTC Ombudsman, AAAs, Care managers and other providers.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other**	☐ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state

spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

DISCOVERY and ANALYSIS
Initial analysis of discovery data is conducted by the appropriate DA staff as part of their day-to-day activities. This discovery data is obtained from the following activities and sources:

• Electronic Care Management Database queries—The DA utilizes several electronic case management database applications which provide routine reports on various performance indicators in addition to allowing for on-demand report generation. These reports provide some of the performance measurement data for the waiver sub-assurances.

• Incident Review—The DA requires all waiver service providers to report critical incidents via a web-based submission tool. All reports are processed by incident review staff within three business days of receipt, except any A-N-E and unexpected death incident reports are reviewed within one working day of receipt. "Processing" entails coding reports by type, designation of sentinel events, determining whether or not follow-up is required, assuring that all events or allegations of abuse, neglect or exploitation may be reported to APS or CPS appropriately, and directing notifications to involved entities. Follow-up reports, when required, are due from the care manager within 7 days of the processing date, at which time the review staff may close the incident or require additional follow-up. All reports of actual or alleged ANE are designated as sentinel events and forwarded to the DA for additional review in addition to any submission to APS/CPS.

• Mortality Review— All incident reports of waiver participants' deaths are forwarded to the DA for review. Death events which may have been impacted by the provision or non-provision of waiver services are referred to designated Mortality Review staff for further investigation.
• Complaints System -—The DA operates a complaint hot-line and all complaints are tracked and addressed by designated DA staff.
• Provider Compliance Tool (PCT) - The PCT review involves a service review visit to each non- licensed/non-certified provider at least one time every three years to establish that the provider continues to meet all provider requirements contained in 455 IAC 2. Additional provider reviews may be authorized by DA administration as warranted by complaints, critical incidents, or other extenuating circumstances. If found deficient the provider will be required to submit and fulfill the requirements of an acceptable CAP. Failure to successfully complete the CAP process may result in corrective action up to and including decertification as a waiver provider.
• Indiana State Department of Health (ISDH) licensure monitoring— The DA and ISDH work cooperatively to assure that licensed providers continue to meet all waiver requirements. Licensed providers are reviewed each year for a compliance review. If found deficient the provider will be required to submit and fulfill the requirements of an acceptable CAP. Failure to successfully complete the CAP process may result in corrective action up to and including decertification as a waiver provider.

COMPILATION and TRENDING OF PERFORMANCE MEASURES
The DA and OMPP have identified key performance measures and present these in numerator/denominator format. These measures are derived from other discovery activities but serve as both discovery and analytical tools. Each of these measures corresponds with a sub-assurance identified in the wavier application.

Data obtained from all of these sources, as well as data generated through remediation processes, is disseminated to the appropriate DA staff' The State recognizes that risk tolerance varies greatly from participant to participant and encourages care managers to recognize and respect the participant's participant desires and preferences when formulating risk mitigation strategies.
Committee for trend analysis and remediation of systemic issues. Remediation of participant findings is initiated immediately at the program and service level.

DA staff and OMPP will meet at least quarterly to review and evaluate the QIS performance measures, sampling strategies, and processes for remediation and improvement. The evaluation compares current performance to past or anticipated performance, analyzes trends in performance improvement/decrement, and analyzes remediation reports to identify systemic deficiencies. DA and OMPP also review reports and descriptions of best-practice quality improvement approaches from other states. DA and OMPP recommendations for system improvements will be researched and developed into proposals for consideration by the DA Management group.

SYSTEM IMPROVEMENT and DESIGN
DA Management group can include upper management personnel from DA and other areas within the FSSA, and

it may also include legal representation. The group's role is to provide leadership and direction for quality improvement projects, policy revision or development, and actions leading to refinement of quality operations and system management.

Proposals for system improvements are considered by the DA Management Group. The Management Group may assign research, design or implementation activities back to appropriate DA staff, other FSSA personnel, or contracted entities.

Prioritization of system improvement activities will be subject to several factors:
- regulatory requirements as specified by law or funding sources;
- potential to reduce risk or negative outcomes for program participants;
- potential to effect positive outcomes for a substantial number of participants;
- potential for implementation success;
- cost and feasibility of implementation activities;
- ability to measure results and outcomes of system improvements;
- organizational will: Are the necessary system actors motivated to implement desired changes?

The DA and FSSA are sensitive to the complexities of the service delivery system and the profound impact that change can have on both that system and on the participants we serve. While the scope of any given system improvement initiative will determine the implementation processes, when appropriate the state will;
- seek and consider stakeholder input;
- communicate changes and timelines to stakeholders, clearly identifying how the change may impact them;
- use beta testing and limited roll-out strategies;
- abide by existing State protocols for approval, development and implementation of new policies, technologies and general practices.

Decisions regarding changes to the waiver program will be documented in meeting notes and minutes which will be distributed internally to FSSA, the DA, as well as other members of the Management Group. The DA will have primary responsibility for implementing changes as directed by the DA Management Group, and for communicating changes to stakeholders. Documentation of communication to external stakeholders will be maintained within the electronic case management database.

Outcomes of all system changes and improvements will be monitored using the discovery and analysis tools and process described above. Measures obtained from these tools and processes will be compared to past and anticipated measures in continuation of the quality improvement cycle.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a

description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The DA utilizes several electronic case management database applications which provide routine reports on various performance indicators in addition to allowing for on-demand report generation. These reports provide key data and allow the DA to monitor and assess the outcome and effects of system design changes. The DA and FSSA have identified key performance measures which are compiled in numerator / denominator format. These measures are derived from a variety of discovery activities and serve as bothdiscovery and analytical tools. Data gathered from these discovery activities is compiled and trend-lines are developed by the DA. This information is disseminated throughout the DA and is provided to other areas within FSSA and the DA staff for review and analysis. These entities assess the outcome of system design changes through comparison of current and past performance measure results. Findings are then used to assess the need for additional changes or refinement, in continuation of the quality improvement cycle.

Lessons learned from these activities will be communicated internally by the DA to the DA Management Group, and externally to Case Management and provider entities.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

While the QIS is designed to identify opportunities for improvement in the service delivery system, the QIS itself must be monitored and improved upon. Improvements in the QIS will be necessary to keep up with changes in the regulatory and service delivery environments, and due to data or tools which the operators find to be inconsistent, incomplete or not conducive to obtaining desired measures or outcomes.

As the focal point for incoming data is the DA staff, who will have primary, but not exclusive, responsibility for analyzing QIS system performance. The DA staff will assess the reliability of the information presented to it by comparing the consistency of performance measurements across various perspectives. For example, results from incident reporting can be compared to health and safety data collected in the electronic case management database. Trend analysis may suggest more effective or more targeted performance measures, or reveal emerging risks which may not have been monitored previously.

As many of the data collection and analysis tools are electronic in nature, the committee will review opportunities to integrate new technology into the QIS. The DA staff will also actively seek input into QIS component performance from staff and contract entities who work with the various components on a day-to- day basis. Any complaints received from service recipients regarding QIS activities will be reviewed by the DA staff. The DA staff will formally review the QIS at least annually, and make recommendations for changes or improvements to the DA Management Group.

The DA Management Group will assess the recommended changes and improvements and coordinate with internal advisory and regulatory groups such as Rules Committee or Technology Committee to evaluate and authorize potential changes. Once a change is approved, the DA Management Group will in most cases authorize the appropriate office to implement the approved changes.

Modifications to the Quality Improvement Strategy will be submitted annually with the 372 report.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ◉ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

FSSA's Audit Unit is responsible for the annual review of services and billing performed by the AAAs with full reporting to the OMPP and the DA. FSSA PI has an agreement with the FSSA Audit Unit to investigate allegations of potential HCBS waiver provider fraud, waste, and abuse. PI and FSSA Audit maintain a natural level of collaboration and cooperation between the two Services. FSSA Audit's staff are knowledgeable of the different HCBS definitions, documentation standards, provider qualifications, and any required staffing ratios so it makes sense for them to audit allegations of wrongdoing in the waiver programs.

Process for Conducting Audits:
Program Integrity receives allegations of provider fraud, waste, and abuse and tracks these in its case management system. When it receives an allegation regarding a waiver provider, PI forwards it to FSSA Audit to begin its research and audit process. FSSA Audit works with PI to vet the providers with the Indiana Medicaid Fraud Control Unit (MFCU). Once MFCU's clearance is determined, FSSA Audit determines means to validate the accuracy of the allegation.

FSSA Audit may decide to conduct a statistically valid random sample of consumers and then PI's Fraud & Abuse Detection System (FADS) vendor will pull a sample for their audit. The size of a random sample audit is dependent upon the universe(s) size, claim/claim line payments, and other statistical criteria. The sample size is ultimately determined utilizing a tool developed by FADS contractors as well as its statistical consultants. The tool generates a statistically valid random sample size. Depending on the concerns identified during the risk assessment FADS will recommend an approach and/or scope for the audit:
- *Targeted Probe Audit Sample - A sample of sufficiently small size designed to focus on specific services, members, time frames or other scenarios that have been identified as higher risk for fraud, waste, and/or abuse to determine potential outcomes of audit findings or payment error issues. If the probe identifies material issues, statistical sampling is used to expand the testing and quantify overpayments.*
- *Random Sample Audit - The goal of the random sample is to identify potential payment errors and extrapolate those errors to the entire universe of claims.*

FSSA Audit conducts its audit activities and develops a findings report for the provider which may include a corrective action plan and request for overpayment. FSSA Audit shares copies of its findings reports with PI.
Audits are performed onsite utilizing a probe test that includes a review of:
- *Providers' source documents. This include documents that support paid claims, e.g. employee signed service notes, logs, evidence of supervisory approvals.*
- *Payroll records. Dates/times/locations of service per claims are compared to related time cards and payroll registers.*
- *Employee background and qualifications. Supporting documents, found in in human relations files, are reviewed. This includes documentation for background checks, licenses (if applicable), and search of the HHS/OIG exclusions list.*

The FSSA PI section regularly utilizes random-sampling and extrapolation in conducting audits of IHCP providers. If the focus of the audit is narrow (typically with algorithmic reviews), and the number of potentially erroneous claims is manageable, the review will be conducted on all identified claims. In the event the issue involves a large number of claims, or if the review is a provider-focused, comprehensive review, PI has the ability to utilize statistically-valid random sampling and extrapolation to determine any potential overpayments from the IHCP. The frequency of utilizing this approach is fluid, based upon the providers in queue for audit as well as the proposed audits included in the yearly FADS Audit Workplans. On-going monitoring of IHCP providers is supported by utilization of Truven Health Analytic's Provider Peer Comparison Tool, J-SURS, which compares providers to peers of like specialty to identify outliers. All provider types are profiled yearly, at a minimum, while higher-risk provider types are profiled on a quarterly basis. The results of the profiles are reviewed by PI staff to determine which providers may need further investigation and these results are discussed in weekly FADS team meetings.

Provider records are reviewed to ensure compliance with applicable state and federal guidelines, as well as policies published by the IHCP. Review scope may vary depending on provider type/specialty and/or concerns identified through pre-audit activities (e.g., data mining, complaints, etc.). Review scopes typically include (at a minimum) procedures to determine provider compliance with applicable documentation requirements and review of provider credentials/qualifications to ensure they are practicing within the scope of their licensure or certification (if applicable). When appropriate, these reviews may include reconciliation of the records to timesheet and/or other payroll records, as well as vehicle insurance (e.g., transportation providers) and/or health records of servicing providers (e.g., TB test records for waiver and home health providers). A detailed claim-level review checklist is prepared for each review that lists all claims included in the review, outlines the scope of the review, and identifies all findings or educational items noted during the review.
FADS investigations/audits can be initiated based on referrals received from different sources/agencies. PI receives information from the following sources which could potentially lead to additional action including audit action:
1. *IHCP Provider and Member Concerns Line;*

2. Other agencies (MFCU);
3. Analyses/Analytics performed by the PI Investigations team
4. Analytics performed by FADS contractors.

Depending on the allegations/information received regarding the provider(s), PI may conduct a Preliminary Investigation, utilizing the Credible Allegation of Fraud (CAF) tool developed by FADS contractors to determine next steps.
In certain instances, PI refers the provider(s) in question to FADS contractors for additional analysis which may include performing a Risk Assessment. The Risk Assessment tool, developed by FADS contractors, is utilized to gather information on a specific provider's background as well as billing patterns utilizing claims data and other research databases, focusing on any potential issues identified during the referral process. FADS contractors utilize this tool to assist in the decision making process when recommending the next appropriate action to be taken for the provider(s) in question.

There are differences in post-payment review methods, scope and frequency based upon audit type, provider type/specialty, background information, and state rules/regulations. PI can audit IHCP providers through either an algorithmic approach or a provider-specific full review. Algorithms processed by the PI FADS contractor, focus on specific codes, diagnoses, or program limitations to identify potentially erroneous claims across the IHCP. These reviews can involve hundreds of IHCP providers, but are limited in scope. The providers are notified of the potential errors upon receipt of the Draft Audit Findings letter, where no medical records are reviewed prior to identification of the problematic claims. If PI decides to conduct a more comprehensive review of an IHCP provider, PI request a full medical record review. The audit can be conducted through a medical record request desk audit, or as an on-site review. The on-site audit can be announced or unannounced, based upon the circumstances behind the audit recommendation.
Depending on multiple factors, risk assessments typically result in one of the following recommended actions (dependent upon the severity of the allegations and other information uncovered during the risk assessment):

- *No further action – No issues uncovered warranting further action.*
- *Provider education – No major issues identified that would result in patient harm or overpayments; however, it may be apparent that the provider as well as the Medicaid Program would benefit from additional education for the provider on proper/best billing practices.*
- *Provider self-audit – Specific concern(s) were identified resulting in a recommended limited-scope audit; however, the concern(s) are in an area which the State is comfortable with the provider conducting the audit to ensure compliance. FADS contractors subsequently perform validation review of the provider self-audit results. If FADS contractors determine they are not in agreement with a high percentage of the provider's self-audit results during the validation review, they will recommend the audit be escalated to a desk review and all records within the provider self- audit sample are evaluated by the contractor.*
- *Provider desk audit – Concern(s) were identified resulting in the need for medical record review (could be full or limited scope). However, the severity of the concerns do not currently warrant an on-site review. Certain provider records, including medical records, are requested for selected claims and clinical staff (if necessary) conduct a review of the services billed to ensure compliance with IHCP guidelines. Providers are allowed thirty (30) days to submit the requested information.*
- *Provider on-site audit (announced or unannounced) – Severity of the concern(s) has resulted in a recommendation of an on-site audit. Providers are generally given shorter notice (or no notice if warranted) of the pending on-site audit. If notice is provided, it can range from a few days to a few of weeks depending on several factors (i.e., type of facility, audit concerns, etc.). Requested information is collected on-site. A facility tour as well as provider/staff interviews are also conducted during on-site reviews. FADS contractors, including clinical staff, are included in on-site reviews and assist with conducting interviews. State Program Integrity personnel often also participate in on-site reviews.*
- *Referral to MFCU – Payment suspension recommended as the potential intent of fraudulent behavior was identified.*

Depending on the allegations/information received regarding the provider(s), the SUR Unit may conduct a Preliminary Investigation, utilizing the Credible Allegation of Fraud (CAF) tool developed by FADS contractors to determine the appropriate next steps, if any.
**Audit reports containing accuracy-related issues, missing documentation, internal control deficiencies, and training issues are prepared. Providers submit corrective action plans. Any overpayments are set up for recoupment. Audit reports are distributed to provider leadership and appropriate FSSA executives. Periodically, PI is advised of any systemic issues identified. FSSA Audit Services seeks PI's advice on audit reporting and direction on technical questions.*
For audits performed based on referrals such as incorrect billing, the reporting varies. If the audit finds the provider made unintentional errors, the typical audit reporting process is followed. However, if the referred audit identifies potential, intentional errors that may be credible allegations of fraud, the provider is referred to Program Integrity for further action. Select analytics are periodically rerun in an attempt to identify if provider billing patterns have changed/improved based on previous audit and/or provider education. Additional audit action may be taken for providers who continue to be identified as potential issues in these algorithms. If providers are again selected for audit, a similar audit process as previously described would occur.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
I.1 Number and percent of claims paid appropriately according to the reimbursement methodology in the waiver application. Numerator: Number of claims paid appropriately according to the reimbursement methodology in the waiver application. Denominator: Number of paid claims submitted.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Medicaid Management Information System claims data

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*

☒ ***Other*** *Specify:* *Fiscal Contractor*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
I.3 Number and percent of claims paid during the review period for services that are specified in the participant's approved service plan. Numerator: Number of claims paid during the review period due to services having been identified on the approved service plan. Denominator: Number of paid claims submitted during the review period.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Medicaid Management Information System claims data

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☒ ***Other*** *Specify:* *Fiscal Contractor*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☐ ***Other***	☐ ***Annually***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
Specify:	
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
I.2 Number and percent of claims paid during the review period for participants enrolled in the waiver on the date that the service was delivered. Numerator: Number of claims paid during the review period for participants enrolled in the waiver on the date that the service was delivered. Denominator: Number of paid claims submitted during the review period.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Medicaid Management Information System claims data

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☒ ***Other*** *Specify:* *Fiscal Contractor*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*

	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
I.4 Number and percent of rates for waiver services adhering to reimbursement

methodology in the approved waiver. Numerator: Total number of waiver rates that follow the approved methodology. Denominator: Total number of waiver rates

Data Source *(Select one):*
Operating agency performance monitoring
If 'Other' is selected, specify:
DA methodology and rate setting report

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

The State assures financial accountability through a systematic approach to the review and approval of services that are specifically coded as waiver services within the waiver case management system and the MMIS. The MMIS links to the waiver case management system in order to ensure that only properly coded services that are approved in a participant's plan of care are processed for reimbursement to providers who are enrolled Medicaid A&D waiver providers.

The FSSA receives monthly printouts from the Medicaid MMIS contractor listing the claims that have been reimbursed for individual participants. FSSA reviews this information to identify any issues in relationship with expectations for approved plans of care. This may include identifying issues of possible under or over utilization of monthly services for follow-up. FSSA investigates these issues and may refer them for follow-up under the Medicaid Surveillance Utilization Review program. Identified problems requiring further resolution are shared, as applicable.

When a need for systems change is identified by FSSA, a process is in place to address the issue. The issue is referred to the Change Control Board for action.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

I.1, I.2, and I.3 The performance measures in this Appendix will result in a percentage of errors as claims appropriately deny or adjust for valid reasons as addressed in the automated remediation process built into the MMIS.

As part of processing a claim, the MMIS performs electronic edit checks disallowing payments that do not meet criteria for billing HCB waiver services.

When the MMIS receives a claim for waiver services, it first verifies that the required fields of the standard claim form are complete and that the information included in these fields is valid. The claim is validated against member and provider files to ensure his/her Medicaid enrollment is active on the date the services were rendered.

Next the claims are subjected to pricing review. The claim pricing process calculates the Medicaid-allowed amount for claims based on claim type, published service rate and the member service authorization on file.

Additional system checks are in place to ensure that providers do not perform excessive or unnecessary services without prior approval. If the claim fails any of the system edits, the claim may be systematically denied, cutback or suspended.

If a provider bills more than the published service rate, the MMIS will systematically cut back payment of a claim to pay no greater than the published service rate. Claims requiring medical policy review are placed in a suspended status by the MMIS. The Resolutions Unit (staff of the fiscal contractor) examines suspended claims and makes a decision based on approved adjudication guidelines for the date of service. The approved guidelines indicate the course of action that must be taken for each edit. These guidelines are based on the medical policies established by FSSA. Suspended claims are reviewed within 30 days. Documentation and records are not requested from the provider during this process.

Resolutions Unit team members have the following options when processing suspended claims, depending on the edit or audit failed:
• Add or change data (only used when the claim is suspended due to data entry errors by the MMIS)
• "Force" the claim to process by overriding the edit
• Deny the claim
• Put the claim on hold (used when there is a system problem or a pending policy decision)
• Resubmit the claim to MMIS for reprocessing

Providers receive a weekly Remittance Advice (RA) statement about the status of processed claims. The provider should review the reasons the claim was returned, make the appropriate corrections, and then resubmit the claim for processing consideration.

Providers must submit all claims for services rendered within one year of the date of service. When submitting claims beyond the one-year filing limit, the provider can submit the claim electronically or on paper with documentation for justification.

Claims reimbursement issues may be identified by a care manager, the public, a provider, contractor, or state staff. Such inquiries are directed to communicate the issue using one of the following avenues.

Customer Assistance
1-800-577-1278 or
(317) 655-3240 in the Indianapolis local area

Written Correspondence
P.O. Box 7263
Indianapolis, IN 46207-7263

or via email to the OMPP Policy Consideration Unit at Policyconsideration@fssa.in.gov

Provider Relations field consultant
View a current territory map and contact information online at indianamedicaid.com

For individual cases, the operating agency and/or the Medicaid Fiscal Contractor Provider Relations staff or SUR address the problem to resolution. This may include individual provider training, recoupment of inappropriately paid monies and if warranted, placing the provider on prepayment review monitoring for future claims submissions. If there is a billing issue involving multiple providers, FSSA will work with the Medicaid Fiscal Contractor and/or SUR to produce an educational clarification bulletin and/or conduct training to resolve billing issues.

If the issue is identified as a systems issue, FSSA will extract pertinent claims data to verify the problem and determine if correction is needed. If the problem indicates a larger systemic issue, it is referred to the Change Control Board for a systems fix.

Each party responsible for addressing individual problems maintains documentation of the issue and the individual resolution. Meeting minutes are maintained as applicable. Depending on the magnitude of the issue, it may be resolved directly with the provider or the participant.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

To develop revised payment rates effective February 1, 2020, Indiana's Family and Social Services Administration (FSSA) used the following primary data sources:

Claims for waiver services flow directly from the providers to the Indiana Medicaid Management Information System (MMIS) and payments are made via FSSA's contracted fiscal contractor.

Data sources: To develop revised payment rates effective February 1, 2020, Indiana's Family and Social Services Administration (FSSA) used the following primary data sources:

BLS data – Data elements incorporated in rate setting include Indiana average wage data for applicable occupation codes, healthcare industry benefits cost data used as a national benchmark, and healthcare inflation data, used to inflate the BLS average wage data from the May 2018 reporting period to the midpoint of the new rate year (July 2020).

Provider survey data –Data collected from providers informed public source gaps and provided corroborating support for key BLS inputs. FSSA collected provider survey response data related to provider costs (for employee salaries, benefits, administration and program support), average wage per hour, staffing information (such as number of employees relative to participants served, and the average number of service hours per employee), and operational structure.

Methodology: To develop prospective payment rate methodologies for the Division of Aging's (DA's) waiver program services, FSSA selected the following approaches:

Traditional cost model build-up - This approach reflects the program-related cost per unit of providing each covered service. The foundation is the labor cost per unit, which includes inflated wages and benefits costs, allocated to the service unit level. Administration and program support costs are calculated as a percentage of the labor cost per unit component. Select services also include an "other" cost component for unique requirements such as Electronic Visit Verification (EVV).

Key default rate inputs under this approach were as follows:

Direct care worker average hourly wage for non-accredited employees (before inflation): $11.35 based on BLS Indiana average of the 50th and 75th percentile wage for Personal Care Aides

Wage inflation (2 years): 4% factor based on changes in Consumer Price Index for All Urban Consumers (CPI-U) levels for medical services

Productivity and Paid Time Off (PTO) factors: 6 % factor for productivity, or non-client facing time (such as training, notetaking, etc.) and 3% factor for PTO, based on provider survey data

Benefits factor: 19% factor based on BLS national benchmarks (includes Federally required benefits and 75% of national "insurance" benefits costs)

Administration and program support factor: 25% for administration and 6% for program support factor, based on costs reported in the provider survey

To appropriately reflect service requirements, rate inputs were modified from the defaults in the following:

Adult Day Services: Separate staffing ratios, supervisor span of control, and mix of supervisor wages (including RNs, LPNs, Psychiatric Aides, and Healthcare Support Workers) for each tier level to reflect higher resource requirements for levels 2 and 3. Also includes a $0.35 per unit meals cost component. Category 1 rates include a 16% program support adjustment to reflect enhanced setting requirements, while Category 2 includes the default 6% program support adjustment.

Adult Family Care: Rates assume 10 hours of service per day, with higher staffing ratios to reflect higher resource requirements for levels 2 and 3, and no productivity factor adjustment. Supervisor wages based on a mix of Healthcare Support Workers and RNs for all levels.

Attendant Care: Rate assume a 1:1 staffing ratio. Adjustments by provider type are as follows:

o Agency services: includes a supervisory cost component with a Healthcare Support Worker wage basis and a $0.05 per unit EVV adjustment

o Non-Agency services: includes a 12.5% administration adjustment and a $0.10 per unit EVV adjustment, with no supervisory cost component or adjustments for productivity, PTO, or program support

o Consumer Directed: includes a $0.10 per unit EVV adjustment, with no supervisory cost component or adjustments for productivity, PTO, program support, or administration

Care Management: Single monthly unit rate, based on the annual wage for Healthcare Social Workers allocated to the participant level with an assumed 50:1 staffing ratio

Healthcare Coordination: Single hourly unit rate with 1:1 staffing ratio, with wage based on LPNs, a 15% productivity factor, and no supervisor cost component

Home Maker: Rates assume a 1:1 staffing ratio, personal care aide median wage basis, and 10% program support factor, with no supervisor cost component. In addition:

o Agency services: includes a $0.05 per unit EVV adjustment

o Non-Agency services: includes a 12.5% administration adjustment and a $0.10 per unit EVV adjustment

Non-Medical Transportation: Uses the direct care worker wage for Bus Drivers, School or Special Client, and supervisor wage for Healthcare Support workers. Mileage unit rate includes a $0.58 per mile IRS allowable vehicle cost component, with no program support adjustment. Assumptions for units per hour and staffing ratio are higher for assisted transportation to reflect higher resource requirements.

Respite: Separate hourly unit rates for RN, LPN and unskilled services, each with a 1:1 staffing ratio and a $0.05 per unit EVV adjustment. Wage input assumptions are as follows:

o RN: Based on RN wage for direct care worker and supervisor

o LPN: Based on LPN wage for direct care worker and RN wage for supervisor

o Unskilled: Based on default wage for direct care worker and Healthcare Support worker wage for supervisor

Participant-directed home care service - Skilled Nursing: Single 15 minute unit rate with 1:1 staffing ratio, with wage based on RNs, a 12.5% administration adjustment, and no supervisor cost component.

Structured Family Caregiving: The assumed hours per day and caregiver stipend vary by level to reflect higher resource requirements for levels 2 and 3. Supervisor wages are based on a mix of RNs and Healthcare Support Workers. Program support assumes 26%, and administration 15%.

Rate composite approach - Based on a composite of rates for service components to reflect the value for the package of services. Includes tiered and bundled rates for Assisting Living, where the tiers are assigned based on the level of service assessment for each participant. The rate composite for Level 2 rates includes the following components:

Attendant Care: 4.5 units (1.13 hours per day)

Home Maker: 4 units (1 hour per day)

Skilled Nursing: 1.5 units (22.5 minutes per day)

Adult Day Service: 4 units (1 hour per day)

Emergency Response: One unit per month, or 0.03 units per day

Non-Medical Transportation: 0.3 trips at 2 miles per trip per day)

Participant levels 1-3 are assigned based on an Indiana-specific Level of Service tool. Level 2 has the highest projected utilization and is the starting point of the Assisted Living tiered rates. Under tiered rate adjustments, the Level 2 Attendant Care, Home Maker and Skilled Nursing rate components are adjusted upwards by 17% for the level 3 rate, and adjusted downward by 10% for the level 1 rate. These Assisted Living level differentials are informed by multiple discussions with stakeholders, provider survey results, and DA's knowledge of service requirements. The enhanced Level 3 differential is also consistent with DA's goal to incentivize services for participants with higher levels of need.

Consistent with the FSSA's goals for person-centeredness and to streamline billing practices, Assisted Living services will be paid on a monthly unit basis for all months except admit and discharge months, in which case payment will be based on a daily unit. The monthly rate is equal to the daily rate multiplied by 29.7 days, based on average monthly utilization.

Market-based approach - Based on market prices (up to an annual or lifetime limit) or commercial benchmarks for Community Transition, Home Delivered Meals, Home Modifications, Nutritional Supplements, Personal Emergency Response, Pest Control, Specialized Medical Equipment, and Vehicle Modifications.

The DA fee schedule can be found in the DA's HCBS Waivers Public Comments webpage at: https://www.in.gov/fssa/da/5479.htm.

Changes to rates and rate setting methodology require 60 day tribal notice and 30 day public comment period as well as a waiver amendment. Further, Indiana code requires that all providers of Medicaid funded services be made aware of changes 30 days prior to the change effective date. All other providers are notified of rate changes through public notice and public comments, IHCP published banner pages; bulletins; and newsletters as prepared by the DA in collaboration with the Indiana Office of Medicaid Policy and Planning (OMPP) and distributed by FSSA's fiscal agent contractor.

The DA and the OMPP will continue to collaborate with the stakeholder community on any revisions made to the waiver rates. Their valuable input into the waiver rate reviews is necessary to ensure that rates are sufficient to continue provider participation and participant access to waiver services.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Claims for waiver services flow directly from the providers to the Indiana Medicaid Management Information System (MMIS) and payments are made via FSSA's contracted fiscal contractor.

The State will have an Electronic Visit Verification (EVV) system that complies with the requirements of the federal 21st Century Cures Act as passed by Congress and signed into law on December 3, 2016. The state has submitted a good faith exemption request form to The Centers for Medicare and Medicaid Services (CMS) in October 2019, requesting additional time to mitigate issues that have caused unavoidable delays. The system shall be implemented no later than January 1, 2021.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- (●) ***No. state or local government agencies do not certify expenditures for waiver services.***
- ( ) ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

The Waiver service plan contains Medicaid reimbursable services that are available only under the A&D Waiver.

The DA approves a participant's service plan within the State's case management database ensuring that only those services which are necessary and reimbursable under the A&D Waiver. The service plan is sent to the state's fiscal agent, via systems interface with the MMIS, serving as the prior authorization for the participant's approved Waiver services. The case management system will not allow the addition of services beyond those services offered under the A&D Waiver. The case management data system has been programmed to alert the Waiver Unit when a service plan is being reviewed for a participant whose Medicaid eligibility status is not currently open within an acceptable category as described under Appendix B-4-b. When the appropriate Medicaid eligibility status is in place, the service plan will be approved, and the system will generate the Individual Service Authorization, which is sent to each authorized provider of services on the Plan. The Individual Service Authorization identifies the individual participant, the service that each provider is approved to deliver, and the rate at which the provider may bill for the service.

The case management database transmits data, on a daily cycle, containing all new or modified service plans to the Indiana MMIS. The service plan data is utilized by the MMIS as the basis to create or modify Prior Authorization fields to bump against the billing of services for each individual waiver participant.

Providers submit electronic (or paper) claims directly to the MMIS. Claims are submitted with date(s) of service, service code, and billing amount. Reimbursements are only authorized and made in accordance with the Prior Authorization data on file. The MMIS also confirms that the waiver participant had the necessary level of care and Medicaid eligibility for all dates of service being claimed against.

Documentation and verification of service delivery consistent with paid claims is reviewed during the post payment review of the operating agency as well as by the OMPP when executing SUR activities. Additional information about these reviews can be found in the Provider and Member Utilization Review provider reference module at the following link: http://provider.indianamedicaid.com/media/155481/provider%20and%20member%20utilization%20review.pdf

RECOUPMENT
If a payment to a provider is identified as paid in error due to error, fraud, policy, system issues, etc, the State can recoup that payment by any of the ways listed below:

1. *Create a non-claim specific accounts receivable*
2. *Claim adjustment*
3. *Remit payment via check*

Non-Claim Specific Accounts Receivable (AR):
When this method is used to recoup payment, an AR is setup under the Medicaid Provider's identification number. Each AR is assigned a reason code. The reason code describes the purpose for the AR. The reason code also maps to various lines on the CMS 64.
Once the AR is setup, a provider's future Medicaid payments will be reduced until the AR is fully satisfied. Claim Adjustments:
Under this process, a claim specific AR will be created when a claim is adjusted. Either the provider or the State may adjust claims. With claim specific ARs, the AR is attached to a specific claim that was previously paid.

The process is the same; however, as non-claim specific ARs, in that a reason code will also be assign to a claim specific AR, and a provider's future Medicaid payments will be reduced until the AR is satisfied.

With claim specific ARs, the CMS 64 line on which the original payment was made, is reduced to reflect returning the federal share. For, example, if an inpatient claim is adjusted to recoup payment, once the recoupment happens, the adjustment would be reflected in line 1A of the CMS 64.9.

Remit Payment Via Check:
Providers may repay overpayments in the form of a check. If a provider remits payment via check, an AR is still necessary to process the check. Under this method, instead of reducing a providers future Medicaid payments until the AR is satisfied, the AR is satisfied with the check.

In summary, the participant's eligibility for Medicaid Waiver services is controlled through the electronic case

management system which is linked to the Medicaid claims system. All services are approved within these systems by the operating agency. As part of the 90 day review, the care manager verifies with participant the appropriateness of services and monitors for delivery of service as prescribed in the plan of care. Modifications to the plan of care are made as necessary.

The State is currently in the design phase of a new integrated case management system which will mirror the functions previously described with added features and increased process automation. The implementation of the new system is slated for the fourth quarter of 2018. The case management system is getting closer to deployment. The final features to be available at launch and data migration are the only remaining items to be completed.

The State is offering an Open Choice Model for Electronic Visit Verification. The State is contracting with an EVV vendor that will allow providers with existing EVV vendors to continue to use those systems. Existing EVV vendors will report standardized aggregate data to the State operated EVV system. The A&D waiver services that will utilize EVV by January 1, 2021 are all forms of attendant care, unskilled respite care, Home and Community Assistance, and specialized medical equipment. This list of services is subject to change as the State moves toward the January 1, 2021 implementation date.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

◉ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- (●) ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ( ) ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ( ) ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- (●) ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ( ) ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ( ) ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- (●) ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ( ) ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- (●) ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ( ) ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

- (●) ***Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.*
- ( ) ***Applicable***

  Check each that applies:

  - [ ] ***Appropriation of Local Government Revenues.***

    Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

  - [ ] ***Other Local Government Level Source(s) of Funds.***

    Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- (●) ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ( ) ***The following source(s) are used***

  Check each that applies:

  - [ ] ***Health care-related taxes or fees***
  - [ ] ***Provider-related donations***
  - [ ] ***Federal funds***

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

The State of Indiana excludes Medicaid payment for room and board for individuals receiving services under the waiver. No room and board costs are figured into allowable provider expenses. There are provider guidelines for usual and customary fee, and the provider agreement states that a provider may only provide services for which the provider is certified. Waiver service providers are paid a fee for each type of direct service provided; no room and board costs are included in these fees.

Note: The waiver does not provide services in waiver group home settings. Participants are responsible for all room and board costs.

Based on the method for establishing the fee for each waiver service, the State of Indiana assures that no room and board costs are paid through Medicaid. Indiana provider audit procedures also review provider billing and all allowable costs to further assure no room and board payments are made

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing *(1 of 5)*

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants*

for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

- (●) ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ( ) ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] ***Nominal deductible***
- [ ] ***Coinsurance***
- [ ] ***Co-Payment***
- [ ] ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost*

sharing on waiver participants. Select one:

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	11861.57	21058.90	32920.47	68476.60	3496.91	71973.51	39053.04
2	13127.64	20263.59	33391.23	69469.13	3732.93	73202.06	39810.83
3	14276.98	20770.18	35047.16	71553.20	3826.26	75379.46	40332.30
4	17308.42	16603.74	33912.16	78180.41	4133.55	82313.96	48401.80
5	17616.65	16985.63	34602.28	80525.82	4228.63	84754.45	50152.17

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates *(1 of 9)*

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	27167		27167
Year 2	31885		31885
Year 3	35501		35501
Year 4	37604		40,609
Year 5	39201		47680

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

Number of Unduplicated Participants Served

The number of slots is proposed to increase for WY4 and WY 5 of the sixth renewal.
Projections rely on actual enrollment data through the first four months of WY4of the sixth renewal (July 2021 through September 2021).
For the rest of the WY4 and for WY 5of the sixth renewal new monthly enrollees are projected to continue increasing annually by 15%, consistent with historical experience.
Based on these assumptions the waiver will grow to 47,680 in WY 5 of the sixth renewal.

Projected average length of stay for WY 4 and WY 5 reflects actual experience through September 2021 in WY 4 of the sixth renewal. It is also consistent with new entrant projections used to estimate slots.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Factor D Derivation
Base Year data reflects experience from Waiver Year 3 of the sixth renewal: July 1, 2020 – June 30, 2021. Thebase year data was projected to WY 4 through WY 5 of the sixth renewal, second amendment in the following manner:

- *Number of users of each service was adjusted based on projected slots.*
- *Average units per user were projected to vary with average length of stay.*
- *Average cost per unit is inflated at an annual rate of 2.4% per year per year for WY4 and WY5.*
- *Average units per user of Attendant care services was increased to reflect the additional time required to take members to medical appointments. This is estimated to increase Attendant Care expenditures by 0.2%, or $0.6 million per year, as estimated by a prior analysis.*
- *Assisted Living reimbursement was increased by 3.9% effective July 1, 2021, with an additional temporary increase of 4.6% effective January 1, 2022, through June 30, 2022. This change was mandated by the HEA 1001.*
- *New Goal Engagement service to be effective July 1, 2021. Based on the input from the division, Factor D projections assume that between 5 and 10 members will be approved for the service every week with purchases related to changes in the home limited to $1,800 per participant per year.*
- *New Caregiving Coaching and Behavior Management service effective July 1, 2021. Based on the input from the division, Factor D projections assume that 1,500 individuals will utilize the service for 2 hours every month. Cost per unit is assumed to be $50 as an average hourly rate (including wages, benefit, and admin/overhead) based on the assumptions used to develop rates for Structured Family Caregiving Services.*

Cost per unit trend of 2.4% was estimated using the average of the Medical CPI-U and CPI-U over the recent 3 years (rounded) as waiver costs tend to trend midway between medical and non-medical costs. The assumption to utilize a 3-year average over 5-year average was based on the substantial change in the trajectory of the observation values due to the impact of the COVID-19 pandemic. Estimates of Factor D each waiver year are illustrated I the cost neutrality summary in section J-1.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Base Year data reflects experience from Waiver Year 3 of the sixth renewal: July 1, 2020 – June 30, 2021. Baseyear data was trended at 2.3% per year to reflect Medical CPI-U over the recent 3 years (rounded).In addition, for WY 4 a mandated increase of 6.9% for Home Health effective July 1, 2021 was incorporated, resulting ina WY 4 trend of 4.5%. Home health service expenditures represent almost half of state plan service expenditures for A&D waiver participants.

Estimates of Factor D' for each waier year are illustrated in the cost neutrality summary in section J-1.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Base year data reflects experience from WY 3 of the sixth renewal: July 1,2020 – June 30, 2021. Base year data was trended at 3.0% per year to reflect recent experience. Factor G for WY 3 also includes $1,127.7 million in Nursing Facility Upper Payment limit expenditures, contributing $33,950 to the base year Factor G.

Estimates of Factor G for each waiver year are illustrated in the cost neutrality summary in section J-1.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Base Year data reflects experience from WY 3 of the sixth renewal: July 1, 2020 – June 30, 2021. Base year data was trended at 2.3% per year to reflect Medical CPI-U over the recent 3 years (rounded).

Estimates of Factor G' for each waiver year are illustrated in the cost neutrality summary in section J-1.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Service	
Attendant Care	
Care Management	
Home and Community Assistance Service	
Respite	
Adult Family Care	
Assisted Living	
Community Transition	
Home Delivered Meals	
Home Modification Assessment	
Home Modifications	
Integrated Health Care Coordination	
Nutritional Supplements	
Participant Directed Home Care Service	
Personal Emergency Response System	
Pest Control	
Specialized Medical Equipment and Supplies	
Structured Family Caregiving	
Transportation	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:						7121725.17
Adult Day Service	1/4 Hour	899	2499.00	3.17	7121725.17	
Attendant Care Total:						107291686.32
Attendant Care	1/4 Hour	13732	1638.00	4.77	107291686.32	
Care Management Total:						31968674.32
Care Management	Monthly	26653	8.00	149.93	31968674.32	
Home and Community Assistance Service Total:						14456574.60
Home and Community Assistance Service	1/4 Hour	6691	554.00	3.90	14456574.60	
Respite Total:						26569562.31
Respite	1/4 Hour	3859	1017.00	6.77	26569562.31	
Adult Family Care Total:						1367230.02
Adult Family Care	Day	78	233.00	75.23	1367230.02	
Assisted Living Total:						71659259.62
Assisted Living	Day	4141	226.00	76.57	71659259.62	
Community Transition Total:						33898.62
Community Transition	Unit	43	1.00	788.34	33898.62	
Home Delivered Meals Total:						16911078.72
Home Delivered Meals	Meal	11208	268.00	5.63	16911078.72	
Home Modification						131025.66

GRAND TOTAL:	322243145.54
Total Estimated Unduplicated Participants:	27167
Factor D (Divide total by number of participants):	11861.57
Average Length of Stay on the Waiver:	270

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assessment Total:						
Home Modification Assessment	Unit	479	1.00	273.54	131025.66	
Home Modifications Total:						4441298.40
Home Modifications	Unit	990	1.00	4486.16	4441298.40	
Integrated Health Care Coordination Total:						20610.59
Health Care Coordination RN Service	1/4 Hour	29	71.00	10.01	20610.59	
Nutritional Supplements Total:						133228.32
Nutritional Supplements	Unit	272	87.00	5.63	133228.32	
Participant Directed Home Care Service Total:						0.00
Participant Directed Home Care Service	1/4 Hour	0	0.01	0.01	0.00	
Personal Emergency Response System Total:						4714814.79
Personal Emergency Response System	Unit	12663	9.00	41.37	4714814.79	
Pest Control Total:						286144.32
Pest Control	Unit	686	3.00	139.04	286144.32	
Specialized Medical Equipment and Supplies Total:						781830.72
Specialized Medical Equipment and Supplies	Unit	1221	2.00	320.16	781830.72	
Structured Family Caregiving Total:						31987846.44
Structured Family Caregiving	Day	2246	198.00	71.93	31987846.44	
Transportation Total:						2204090.56
Transportation	Trip	686	172.00	18.68	2204090.56	
Vehicle Modifications Total:						162566.04
Vehicle Modifications	Unit	52	1.00	3126.27	162566.04	

GRAND TOTAL:	322243145.54
Total Estimated Unduplicated Participants:	27167
Factor D (Divide total by number of participants):	11861.57
Average Length of Stay on the Waiver:	270

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:						8580218.40
Adult Day Service	1/4 Hour	1090	2523.00	3.12	8580218.40	
Attendant Care Total:						146281976.72
Attendant Care	1/4 Hour	16252	1793.00	5.02	146281976.72	
Care Management Total:						44715736.80
Care Management	Monthly	31176	10.00	143.43	44715736.80	
Home and Community Assistance Service Total:						18066826.50
Home and Community Assistance Service	1/4 Hour	7342	579.00	4.25	18066826.50	
Respite Total:						31700828.16
Respite	1/4 Hour	4672	912.00	7.44	31700828.16	
Adult Family Care Total:						1514281.36
Adult Family Care	Day	92	226.00	72.83	1514281.36	
Assisted Living Total:						86779561.70
Assisted Living	Day/Monthly	5270	221.00	74.51	86779561.70	
Community Transition Total:						36351.30
Community Transition	Unit	30	1.00	1211.71	36351.30	
Home Delivered Meals Total:						20635731.74
Home Delivered Meals	Meal				20635731.74	

GRAND TOTAL:	418574701.78
Total Estimated Unduplicated Participants:	31885
Factor D (Divide total by number of participants):	13127.64
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		12883	283.00	5.66		
Home Modification Assessment Total:						315400.50
Home Modification Assessment	Unit	1098	1.00	287.25	315400.50	
Home Modifications Total:						5481322.92
Home Modifications	Unit	1292	1.00	4242.51	5481322.92	
Integrated Health Care Coordination Total:						14838.72
Health Care Coordination RN Service	1/4 Hour	26	58.00	9.84	14838.72	
Nutritional Supplements Total:						228960.60
Nutritional Supplements	Unit	452	55.00	9.21	228960.60	
Participant Directed Home Care Service Total:						103643.10
Participant Directed Home Care Service	1/4 Hour	6	1653.00	10.45	103643.10	
Personal Emergency Response System Total:						5372133.84
Personal Emergency Response System	Unit	15363	8.00	43.71	5372133.84	
Pest Control Total:						360119.76
Pest Control	Unit	858	4.00	104.93	360119.76	
Specialized Medical Equipment and Supplies Total:						1812777.66
Specialized Medical Equipment and Supplies	Unit	1978	3.00	305.49	1812777.66	
Structured Family Caregiving Total:						43743986.50
Structured Family Caregiving	Day	3065	205.00	69.62	43743986.50	
Transportation Total:						2543810.40
Transportation	trip	786	180.00	17.98	2543810.40	
Vehicle Modifications Total:						286195.10

GRAND TOTAL:	418574701.78
Total Estimated Unduplicated Participants:	31885
Factor D (Divide total by number of participants):	13127.64
Average Length of Stay on the Waiver:	277

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Vehicle Modifications	Unit	62	1.00	4616.05	286195.10	

GRAND TOTAL:	418574701.78
Total Estimated Unduplicated Participants:	31885
Factor D (Divide total by number of participants):	13127.64
Average Length of Stay on the Waiver:	277

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:						10006449.42
Adult Day Service	1/4 Hour	1213	2586.00	3.19	10006449.42	
Attendant Care Total:						186248216.00
Attendant Care	1/4 Hour	18095	1838.00	5.60	186248216.00	
Care Management Total:						46613401.90
Care Management	Monthly	34711	10.00	134.29	46613401.90	
Home and Community Assistance Service Total:						24036952.50
Home and Community Assistance Service	1/4 Hour	8175	594.00	4.95	24036952.50	
Respite Total:						42401464.56
Respite	1/4 Hour	5201	936.00	8.71	42401464.56	
Adult Family Care Total:						1758745.60
Adult Family Care	Day	103	232.00	73.60	1758745.60	
Assisted Living Total:						100108621.00

GRAND TOTAL:	506847178.92
Total Estimated Unduplicated Participants:	35501
Factor D (Divide total by number of participants):	14276.98
Average Length of Stay on the Waiver:	284

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living	Monthly/Day	5867	226.00	75.50	100108621.00	
Community Transition Total:						41198.14
Community Transition	Unit	34	1.00	1211.71	41198.14	
Home Delivered Meals Total:						24918699.50
Home Delivered Meals	Meal	14345	290.00	5.99	24918699.50	
Home Modification Assessment Total:						380022.79
Home Modification Assessment	Unit	1223	1.00	310.73	380022.79	
Home Modifications Total:						6100729.38
Home Modifications	Unit	1438	1.00	4242.51	6100729.38	
Integrated Health Care Coordination Total:						17400.87
Health Care Coordination RN Service	1/4 Hour	29	59.00	10.17	17400.87	
Nutritional Supplements Total:						259943.04
Nutritional Supplements	Unit	504	56.00	9.21	259943.04	
Participant Directed Home Care Service Total:						427363.20
Participant Directed Home Care Service	1/4 Hour	6	6816.00	10.45	427363.20	
Personal Emergency Response System Total:						6728935.95
Personal Emergency Response System	Unit	17105	9.00	43.71	6728935.95	
Pest Control Total:						401252.32
Pest Control	Unit	956	4.00	104.93	401252.32	
Specialized Medical Equipment and Supplies Total:						2018983.41
Specialized Medical Equipment and Supplies	Unit	2203	3.00	305.49	2018983.41	
Structured Family Caregiving Total:						50877594.44

GRAND TOTAL:	506847178.92
Total Estimated Unduplicated Participants:	35501
Factor D (Divide total by number of participants):	14276.98
Average Length of Stay on the Waiver:	284

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Structured Family Caregiving	Day	3412	211.00	70.67	50877594.44	
Transportation Total:						2864190.00
Transportation	Trip	875	184.00	17.79	2864190.00	
Vehicle Modifications Total:						637014.90
Vehicle Modifications	Unit	69	2.00	4616.05	637014.90	
				GRAND TOTAL:		506847178.92
				Total Estimated Unduplicated Participants:		35501
				Factor D (Divide total by number of participants):		14276.98
				Average Length of Stay on the Waiver:		284

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:						6963684.12
Adult Day Service	1/4 Hour	879	2468.00	3.21	6963684.12	
Attendant Care Total:						277507707.12
Attendant Care	1/4 Hour	18879	2517.00	5.84	277507707.12	
Care Management Total:						52825357.80
Care Management	Monthly	38,466	10.00	137.33	52825357.80	
Home and Community Assistance Service Total:						18,454,184.32
Home and Community Assistance Service	1/4 Hour	6376	572.00	5.06	18454184.32	
Respite Total:						24407537.70
				GRAND TOTAL:		
				Total Estimated Unduplicated Participants:		
				Factor D (Divide total by number of participants):		
				Average Length of Stay on the Waiver:		

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	ComponentCost	Total Cost
Respite	1/4 Hour	2127	1183.00	9.70	24407537.70	
Adult Family Care Total:						937665.96
Adult Family Care	Day	57	218.00	75.46	937665.96	
Assisted Living Total:						153349955.85
Assisted Living	Monthly/Day	7449	131.00	157.15	153349955.85	
Community Transition Total:						186550.56
Community Transition	Unit	199	1.00	937.44	186550.56	
Home Delivered Meals Total:						30012290.28
Home Delivered Meals	Meal	17087	287.00	6.12	30012290.28	
Home Modification Assessment Total:						679438.15
Home Modification Assessment	Unit	2143	1.00	317.05	679438.15	
Home Modifications Total:						8495929.62
Home Modifications	Unit	1389	1.00	6116.58	8495929.62	
Integrated Health Care Coordination Total:						3,596101.60
Health Care Coordination RN Service	1/4 Hour	2444	140.00	10.51	3,596101.60	
Nutritional Supplements Total:						612773.28
Nutritional Supplements	Unit	954	28.00	22.94	612773.28	
Participant Directed Home Care Service Total:						877331.28
Participant Directed Home Care Service	1/4 Hour	6	11956.00	12.23	877331.28	
Personal Emergency Response System Total:						7056663.84
Personal Emergency Response System	Unit	169869	9.00	46.16	7056663.84	
Pest Control Total:						937,815.20
Pest Control	Unit				937,815.20	

GRAND TOTAL:

Total Estimated Unduplicated Participants:

Factor D (Divide total by number of participants):

Average Length of Stay on the Waiver:

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		1190	4.00	197.02		
Specialized Medical Equipment and Supplies Total:						**2036565.60**
Specialized Medical Equipment and Supplies	Unit	2018	3.00	336.40	**2036565.60**	
Structured Family Caregiving Total:						**108167784.96**
Structured Family Caregiving	Day	6001	256.00	70.41	**108167784.96**	
Transportation Total:						**2451363.95**
Transportation	Trip	721	1283.00	2.65	**2451363.95**	
Vehicle Modifications Total:						**818,757.45**
Vehicle Modifications	Unit	161	1.00	5085.45	**818,757.45**	
Goal Engagement	Unit	390	8.00	225.00		702,000.00
Caregiver Coaching & Behavior Management Support	Hours	1500	24	50.00		1,800,000.00

GRAND TOTAL:	**702877458.64**
Total Estimated Unduplicated Participants:	**40609**
Factor D (Divide total by number of participants):	**17308.42**
Average Length of Stay on the Waiver:	284

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:						**8384545.92**
Adult Day Service	1/4 Hour	1032	2477.00	3.28	**8384545.92**	
Attendant Care Total:						**334828069.68**
Attendant Care	1/4 Hour	22166	2526.00	5.98	**334828069.68**	

Care Management Total:						***63509616.80***
Care					***63509616.80***	

GRAND TOTAL:

Total Estimated Unduplicated Participants:

Factor D (Divide total by number of participants):

Average Length of Stay on the Waiver:

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Management	Monthly	45,164	10.00	140.62		
Home and Community Assistance Service Total:						22261246.84
Home and Community Assistance Service	1/4 Hour	7487	574.00	5.18	22261246.84	
Respite Total:						29443701.18
Respite	1/4 Hour	2498	1187.00	9.93	29443701.18	
Adult Family Care Total:						1133782.71
Adult Family Care	Day	67	219.00	77.27	1133782.71	
Assisted Living Total:						177349988.64
Assisted Living	Monthly/Day	8746	132.00	153.62	177349988.64	
Community Transition Total:						224625.96
Community Transition	Unit	234	1.00	959.94	224625.96	
Home Delivered Meals Total:						36227157.12
Home Delivered Meals	Meal	20,062	288.00	6.27	36227157.12	
Home Modification Assessment Total:						224625.96
Home Modification Assessment	Unit	2516	1.00	324.66	224625.96	
Home Modifications Total:						10215572.78
Home Modifications	Unit	1631	1.00	6263.38	10215572.78	
Integrated Health Care Coordination Total:						4354249.20
Health Care Coordination RN Service	1/4 Hour	2870	141.00	10.76	4354249.20	
Nutritional Supplements Total:						736646.40
Nutritional Supplements	Unit	1120	28.00	23.49	736646.40	
Participant Directed Home Care Service Total:						901289.76
Participant Directed Home	1/4 Hour				901289.76	

GRAND TOTAL:

Total Estimated Unduplicated Participants:

Factor D (Divide total by number of participants):

Average Length of Stay on the Waiver:

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care Service		6	11998.00	12.52		
Personal Emergency Response System Total:						8484775.92
Personal Emergency Response System	Unit	19944	9.00	47.27	8484775.92	
Pest Control Total:						1127379.00
Pest Control	Unit	1397	4.00	201.75	1127379.00	
Specialized Medical Equipment and Supplies Total:						2448219.36
Specialized Medical Equipment and Supplies	Unit	2369	3.00	344.48	2448219.36	
Structured Family Caregiving Total:						130560266.20
Structured Family Caregiving	Day	7046	257.00	72.10	130560266.20	
Transportation Total:						2961541.44
Transportation	Trip	846	1287.00	2.72	2961541.44	
Vehicle Modifications Total:						984,217.50
Vehicle Modifications	Unit	189	1.00	5207.50	984,217.50	
Goal Engagement	Unit	458	8.00	230.40	844,185.60	
Caregiver Coaching and Behavior Management Support	Hours	1761	24.00	51.20	2163916.80	

GRAND TOTAL:	839961839.37
Total Estimated Unduplicated Participants:	47680
Factor D (Divide total by number of participants):	17616.65
Average Length of Stay on the Waiver:	285