

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:

Traumatic Brain Injury Waiver

C. Waiver Number: IN.4197

Original Base Waiver Number: IN.40197.90

D. Amendment Number: IN.4197.R05.01

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

07/01/23

Approved Effective Date: 07/01/23

Approved Effective Date of Waiver being Amended: 01/01/23

2. Purpose(s) of Amendment

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

In state fiscal year (SFY) 2023, Indiana's Family and Social Services Administration (FSSA) completed a rate review (rate study) for the Traumatic Brain Injury (TBI) waiver. FSSA conducted a provider survey to capture the current provider experience of delivering the applicable waiver services, service specific workgroups, and all provider meetings.

APPENDIX I

- Appendix I-2-a updated to reflect FSSA's state fiscal year 2023 rate review/rate study

APPENDIX J

- J-1 - updated to reflect rate increases for waiver years 1-5
 - J-2-a - updated to reflect rate increases for waiver years 1-5
 - J-2-d - updated to reflect rate increases for waiver years 1-5

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	<input type="text"/>
Appendix A Waiver Administration and Operation	<input type="text"/>
Appendix B Participant Access and Eligibility	<input type="text"/>
Appendix C Participant Services	<input type="text"/>
Appendix D Participant Centered Service Planning and Delivery	<input type="text"/>
Appendix E Participant Direction of Services	<input type="text"/>
Appendix F Participant Rights	<input type="text"/>
Appendix G Participant Safeguards	<input type="text"/>
Appendix H	<input type="text"/>
Appendix I Financial Accountability	I-2-a
Appendix J Cost-Neutrality Demonstration	J-1, J-2-a, J-2-d

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:

Updated rate information in Appendix I-2-a.

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):

Traumatic Brain Injury 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.40197

Waiver Number: IN.4197.R05.01

Draft ID: IN.002.05.01

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 01/01/23

Approved Effective Date of Waiver being Amended: 01/01/23

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 in 42 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:

Waiver participants must meet the minimal LOC requirements for that of a nursing facility (NF) and have a diagnosis of Traumatic Brain Injury.

Indiana defines a traumatic brain injury as a trauma that has occurred as a closed or open head injury by an external event that results in damage to brain tissue, with or without injury to other body organs. Examples of external agents are: mechanical; or events that result in interference with vital functions. Traumatic brain injury means a sudden insult or damage to brain function, not of a degenerative or congenital nature. The insult or damage may produce an altered state of consciousness and may result in a decrease in cognitive, behavioral, emotional, or physical functioning resulting in partial or total disability not including birth trauma related injury.

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:

Waiver participants must meet the minimal LOC requirements for that of an intermediate care facility for individuals with Intellectual Disabilities (ICF/IID) and have a diagnosis of Traumatic Brain Injury.

Indiana defines a traumatic brain injury as a trauma that has occurred as a closed or open head injury by an external event that results in damage to brain tissue, with or without injury to other body organs. Examples of external agents are: mechanical; or events that result in interference with vital functions. Traumatic brain injury means a sudden insult or damage to brain function, not of a degenerative or congenital nature. The insult or damage may produce an altered state of consciousness and may result in a decrease in cognitive, behavioral, emotional, or physical functioning resulting in partial or total disability not including birth trauma related injury.

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 Eligibility 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 amendment is requested in order to continue to provide home and community-based services to individuals who, but for the provision of such services, would require institutional care. Through the use of the Traumatic Brain Injury Waiver (TBI), Indiana's Family and Social Services Administration's (FSSA) Office of Medicaid Policy and Planning (OMPP) and the Division of Aging (DA) seek to increase availability and access to cost-effective traumatic brain injury waiver services to people who have suffered a traumatic brain injury.

Based on language approved in the Appendix K amendment associated with this waiver, due to the COVID pandemic, a quality review report was not completed for the previous waiver cycle. Additionally, 372 reports due during the emergency have not been submitted. Upon expiration of the Appendix K amendment, Indiana will gather data and submit the quality review in addition to any outstanding 372 report (s) as quickly as the required information can be gathered and analyzed. If necessary, the state will submit waiver amendments based on identified deficiencies in the quality review report and/or 372 report(s) within 90 days of receiving the final quality review report and 372 report acceptance decision.

Indiana defines a traumatic brain injury as a trauma that has occurred as a closed or open head injury by an external event that results in damage to brain tissue, with or without injury to other body organs. Examples of external agents are mechanical; or events that result in interference with vital functions. Traumatic brain injury means a sudden insult or damage to brain function, not of a degenerative or congenital nature. The insult or damage may produce an altered state of consciousness and may result in a decrease in cognitive, behavioral, emotional, or physical functioning resulting in partial or total disability not including birth trauma related injury.

Goals: Indiana's fundamental goal is to ensure that individuals with a traumatic brain injury receive appropriate services based on their needs and the needs of their families.

This 5-year amendment anticipates serving the following unduplicated participants:

Year 1 (2023)	200
Year 2 (2024)	200
Year 3 (2025)	200
Year 4 (2026)	200
Year 5 (2027)	200

Organizational Structure: The Family Social Services Administration (FSSA) is the Single State Medicaid Agency. The Indiana Division of Aging, a division under the FSSA, has been given the authority to administer the TBI Waiver. The Office of Medicaid Policy and Planning (OMPP) also a division under the FSSA has been given the administrative authority for the TBI waiver by the FSSA. The Indiana Division of Aging performs the daily operational tasks of the waiver.

Person Centered Support Planning:

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

No

Yes

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

Geographic Limitation. A waiver of statewide requirements 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 statewide requirements 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:

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 inpatients 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:

The Indiana Family and Social Service Administration (FSSA) Office of Medicaid Policy and Planning (OMPP) and the Division of Aging (DA) is seeking public input for renewing the Traumatic Brain Injury waiver. FSSA intends to submit a waiver renewal for the Traumatic Brain Injury waiver to the Centers for Medicare and Medicaid Services (CMS) for consideration. The current waiver expiration date is December 31, 2022.

The 30-day public comment period for this waiver renewal will run from August 3, 2022 and is extended until September 30, 2022. The renewal is provided in the following public notice formats:

1. A copy is posted on the on the FSSA's Division of Aging Draft Policies for Public Comment webpage site at <http://www.in.gov/fssa/da/3476.htm>.
2. A non-electronic notice is provided via the Indiana Register at <http://iac.iga.in.gov/iac//20220803-IR-405220236ONA.xml.pdf>.
3. Paper copies of the amendment are available upon request at local Division of Family Resources offices as well as local Area Agency on Aging offices.

Comments may be submitted electronically via email to DAComments@fssa.IN.gov and/or via mail to:

FSSA–Division of Aging

RE: TBI Renewal Public Comment

402 West Washington Street, Room W454

P.O. Box 7083

Indianapolis, IN 46027

Comments for this waiver renewal will be accepted until 4:30 EST Friday September 30, 2022.

Summary of Public Comments

FSSA received a total of three comments. FSSA staff received one comment from a Medicaid member requesting assistance with program service navigation. This comment was submitted under the subject of public notice regarding the TBI waiver but did not directly address the TBI waiver renewal. FSSA staff provided the needed assistance. FSSA staff received two comments requesting the addition of reimbursement for a Home Modification Assessment service to the TBI waiver. The request is under consideration by FSSA staff and if a determination is made to cover this service, it will be addressed in a future waiver amendment as applicable. No changes were made to the TBI waiver renewal request in response to the comments received.

Indiana Medicaid Tribal Consultation Notification – FSSA and DA 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. The applicable tribal consultation notice and waiver renewal documents were sent to the Tribal Government on July 20, 2022, to begin the 60-day tribal consultation period that was conducted until September 19, 2022. Per the tribal consultation notice, FSSA and DA staff offered to provide an in-person or phone consultation.

On July 27, 2022, FSSA and DA staff followed-up with the Tribal Government to confirm they received the tribal consultation notice and the full TBI renewal document. The Tribal Government confirmed receipt.

No comments were received from the Tribal Government.

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:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Indiana**

Zip:

Phone: **Ext:** **TTY**

Fax:

E-mail:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Indiana**

Zip:

46204

Phone:

(317) 232-1246

Ext:

TTY

Fax:

(317) 233-2182

E-mail:

leslie.huckleberry@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:

BRIAN GILBERT

State Medicaid Director or Designee

Submission Date:

Aug 17, 2023

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:

Family & Social Services Administration, Office of Medicaid Planning and Policy

Address:

402 West Washington Street, Room W374 (MS07)

Address 2:

City:

Indianapolis

State:

Indiana

Zip:

46204

Phone:

(317) 234-8725

Ext:

TTY

Fax:

(317) 232-7382

E-mail:

Attachments

allison.taylor@fssa.in.gov

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 Following Addendum is added per CMS Directive

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.

04/12/2024

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 Division of Aging (DA), a division under the single State Medicaid agency. The 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 FSSA
- 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

FSSA's OMPP:

- 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 its 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 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 Indiana Health Coverage Programs (IHCP) Provider and Member Utilization Review provider reference module.

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 its 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 its 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 through their qualified case managers are responsible for preparing a written service plan for each individual waiver 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. All services will be furnished pursuant to a written service plan. The service plan will be subject to the approval of the Division of Aging. Federal Financial Participation (FFP) will not be claimed for waiver services furnished prior to the development of the service plan. FFP will not be claimed for waiver services which are not included in the individual written service plan.

Each of the sixteen (16) Area Agencies on Aging 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 a written service plan for each individual waiver 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. All services will be furnished pursuant to a written service plan. The service plan will be subject to the approval of the Division of Aging and/or the Office of Medicaid Policy and Planning. Federal Financial Participation (FFP) will not be claimed for waiver services furnished prior to the development of the service plan. FFP will not be claimed for waiver services which are not included in the individual written 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 and the Person-Centered Monitoring Tool (PCMT).
- 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 Area Agencies on Aging and are audited by the Indiana State Board of Accounts and the Family and Social Services Administration'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 provider relations specialist forwards complaints about the timeliness or performance of the Fiscal Contractor to the FSSA Director of Provider Relations.

FSSA Compliance exercises oversight and monitoring of the deliverables stipulated within the Fraud and Abuse Detection System (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 Compliances oversees the contractor's aggregate data to identify common problems, determine benchmarks, and offer data to providers to compare against aggregate data.

During 2011, the State of Indiana formed the Benefit Integrity Team comprised of both state and contract staff. This team meets biweekly to review and approve audit plans, provider communications and make policy recommendations to affected program areas.

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 State Medicaid Agency oversees the contracting Medicaid Fiscal Agent's monthly reports of reviews. Oversight of the Fiscal Agent also involves the DA. The DA's Provider Relations Specialist position monitors the Fiscal Contractor and assures that providers are appropriately enrolled through the Medicaid fiscal agent. The required Waiver Enrollments and Updates Weekly Report is sent by the fiscal agent to the Provider Relations Specialist. Providers are to be enrolled by the dedicated fiscal agent within an average 30 calendar days from receipt of the completed provider agreement paperwork.

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 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			
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):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Specify: <input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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):

Financial records (including expenditures)

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100%

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="Fiscal Contractor"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text" value="Fiscal Contractor"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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:** Total number of providers assigned a Medicaid provider number.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="fiscal contractor"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
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: <input data-bbox="325 479 748 524" type="text" value="fiscal contractor"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="820 723 1243 801" type="text"/>

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 meet at least monthly with the 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 the 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.

FSSA 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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	
		Disabled (Physical)	<input type="checkbox"/>	<input type="checkbox"/>	
		Disabled (Other)	<input type="checkbox"/>	<input type="checkbox"/>	
Aged or Disabled, or Both - Specific Recognized Subgroups					

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Brain Injury	0		
		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:

Waiver participants must meet the minimal Level of Care (LOC) requirements for that of a nursing facility (NF) or intermediate care facility for the Individuals with Intellectual Disabilities (ICF/IID) and have a diagnosis of Traumatic Brain Injury.

Indiana defines a traumatic brain injury as a trauma that has occurred as a closed or open head injury by an external event that results in damage to brain tissue, with or without injury to other body organs. Examples of external agents are mechanical, or events that result in interference with vital functions. Traumatic brain injury means a sudden insult or damage to brain function, not of a degenerative or congenital nature. The insult or damage may produce an altered state of consciousness and may result in a decrease in cognitive, behavioral, emotional, or physical functioning resulting in partial or total disability not including birth trauma related injury.

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:

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	200
Year 2	200
Year 3	

Waiver Year	Unduplicated Number of Participants
	200
Year 4	200
Year 5	200

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	<input type="text"/>
Year 2	<input type="text"/>
Year 3	<input type="text"/>
Year 4	<input type="text"/>
Year 5	<input type="text"/>

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).

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 Traumatic Brain Injury 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

SSI recipients

Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121

Optional state supplement recipients

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)

Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIA 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:

Sec. 1902(a)(10)(A)(i)(I) - Children receiving Adoption Assistance or Children receiving Federal Foster Care Payments under Title IV E Sec 1902(a)(10)(A)(i)(IX) Former Foster Care children
 Sec 1902(a)(10)(A)(ii)(VIII) Children receiving adoption assistance under a state adoption agreement Sec 1902(a)(10)(A)(ii)(XVII) Independent Foster Care Adolescents
 42 CFR 435.118 - Infants and children under age 19 Sec 1925 of the Act --Transitional Medical Assistance 42 CFR 435.116 - Pregnant Women
 42 CFR 435.110 - Parents and Other Caretaker Relatives

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:

[Empty text box]

Other

Specify:

[Empty text box]

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:

[Empty text box]

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:

[Empty text box]

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.

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 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 (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-5-a 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 that you do not need to complete this section and therefore this section is not visible.

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:

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:

[Empty text box]

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:

[Empty text box]

Other

Specify:

All initial evaluations are completed by the Area Agency on Aging (AAA) care manager and determinations are rendered by the care manager supervisor. All initial level of care approvals are reviewed and verified by the operating Agency- Division of Aging (DA) staff prior to service implementation.

Re-evaluations completed by 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

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 Area Agency on Aging (AAA) care manager and determinations are rendered by the care manager supervisor.

Care managers performing level of care evaluations and care management supervisors must meet all care management qualifications as detailed in Appendix C and have received training in the nursing facility level of care process by the Division of Aging or their 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 TBI Waiver are first screened for nursing facility (NF) level of care. Any individuals identified to have suffered the brain injury prior to age 22 may meet intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care. Screening for ICF/IID level of care will then be completed for these individuals.

Nursing Facility (NF)

Indiana has established the Eligibility Screen (E-Screen) , a tool that is used to determine basic level of care criteria that identifies nursing facility level of care (405 IAC 1-3). The Eligibility Screen along is required to be completed by the care manager as part of the LOC 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 or if the participant does not have a diagnosis of Traumatic Brain Injury (TBI). Initially, the individual's physician must complete the Physician Certification for Long Term Care (450B). The 450B includes the physician recommendation regarding the safety and feasibility of the individual to receive home and community-based services. Care managers complete an interRAI-HC assessment tool that aids in the discovery of the information needed for completion of the E-screen.

Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID)

Any individuals identified to have suffered the brain injury prior to age 22 may meet ICF/ID level of care, which is assessed using the Level of Care Screening Tool. To complete an ICF/IID waiver level of care determination, operating agency staff, or the provider of Care Management must obtain and review the following:

- 1) Psychological records including I.Q. score;
- 2) Social assessment records;
- 3) Medical records;
- 4) Additional records necessary to have a current and valid reflection of the individual; and
- 5) A completed 450B Confirmation of Diagnosis form, signed and dated by a physician within the past year.

If collateral records are not available or are not a valid reflection of the individual, additional assessments may be obtained from psychologists, physicians, nurses and licensed social workers.

The BDDS Central Office or Case Manager (re-evaluations) reviews the LOC Screening Tool and collateral material, applicable to individuals with intellectual disability*, developmental disability and other related conditions, in order to ascertain if the individual meets ICF/ID LOC.

An applicant/participant must meet three of six substantial functional limitations and each of four basic conditions (listed below) in order to meet LOC.

The substantial functional limitation categories, as defined in 42 CFR 435.1010, are: 1)self-care, 2)learning, 3)self-direction, 4)capacity for independent living, 5)receptive and expressive language, and 6)mobility.

The basic conditions are: 1)intellectual disability*, cerebral palsy, epilepsy, autism, or condition similar to intellectual disability*, 2)the condition identified in #1 is expected to continue, 3)the condition identified in #1 had an age of onset prior to age 22, and 4)the applicant needs a combination or sequence of services.

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 to the TBI Waiver are first screened for nursing facility (NF) level of care. Any individuals identified to have suffered the brain injury prior to age 22 may meet intermediate care facility for the intellectually disabled (ICF/ID) level of care. Screening for ICF/ID level of care will then be completed for these individuals.

All applicants for the Waiver are evaluated to assure that level of care (LOC) is met prior to receiving services. Waiver participants must meet the minimal LOC requirements for that of a nursing facility (NF) or Intermediate care facility for individuals with intellectual disability (ICF/ID) and have a diagnosis of Traumatic Brain Injury. All initial evaluations are completed by the Area Agency on Aging (AAA) care manager and determinations are rendered by the care manager supervisor. Indiana has established the Eligibility Screen, a tool that is used to determine basic level of care criteria that identifies nursing facility level of care (405 IAC 1-3). The Eligibility Screen along with the additional TBI specific information (Explain what happened; When did it happen; Specific quantifiable dysfunctions; How does dysfunction differ from pre-injury; Level of care comments) is required to be completed by the care manager as part of the LOC packet. Initially, the individual's physician must complete the Physician Certification for Long Term Care (450B). The 450B includes the physician recommendation regarding the safety and feasibility of the individual to receive home and community-based services.

Any individuals identified to have suffered the brain injury prior to age 22 may meet ICF/ID level of care, which is assessed using the Level of Care Screening Tool.

LOC evaluations are structured and monitored to assure that decisions are appropriately rendered. The waiver database contains certain edits and audits that prevent submission of an initial plan of care until all LOC requirements are met. The DA investigates and resolves plan of care and level of care issues prior to making final decision.

RE-EVALUATIONS

LOC evaluations are made as part of the individual's annual waiver renewal process or more often if there is a significant change in the individual's condition which impacts LOC.

The above mentioned documents are the same for LOC re-evaluation process, except the 450B is not required. In addition, all LOC re-evaluations for clients managed by the Area Agency on Aging (AAA) are completed by the Area Agency supervisors meet all care management qualifications as detailed in Appendix C and have received training in the nursing facility (NF) and intermediate care facility for the intellectually disabled (ICF/IID) level of care process by the Division of Aging or designee.

For those participants who have chosen to be case managed by non-AAA care managers the LOC re-evaluation decisions are required to be reviewed by and a decision rendered by designated staff members within the Division of Aging (DA). Designated staff members within the DA meet all care management qualifications as detailed in Appendix C and have received training in the nursing facility (NF) and intermediate care facility for individuals with intellectual disability (ICF/IID) level of care process by the Division of Aging or designee.

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 Division of Aging is using a reporting tool that generates a report at least sixty (60) calendar days prior to the annual level of care (LOC) reevaluation to advise care managers that reviews are due. The report was designed to establish trends and needed education regarding annual level of care.

Notifying the care managers at least sixty (60) calendar 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) calendar 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 LOC reevaluation and notifies the care managers that the reevaluation is due within fifteen (15) calendar days. If the reevaluation is not received by the DA within fifteen (15)calendar days of notification, the DA requires a corrective action from the delinquent care manager.

- 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 evaluations and reevaluation documentation is maintained for a minimum of three years within the electronic care management database within the Division of Aging.

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 Level of Care (LOC) evaluation prior to enrollment. Numerator: Number of new enrollees who received a LOC 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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
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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: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

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.

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:

Electronic Case Management Database System

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 1191 1264 1272" type="text"/>
Other Specify: <input data-bbox="408 1415 647 1496" type="text"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1415 1264 1496" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1639 1264 1720" type="text"/>
	Other Specify: <input data-bbox="718 1863 954 1944" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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.

LOC determinations are facilitated through a module in the electronic Care Management application referred to as the E-Screen. This tool is structured to assure that LOC criteria is consistently applied and other automated features prevent service plan approval prior to LOC approval, and provide prompts to assure redeterminations are conducted timely. Additionally, discovery reports are monitored by the Division of Aging (DA) Quality Assurance Unit to identify any individual instances of non-compliance, which are remediated individually and analyzed for systemic issues. Specific remediation processes are identified for instances of non-compliance for each performance measure. All documentation of resolution activities will be maintained within the electronic care management database. Care managers complete an interRAI-HC assessment tool that aids in the discovery of the information needed for completion of the E- screen.

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.

If redetermination reveals that the individual does not meet one of the approved LOC categories, any claims submitted will be denied back to the date of expiration of the prior LOC period. The care manager will be advised to refer the individual for any other services which may be available and the individual 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 LOC determination decision.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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 the waiver services available to the individual requesting services. The care manager assesses the individual 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 individual.

"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 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 Division of Aging.

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):

The Family and Social Services Administration and the Division of Aging address the needs of individuals with limited English in a variety of ways:

- Public informational materials regarding TBI waiver services will be available in Spanish and English.
- The care manager identifies the individual'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:
 - (a) bilingual staff, contractual interpreters, telephone interpreters; or
 - (b) 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. An individual 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 Services		
Statutory Service	Attendant Care		
Statutory Service	Care Management		
Statutory Service	Home and Community Assistance		
Statutory Service	Residential Based Habilitation		
Statutory Service	Respite		
Statutory Service	Structured Day Program		
Statutory Service	Supported Employment		
Other Service	Adult Family Care		

Service Type	Service		
Other Service	Assisted Living		
Other Service	Behavior Management/ Behavior Program and Counseling		
Other Service	Community Transition		
Other Service	Home Delivered Meals		
Other Service	Home Modifications		
Other Service	Integrated Health Care Coordination		
Other Service	Nutritional Supplements		
Other Service	Personal Emergency Response System		
Other Service	Pest Control		
Other Service	Specialized Medical Equipment and Supplies		
Other Service	Transportation		
Other Service	Vehicle Modifications		

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 Services

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:

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

ADS Provider:

- Attendance record documenting the date of service and the number of units of service delivered that day
- Provide documentation to the participant's care manager of the person centered service plan on a quarterly basis or as updated according to changes in participant's needs.

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 Services

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 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 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 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:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Attendant Care

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:

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 Activities of Daily Living (ADLs). ATTC is provided to participants with either nursing facility or ICF/IID level of care needs.

ALLOWABLE ACTIVITIES

All non-skilled ADL care as identified in the Person Centered Assessment (PCA) that includes 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 community activities. Out of State transportation is limited to 50 miles of State geographic limits. Escorting does not include costs that are not associated with the provision of personal care, for example mileage.

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 his/her SSN and operating without employees.

•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 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 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 care manager must document how the skilled need is being met and by whom. If ATTC is being requested for an individual with skilled care, the documentation must describe who will be providing ATTC, the frequency of care and activities being performed.

•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:

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 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, 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):

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

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:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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 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 his/her circle of support. The assessment and planning phase, 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:

- 1)Notifying all providers about the change and when they are to begin or end services.
- 2)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:

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 managers will engage the participant and his/her 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 discovering the participants strengths, needs, goals, and preferences. The care manager will appropriately facilitate the assessment process to engage the individual and his/her circle of support. The assessment and planning phase can include, 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 incident reports timely.

The care manager will be responsible to evaluate the effectiveness of all services. Evaluation is demonstrated through:

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 his/her ability to make choices concerning all services they receive. This includes care management services. In the event the individual chooses another care manager agency the current care management agency is to fully assist the individual in his/her transition, to the new agency or individual care manager 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 care 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
Agency	FSSA/DA approved Care Management Agency
Individual	FSSA/ DA approved Care Management Individual

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 Care Management Agency

Provider Qualifications

License *(specify):*

[Empty box]

Certificate (specify):

[Empty box]

Other Standard (specify):

DA, or its designee, approved
 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 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 455 IAC 2 Maintenance of records of services provided
 455 IAC 2 Individual’s personal file; site of service delivery 455 IAC 2 Care Management

Education and work experience
 -An individual continuously employed as a care manager by an AAA since June 30, 2018
 -Bachelor’s degree in any field; or
 -Master's degree in any field; or.
 -Associate’s degree in nursing
 -Associate’s degree in any field with a minimum of four year full-time, direct service experience with the elderly or disabled (this experience includes assessment, care plan development, and monitoring).

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:

Individual

Provider Type:

FSSA/ DA approved Care Management Individual

Provider Qualifications

License (specify):

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: 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

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:

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

ALLOWABLE ACTIVITIES:

Provides IADL care that may include 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
- assistance with outdoor tasks including raking leaves, snow removal, lawn mowing, weeding,
- *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

SERVICE STANDARDS

- Care Manager Standards:
- Care manager will document through the Person Centered Assessment (PCA) the need for Home and Community Assistance, the frequency of need, the required type of Home and Community Assistance activities.

DOCUMENTATION STANDARDS

Care Manager Documentation Standards:

- Care manager will document through the PCA the need for Home and Community Assistance, the frequency of need, the required type of Home and Community and Assistance 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's 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 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, 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	Licensed Personal Services Agency
Individual	FSSA/DA approved Home and Community Assistance Individual

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Home and Community Assistance

Provider Category:

Agency

Provider Type:

Licensed Home Health Agency

Provider Qualifications

License (*specify*):

IC 16-27-1

IC 16-27-4

Certificate (*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

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: Home and Community Assistance

Provider Category:

Individual

Provider Type:

FSSA/DA approved Home and Community Assistance Individual

Provider Qualifications

License (specify):

[Empty text box]

Certificate (specify):

[Empty text box]

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: 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:

Residential Habilitation

Alternate Service Title (if any):

Residential Based Habilitation

HCBS Taxonomy:

Category 1:

[Empty text box]

Sub-Category 1:

[Empty text box]

Category 2:

[Empty text box]

Sub-Category 2:

[Empty text box]

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Residential Based Habilitation service provides training to regain skills that were lost secondary to the traumatic brain injury.

ALLOWABLE ACTIVITIES

Goal oriented training and demonstration with:

1.Skills related to activities of daily living:

- personal grooming;
- bed making and household chores; and
- planning meals, the preparation of food.

2.Skills related to living in the community:

- using the telephone
- learning to prepare lists and maintaining calendars of essential activities and dates, and other organizational activities to improve memory;
- handling money and paying bills;
- shopping and errands;
- accessing public transportation;

SERVICE STANDARDS

- Residential Based Habilitation services must follow a written service plan addressing specific measurable goals and objectives to help with the acquisition, retention, or improvement of skills that were lost secondary to the TBI.
- Residential Based Habilitation services must be monitored monthly.

DOCUMENTATION STANDARDS

- Identified need in the service plan
- Services outlined in the service plan
- Data record of services provided, including:
 - complete date and time of service (in and out)
 - specific services/tasks provided
 - monthly documentation of progress toward identified goals
 - 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 of the individual must also be included.
- Each staff member providing direct care or supervision of care to the individual must make at least one entry on each day of service. All entries should describe an issue or circumstance concerning the individual.
- 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:

NOTE: Services provided through Residential Based Habilitation service will not duplicate services provided under the Medicaid State Plan or any other waiver service.

ACTIVITIES NOT ALLOWED

- Payments for residential based habilitation are not made for room and board
- Payment for residential based habilitation does not include payments made directly or indirectly 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
- Payments will not be made for the routine care and supervision
- Residential Based Habilitation services to participants receiving Adult Family Care 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 Residential Based Habilitation Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Residential Based Habilitation

Provider Category:

Agency

Provider Type:

FSSA/DA approved Residential Based Habilitation Agency

Provider Qualifications

License (specify):

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

Habilitation services must be performed by persons who are supervised by a Certified Brain Injury Specialist (CBIS), a Qualified Mental Retardation Professional (QMRP), a Qualified Intellectual Disability Professional (QIDP), or a physical, occupational, or speech therapist licensed by the state of Indiana and have successfully completed training or have experience in conducting habilitation programs.

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):

Respite

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:

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

ALLOWABLE ACTIVITIES

- Home health aide services (RHHA)
- *Skilled nursing services (RNUR)

SERVICE STANDARDS

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.

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

RNUR 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.

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, 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:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Structured Day Program

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:

Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home in which the individual resides. Services shall normally be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week unless provided as an adjunct to other day activities included in an individual's service plan.

SERVICE STANDARDS

- Structured Day Program services must follow a written service plan addressing specific needs determined by the individual's assessment
- Structured Day Program services shall focus on enabling the individual to attain or maintain his or her functional level
- Structured Day Program services may serve to reinforce skills or lessons taught in school, therapy, or other settings

DOCUMENTATION STANDARDS

- Identified need in the service plan
- Services outlined in the service plan
- Data record of services provided, including:
 - complete date and time of service (in and out)
 - specific services/tasks provided
 - 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 of the individual must also be included.
- Each staff member providing direct care or supervision of care to the individual must make at least one entry on each day of service. All entries should describe an issue or circumstance concerning the individual.

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

NOTE: Services provided through Structured Day Program will not duplicate any service provided under the Medicaid State Plan or other 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 Structured Day Program Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Structured Day Program

Provider Category:

Agency

Provider Type:

FSSA/DA approved Structured Day Program Agency

Provider Qualifications

License (specify):

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

Habilitation services must be performed by persons who are supervised by a Certified Brain Injury Specialist (CBIS), a Qualified Mental Retardation Professional (QMRP), a Qualified Intellectual Disability Professional (QIDP), or a physical, occupational, or speech therapist licensed by the state of Indiana and have successfully completed training or have experience in conducting habilitation programs.

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:

Supported Employment

Alternate Service Title (if any):

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:

Supported Employment services consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported Employment is conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Supported Employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training.

SERVICE STANDARDS

- Supported Employment services must follow a written service plan addressing specific needs determined by the individual's assessment.
- When Supported Employment services are provide at a worksite where persons without disabilities are employed, payment will only be made for the adaptation, supervision and training required by individuals receiving waiver services as a result of their disabilities and will not include payment for the supervisory activities rendered as a normal part of the business setting.
- Supported Employment services furnished under the waiver must be services which are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service showing that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973 or P.L. 94-142

DOCUMENTATION STANDARDS

- Identified need in the service plan
- Services outlined in the service plan
- Data record of services provided, including:
 - complete date and time of service (in and out)
 - specific services/tasks provided
 - 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 of the individual must also be included.
- Each staff member providing direct care or supervision of care to the individual must make at least one entry on each day of service. All entries should describe an issue or circumstance concerning the individual.

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

When Supported Employment services are provided at a worksite where persons without disabilities are employed, payment will only be made for the adaptation, supervision and training required by individuals receiving waiver services as a result of their disabilities.

ACTIVITIES NOT ALLOWED

- Services funded under the Rehabilitation Act of 1973 or P.L. 94-142
- Reimbursement for supervisory activities rendered as a normal part of standard business procedures in a business setting where persons without disabilities are also employed
- Reimbursement for incentive payments, subsidies, or unrelated vocational training expenses for the following:
 - 1.Incentive payments made to an employer to encourage or subsidize the employer's participation in a Supported Employment program;
 - 2.Payments that are passed through to users of Supported Employment programs; or
 - 3.Payments for vocational training that are not directly related to an individual's employment program.

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	Community Mental Health Center
Agency	FSSA/DA approved Supported Employment Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Community Mental Health Center

Provider Qualifications

License (specify):

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
 IC 12-7-2-38(1) Community Mental Health Center

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: Supported Employment

Provider Category:

Agency

Provider Type:

FSSA/DA approved Supported Employment Agency

Provider Qualifications

License (specify):

Certificate (specify):

CARF

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

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:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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 (PCA).
- 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 his/her 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 care manager must justify how the skilled need will be met and by whom. The documentation must describe the ADL and IADL assistance provided, who will be providing the assistance, and the activities and frequency to be performed.
- 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:
 - 1.social security number
 - 2.medical insurance number
 - 3.birth date
 - 4.emergency contact(s)
 - 5.all medical information available including all prescription and non-prescription drug medication currently in use
 - 6.most recent prior residence

7.hospital preference
 8.primary care physician
 9.mortuary (if known), and 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:
 - 1.advance directive
 - 2.living will
 - 3.power of attorney (POA)
 - 4.health care representative
 - 5.do not resuscitate (DNR) order
 - 6.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, Environmental Modifications, Attendant Care, Home Delivered Meals, Pest Control, or Community Transition 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
Individual	FSSA/DA approved Adult Family Care Individual
Agency	FSSA/DA approved Adult Family Care Agency

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 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: 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 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:

Assisted Living

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:

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 and monthly rate 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 (AL) 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 CM 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:

A.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.

B.Maintenance of participant's personal records to include:

- social security number
- medical insurance number
- birth date
- emergency contact(s)
- available medical information including all known prescription and non-prescription drug medication currently in use
- hospital preference
- primary care physician
- mortuary (if known)

C.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 (POA)
- health care representative
- do not resuscitate (DNR) order
- letters of guardianship
- Fully executed lease agreement with the AL

D.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 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, or Pest Control furnished to a participant selecting Assisted Living Services as these activities are integral to and inherent in the provision of the Assisted Living Service.

FFP is not available for items of comfort or convenience, or costs of facility maintenance, upkeep and improvement.

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:

Behavior Management/ Behavior Program and Counseling

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:

Behavior Management includes training, supervision, or assistance in appropriate expression of emotions and desires, assertiveness, acquisition of socially appropriate behaviors, and the reduction of inappropriate behaviors.

Behavior plans must be developed, monitored, and amended by a master’s level Psychologist or a master’s in Special Education, supervised by an individual with a Ph.D. in Behavioral Science. Persons providing Behavior Management/ Behavior Program and Counseling who are employed by a qualified agency must be a Master's level behaviorist, a Certified Brain Injury Specialist (CBIS), a Qualified Mental Retardation Professional (QMRP), a Qualified Intellectual Disability Professional (QIDP), or a Certified Social Worker who is supervised by a Master's level behaviorist. An individual practitioner providing this service must be a Master's level behaviorist.

ALLOWABLE ACTIVITIES

- Observation of the individual and environment for purposes of development of a plan and to determine baseline
- Development of a behavioral support plan and subsequent revisions
- Training in assertiveness
- Training in stress reduction techniques
- Training in the acquisition of socially accepted behaviors
- Training staff, family members, roommates, and other appropriate individuals on the implementation of the behavior support plan
- Consultation with members
- Consultation with Health Service Provider in Psychology (HSPP)

SERVICE STANDARDS

- Behavior Management/ Behavior Program and Counseling services must follow a written service plan addressing specific needs determined by the individual’s assessment.
- The behavior specialist will observe the individual in his/her own milieu and develop a specific plan to address identified issues.
- The efficacy of the plan must be reviewed not less than quarterly and adjusted as necessary.
- behavior specialist will provide a written report to pertinent parties at least quarterly. “Pertinent parties” includes the individual, guardian, waiver care manager, all service providers, and other involved entities.

DOCUMENTATION STANDARDS

- Identified need in the service plan
- Services outlined in the service plan
- Service plan must have the identified level clinician
- Behavioral support plan
- Data record of clinician service documenting the date and time of service, and the number of units of service delivered that day with the service type.

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

ACTIVITIES NOT ALLOWED

- Aversive techniques
- Any techniques not approved by the individual’s person centered planning team and the Division of Aging
- Behavior Management/ Behavior Program and Counseling 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 Behavior Management/ Behavior Program and Counseling Individual
Agency	FSSA/ DA approved Behavior Management/ Behavioral Program and Counseling Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavior Management/ Behavior Program and Counseling

Provider Category:

Individual

Provider Type:

FSSA/ DA approved Behavior Management/ Behavior Program and Counseling Individual

Provider Qualifications

License (specify):

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
 An individual practitioner providing this service must be a Master's level behaviorist.

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: Behavior Management/ Behavior Program and Counseling

Provider Category:

Agency

Provider Type:

FSSA/ DA approved Behavior Management/ Behavioral Program and Counseling Agency

Provider Qualifications

License (specify):

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

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:

16 Community Transition Services

Sub-Category 1:

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) supports 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 and/ or the participant’s guardian or family, or a home that is owned and/ or operated by the agency providing supports.

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, even if the residence from which he or she is moving is owned by a provider agency. Nursing Facilities are not reimbursed for Community Transition because those services are part of the per diem. 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.

Providers can directly relate to the State Medicaid Agency at their election.

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. Approved items have been a bed, table or chairs, assembly of flat-packed furniture, window coverings, (1) land line telephone, eating utensils, housekeeping supplies, food preparation items, hygiene products 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, or one-time cleaning prior to occupancy.
- *Cover related costs with Government issued identification items, birth certificate, Social Security Card, State ID, State Driver’s license.

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 CM 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.

ACTIVITIES NOT ALLOWED

- Apartment or housing rental or mortgage expenses
- Large Appliances
- Diversional or recreational items such as hobby supplies
- Cable TV access
- VCRs
- Regular utility charges

*When participant discharges from facility the CTS must be identified, ordered, and delivered within 3 months.

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 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:

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:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Continued)

A Home Delivered Meal is a nutritionally balanced meal. ALLOWABLE ACTIVITIES

Approved Home delivered meals have included the following items:

- 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.

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 Home Delivered Meals 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 Modifications

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:

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 their 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

Approved Home modifications may include the following:

A.Adaptive door openers and locks -

B.Bathroom Modification –including:

- 1.removal of existing bathtub, toilet and/or sink;
- 2.installation of roll in shower, grab bars, toilet and sink;
- 3.installation of replacement incidental items such as flooring, storage space, cabinets that are necessary due to the bath modification.

C.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.

D.Kitchen modification- including:

- 1.Removal of existing cabinets, sink;
- 2.installation of sink, cabinet,;
- 3.installation of replacement incidental items such as flooring, storage space, and cabinets if necessary due to kitchen modification.

D.Home safety devices such as:

- 1.door alarms;
- 2.anti-scald devices;
- 3.hand held shower head;
- 4.grab bars for the bathroom.

E.Ramp – including:

Portable - considered for rental property only; Permanent;
Vertical lift.

F.Stair lift -

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

H.Widen doorways -

- 1.Exterior -
- 2.Interior bedroom, bathroom, kitchen door or any internal doorway as needed to allow for access. Pocket doors may be requested.

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

J.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;

K.Home Modification Maintenance (HOMM) - limited to \$1,000.00 annually for the repair and service of environmental modifications that have been provided through a HCBS waiver:

1.Requests for service must detail parts cost and labor cost;

2.If the need for maintenance 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.

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

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

N.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

*Share expected modification requests identified by the participant determined through the PCA 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:

1. Property owner of the residence where the requested modification is proposed;
2. Property owner's relationship to the participant;
3. What, if any, relationship the property owner has to the waiver program;
4. 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.

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

J.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;

K.Home Modification Maintenance (HOMM) - limited to \$1,000.00 annually for the repair and service of environmental modifications that have been provided through a HCBS waiver:

1.Requests for service must detail parts cost and labor cost;

2.If the need for maintenance 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.

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

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

N.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

*Share expected modification requests identified by the participant determined through the PCA 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:

1. Property owner of the residence where the requested modification is proposed;
2. Property owner's relationship to the participant;
3. What, if any, relationship the property owner has to the waiver program;
4. 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 a 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, \$1000.00 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 following:

A. Adaptations or improvements which are not of direct medical or remedial benefit to the participant:

1. central heating and air conditioning;
2. routine home maintenance;
3. roof repair;
4. structural repair that is not incidental to the original modification ;
5. driveways, decks, patios, publicly owned sidewalks, household furnishings;
6. swimming pools, spas or hot tubs;
7. outside storage spaces;
8. 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.

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.

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
Individual	Plumber
Agency	FSSA/ DA approved Home Modification Agency/ Contractor
Individual	FSSA/ DA approved Home Modification Individual
Individual	Architect

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: 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 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:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Integrated Health Care Coordination (IHCC) 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 SERVICE 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 their 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/Person Centered Assessment.

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.

IHCC is not to exceed sixteen (16) hours per month.

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	Licensed Home Health Agencies

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:

Licensed Home Health Agencies

Provider Qualifications

License (*specify*):

IC 16-27-1 Home Health Agency
 IC 25-23-1 RN
 IC 2-23-1 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:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Nutritional (Dietary) supplements include liquid supplements, such as "Boost" or "Ensure" to support participants 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 Formulae, 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 PCA

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.

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
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:

Personal Emergency Response System

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:

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 GPS or video monitoring service. No remote monitoring will be placed in participant bedrooms or bathrooms.

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.

Yes, 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.

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 PRSM

*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.

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:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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.

DOCUMENTATION STANDARDS

CM 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:

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
 Area Agencies on Aging verify license number.

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:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Specialized Medical Equipment and Supplies are medically prescribed items required by the participant's service plan, which assist the participant in maintaining their 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.

- 1.There should be no duplication of services between HCBS waiver and Medicaid State Plan;
- 2.The refusal of a Medicaid vendor to accept the Medicaid reimbursement through the Medicaid State Plan is not a justification for waiver purchase;
- 3.Preference for a specific brand name is not a medically necessary justification for waiver purchase. 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;
- 4.Reimbursement is limited to the Medicaid State Plan fee schedule, if the requested item is covered under Medicaid State Plan;
- 5.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).

A.Lift chairs-The HCBS program will cover the chair. State Plan should be pursued first for prior approval of the lift mechanism.

B.Medication Dispensers.

C.Toileting and/or incontinence supplies that do not duplicate State Plan Services.

D.Slip resistant socks.

E.Self-help devices - including over the bed tables, reachers, adaptive plates, bowls, cups, drinking glasses and eating utensils.

F. 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.

G.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.

H.Voice activated smart devices

I.Maintenance - limited to \$1,000.00 annually for the repair and service of items that have been provided through a HCBS waiver:

- 1.Requests for service must detail parts cost and labor cost;
- 2.If the need for maintenance 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 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.

SERVICE STANDARDS

A.Specialized Medical Equipment and Supplies must be of direct medical or remedial benefit to the participant;

B.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:

1.POC/SERVICE PLAN; and

2.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.

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

Maintenance - limited to \$1000.00 annually for the repair and service of items that have been provided through a HCBS waiver:

- 1.Requests for service must detail parts cost and labor cost;
- 2.If the need for maintenance 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 provided through a non-waiver funding source.

ACTIVITIES NOT ALLOWED

A.Unallowable items include 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;
- electronics - such as CD players, radios, cassette players, tape recorders, television, VCR/DVDs, cameras or film, videotapes and other similar items;
- 9.computers and software;
- 10.exercise equipment such as treadmills or exercise bikes;
- 11.furniture;
- 12.appliances - such as refrigerator, stove, hot water heater;
- 13.indoor and outdoor play equipment such as swing sets, swings, slides, bicycles adaptive tricycles, trampolines, play houses, merry-go-rounds;
- 14.swimming pools, spas, hot tubs, portable whirlpool pumps;
- 15.adjustable mattresses, positioning devices, pillows;
- 16.motorized scooters;
- 17.barrier creams, lotions, personal cleaning cloths;
- 18.essential oils
- 19.totally enclosed cribs and barred enclosures used for restraint purposes;
- 20.manual wheelchairs'
- 21.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 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:

Transportation

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:

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 PCA

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:

- 1.Level 1 Transportation - the participant does not require mechanical assistance to transfer in and out of the vehicle
- 2.Level 2 Transportation - the participant requires mechanical assistance to transfer into and out of the vehicle
- 3.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.

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	FSSA/DA approved Transportation Agency
Agency	Licensed Home Health 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:

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 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 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 Individuals personal file; site of service delivery

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:

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: 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:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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 \$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 provided through a non-waiver funding source.

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:

D.Provider of services must maintain receipts for all incurred expenses related to the modification;

E.All bids must be itemized.

F.Must be in compliance with FSSA and Division specific guidelines and/or policies.

Warranty information.

Picture of vehicle modification is included with the bid.

Provider Standards:

D.Provider of services must maintain receipts for all incurred expenses related to the modification;

E.All bids must be itemized.

F.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 \$1000.00 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 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

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 providers must submit a criminal background check as required by 455 IAC 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 Division of Aging also requires that a current limited criminal history be obtained from the Indiana State Police central repository as prescribed in 455 IAC 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 individuals 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 individuals receiving services. The Division of Aging provider relations waiver specialist verifies receipt of documentation as a part of provider enrollment.

Criminal history checks are maintained in agency files and are available upon request.

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 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 individuals receiving services. The Division of Aging 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. The Home- and Community-Based Services (HCBS) provider ensures the nurse aide remains current on the registry. Their certifications expire and must be renewed every 2 years, which includes verification of their status against the abuse registry.

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)

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

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:

Adult Family Care, Attendant Care, Behavior Management/Behavior Program and Counseling, Care Management, Home and Community Assistance and Respite waiver 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.

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.

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 Office of Medicaid Policy and Planning and the Division of Aging are dedicated to increasing home and community-based providers for the waiver. The Division of Aging is promoting home and community-based services by using new marketing tools and personal visits to potential providers. The Division of Aging is dedicated to focusing on recruitment, certification, timely enrollment of providers by the fiscal agent contractor, and retention of waiver providers. Information regarding home and community-based services is posted on the Family and Social Services Administration's website. The Division of Aging 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 Department of Health (IDOH) Notice

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="Indiana Department of Health (IDOH)"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify:

		<input type="checkbox"/>
	<p>Other Specify:</p> <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
<p>Other Specify:</p> <input type="text"/>	Annually
	Continuously and Ongoing
	<p>Other Specify:</p> <input type="text"/>

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:

Provider Relations Tracking Sheet

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
---	--	--

State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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:

Provider Relations Tracking Sheet

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
Other	Annually	Stratified

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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:

Provider Compliance Tool

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text" value="100% over a 3 year period."/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
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):
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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 =

		<input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

C.6 Number and percent of Care Management providers who continue to meet training requirements. Numerator: Number of Care Management providers who meet training requirements. Denominator: Number Care Management providers

reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider Compliance Tool

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text" value="100% review over a 3 year period"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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:

Provider Compliance Tool

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify:	Annually	Stratified Describe Group:

	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;">100% review over a 3 year period</div>
	Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	

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: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>

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 Division of Aging 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.

Various discovery activities conducted by the Division of Aging (DA) may lead to the identification of areas of non-compliance with the waiver provider agreement. 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. If existing documentation does not indicate resolution, DA personnel initiate corrective actions. Corrective actions vary according to the scope and severity of the identified problem. In some cases, informal actions, such as verifying 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), or a referral to the State Department of Health. The DA is responsible for verifying that corrective actions are completed. 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 their 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 disenroll 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 Department of Health (IDOH). Non-licensed providers are reviewed by a quality assurance (QA) team contracted through the operating agency. Both IDOH and the contracted entity 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 training conducted by State personnel prior to being entered into the electronic care management database system as an approved provider of Care 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 disenroll that individual as a provider of Care Management services. The CM-applicant will be required to complete the required training before being re-enrolled. The DA will implement an investigation of internal and FI practices to identify deficiencies or vulnerabilities in the enrollment and approval processes and undertake improvements. The DA will also 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, service reviews are conducted on all Care Management entities by the DA. This review includes verification of documentation of individual CM training. Any finding of non-compliance with training requirements will result in formal remediation utilizing a CAP, submitted by the provider, with approval or denial by the QA Reviewer. If denied, the provider is required to re-submit the CAP within a two- week time frame. Once approved, the reviewing entity verifies successful implementation of the CAP. Any provider not successfully completing remediation to meet Care Manager training requirements is decertified as a CM provider.

C.7: To assure service delivery standards are met by provider personnel, service reviews are conducted on approved waiver providers by the DA. Included in each participant's service review is verification of documentation of training of each individual caregiver or service delivery personnel as required in the provider agreement. Any finding of non-compliance with training requirements will result in a formal remediation process

utilizing a CAP submitted by the provider, with approval or denial by the QA Reviewer. If denied, the provider is required to re-submit the CAP within a two-week time frame. Once approved, the reviewing entity verifies successful implementation of the CAP. Any provider not successfully completing remediation to assure required personnel training is decertified as a provider.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

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 their circle of support. The participant and their 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 their circle of support. The participant and their 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 their service needs, then the participant with their 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 CM 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.

The CaMMS system has gone live and we are working towards full implementation to have our providers sign the PCP. Providers continue to receive a copy of the PCP along with notice of action.

All applicants for the waiver are evaluated to assure that level of care (LOC) is met prior to receiving services. All applicants are first screened for nursing facility (NF) level of care. Any individuals identified to have suffered the brain injury prior to age 22 may meet intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care. Screening for ICF/IID level of care will be completed for these individuals.

Individuals must meet the minimal LOC requirements for that of a nursing facility (NF) or intermediate care facility for individuals with intellectual disabilities (ICF/IID) and have a diagnosis of Traumatic Brain Injury to meet the qualifications for the waiver. Indiana has established the Eligibility Screen, a tool that is used to determine basic NF LOC. The Eligibility Screen along with the additional TBI specific information (Explain what happened; When did it happen; Specific quantifiable dysfunctions; How does dysfunction differ from pre-injury; Level of care comments) is required to be completed by the Care Manager as part of the LOC packet.

Initially, the individual's physician must complete the Physician Certification for Long Term Care (450B). This medical document lists the diagnosis, medications, abilities, disabilities and prognosis. The 450B also includes the physician recommendation regarding the safety and feasibility of the participant to receive home and community-based services.

Any individuals identified to have suffered the brain injury prior to age 22 may meet ICF/IID level of care., In addition to the basic requirements found in IC 12-7-2- 61, Indiana also requires that waiver participants have at least three of the six substantial limitations as defined in 42 CFR 435.1009, in the areas of: 1) self-care; 2) learning; 3) self-direction; 4) capacity for independent living; 5) receptive and expressive language; and 6) mobility. These criteria are considered along with an array of collateral materials when considering eligibility for waiver services.

The care manager informs the participant of the services available under the waiver. If the individual meets NF or ICF/IID LOC and has a diagnosis of Traumatic Brain Injury, the individual will be provided with a pick list of all Medicaid Waiver approved providers in the individual's geographic area that provide home and community-based services. It is the individual's choice to choose their services and service providers to meet their identified medical needs and goals.

The care manager in collaboration with the individual and providers completes an initial, ninety (90) calendar day, and annual re-determination assessment to evaluate the participant's strengths, capacities, needs, preferences and desired outcomes, health status, and risk factors. Assessments can be conducted more often if needed. Based on the outcomes of the assessments, a comprehensive service plan is developed. The care manager assures the service plan meets the medical needs and goals of the participant and includes the participant's preferences of services, if available through the waiver, and assigns specific responsibilities for completion of the various components of the plan. The Service Plan is signed by the care manager, the participant or the participant's legal guardian, and all individuals and providers responsible for the implementation of the service plan. The DA waiver specialist provides a second level of review of the service plan to assure that the participant's goals, needs (including healthcare needs), and preferences are met.

The participant signs a release form that allows the care manager to contact service providers once the client has selected the providers of choice. 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 participant and other people involved in the plan receive 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. The DA's policy and processes require the person-centered plan to be finalized, agreed to, and to obtain informed consent of the individual in writing. Then the plan is to be signed by all individuals and providers responsible for its implementation. The person-centered plan includes signature lines for all individuals and providers responsible for its implementation. Care Managers are responsible for updating the plan and obtaining applicable signatures. A signed person-centered plan is made available to other providers responsible for its implementation.

The care manager is required to conduct a face-to-face visit with the participant at least every ninety (90) calendar days to ensure the health and welfare of the participant and to determine if the previously approved services continue to meet the medical needs and goals of the waiver participant. The service plan is also reviewed every ninety (90) calendar days, or more often as necessary. Updates to the service plan can be made as often as necessary to reflect the participant's medical needs and goals.

All individuals must be Medicaid eligible prior to receiving waiver services, therefore, the State does not use temporary or interim service plans to get services initiated until a more detailed service plan can be finalized.

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 LOC and service planning processes. During the initial and renewal LOC processes, the Eligibility Screen tool is used to identify potential risks and vulnerabilities. When ICF/IID LOC is determined, the ICF/IID Provisional Level of Care Screening Instrument Revised is used. Service plan development takes into account risks identified from the 90 Day Review tool, which is used to develop the initial service plan and then at least every ninety (90) calendar days thereafter. Appropriate interventions may be initiated immediately through the usual service system to address emergent needs.

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 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 members of their 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 individual 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, a pick list of approved Medicaid Waiver providers is generated in randomized sequence and is presented to the participant by the care manager. Participants and family members are encouraged to interview potential service providers and make their own choice. If the participant or parent/guardian wishes to select a provider that is not an approved waiver service provider, the Office of Medicaid Policy and Planning (OMPP) and the Division of Aging (DA) will assist in reviewing and processing applications from potential 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's Office of Medicaid Policy and Planning (OMPP) will retain responsibility for service plan approvals made by the Division of Aging (DA).

As part of its routine operations, DA will review each service plan submitted to ensure the plan addresses all pertinent issues identified through the assessment, including physical health issues.

As designated by the single state agency, 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 OMPP may review and overrule the approval or disapproval of any specific service plan acted upon by the DA serving in its capacity as the administrative oversight for this waiver. As designated by the single state agency, 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 the waiver, this also allows OMPP staff to review and overrule the approval or disapproval of any specific service plan acted upon by the DA. While OMPP has this authority to review service plans, the occurrences of service plan review are infrequent and have not occurred in the past year. This language exists to give OMPP the authority to make changes as needed.

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:

The Service plan is reviewed every 90 calendar days or more frequently, when necessary, by the Care Manager. It is updated as needed by the participant at any time during the service plan year but is only required to be updated annually after their annual assessment/re-assessment for Level of Care.

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) calendar days. At this 90 Day Review, the care manager completes the 90 Day Checklist to assure that approved services continue to meet the medical needs and goals of the participant. The 90-Day Checklist is a comprehensive assessment tool 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 Division of Aging (DA) and the care manager. If follow-up is required for an incident, the State requires the care manager to provide follow-up every 7 calendar 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 their 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 quality assurance contractor 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 that address participants assessed needs and personal goals. Numerator: Number of participants service plans that address participants assessed needs and personal goals. Denominator: Number of service plans submitted.

Data Source (Select one):

Other

If 'Other' is selected, specify:

D.1a Electronic Care Management Database System- 90 Day Review

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

	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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.

Performance Measure:

D.2 Number and percent of participant’s service plans that were developed in accordance with State policies and procedures. Numerator: Number of participant’s service plans that were developed in accordance with State policies and procedures.
Denominator: Number of service plans submitted.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic Care Management Database

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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.3 D.3 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 Care Management Database

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review

Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

D.4 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 Care Management Database System

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 1093 1264 1178" type="text"/>
Other Specify: <input data-bbox="408 1317 647 1402" type="text"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1317 1264 1402" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1541 1264 1626" type="text"/>
	Other Specify: <input data-bbox="718 1765 954 1850" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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.5 Number and percent of participants receiving services in accordance with the service plan. Numerator: Number of participants receiving services in accordance with the service plan. Denominator: Number of service plans reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

D.5a Electronic Care Management Database System

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

Agency		
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

D.5b Person Centered Compliance Tool (PCCT)

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

		95
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text" value="Statistically valid sample was proportioned across AAAs to assure mixture of rural and urban populations. Distribution was based upon each geographic areas percentage of the total waiver population."/>
	Other Specify: <input type="text"/>	

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 (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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.6 Number and percent of participants that are afforded choice between/among waiver services and institutional care. Numerator: Number of participant’s service plans with a signed Freedom of Choice form indicating the choice between waiver services and institutional care. Denominator: Number of participant service plans reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

D.6a Electronic Case Management Database System

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

		Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

D.7 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 Care Management Database System

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 994 1264 1077" type="text"/>
Other Specify: <input data-bbox="408 1218 647 1301" type="text"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1218 1264 1301" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1442 1264 1525" type="text"/>
	Other Specify: <input data-bbox="718 1666 954 1749" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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 Division of Aging (DA) using electronic reports which gather data from each participant's individual electronic Care Management record, including the Service Plan and 90 Day Review. As individual service plan problems are identified through discovery processes, the DA will require corrective measures of the Care Manager or service provider, as appropriate, to assure the problem is resolved. 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), or a referral as a formal complaint to the DA which can result in sanctions up to and including termination as a provider. The DA will monitor implementation of corrective measures to verify resolution. As a safeguard against interruption of services, an "extension service plan" will be generated when necessary to continue services. If a participant's services are directly impacted by the suspension or termination of a provider, the care manager will be directed to assist the participant in choosing a new provider and the operating agency will assist in expediting this change.

D.1: Identification of an individual service plan which does not meet a participant's assessed needs and personal goals will result in a review of case notes to identify the circumstances surrounding non-compliance. If resolution activities have not already been initiated, the DA will contact the waiver Care Manager (CM) and require an updated assessment or development of compliant service plan, as appropriate, recognizing the individual participant's choice of services and providers, and who to include in service planning. Failure by the CM 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 case notes, timelines and signatures to identify the circumstances surrounding non-compliance. If resolution activities have not already been initiated, the DA will contact the CM 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 CM. Findings of late service plan submission will be tracked to identify area or CM-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 handling as a formal complaint.

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 case notes, incident reports and other available documentation to determine the cause and circumstance of the finding. If resolution activities have not already been initiated, the DA will contact the waiver Care Manager to determine steps needed to obtain 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 service plan 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 provider may also be referred for handling as a formal complaint.

Performance measures D.1, D.5, D.6 and D.7 have a secondary data source derived from the Person Centered Compliance Tool (PCCT) administered to a statistically significant sample population. When specific PCCT probes reveal negative findings, the QA reviewer implements a formal remediation process utilizing a CAP, submitted by the appropriate provider, with approval or denial by the Reviewer, under supervision of the DA. If a CAP is denied, the provider is required to re-submit the CAP. Once approved, the Reviewer verifies successful implementation of the CAP. Any provider not completing the required corrective action(s) is referred to the DA for handling as a formal complaint. The complaint process can result in sanctions up to and including termination as a waiver provider. Prior to termination any current participants will be assisted in securing services from other providers. Any provider who is de-certified as a result of failing to complete corrective actions will be notified of

the decision, and of their right to appeal.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="319 667 794 745" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="865 978 1339 1057" type="text"/>

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)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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, annual 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 Notice of Action, also referred to as the Provider Authorization Notice, is used to notify each Medicaid applicant or participant of any action that affects the individual'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 Notice of Action. Part 2, "Your Right to Appeal and Have a Fair Hearing" advises individuals of their right to appeal and the timely actions which are required. Part 3, "How to Request an Appeal" provides instructions for individuals regarding the procedures that are necessary in the appeal process. Notice of Action (NOA) is emailed to the provider by the Care Management entity identified in the service plan. The emails are automatically sent from our CaMSS system to the provider after the information is entered into the system.

The individual receives an Appeal rights letter with each decision made in the service plan or Eligibility determination. The appeal rights letter includes the Care Manager contact information for questions concerning the document, and instructions for requesting an appeal. TBI waiver Care Management providers are available to provide assistance and supports with filing an appeal or requesting a fair hearing. Additionally, they may also participate in Medicaid Fair Hearing process upon request.

If a participant is receiving services during an appeal process, those services continue pending the Administrative Law Judge Ruling on the appeal.

The waiver Notice of Action informs the participant (and the participant's guardian or advocate, as appropriate) of his/her right to an appeal. The Notice of Action also advises the participant that services will be continued if he/she files the appeal in a timely manner, which is within 33 calendar days of the decision date noted on the Notice of Action.

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 an individual's service plan and the individual's right to a Medicaid Fair Hearing. The care manager must ensure that the Notice of Action is sent to the applicant or participant within 10 calendar days of the issue date and must document the date the Notice of Action was sent to the applicant or participant.

If an applicant is denied waiver services, a written Notice of Action is sent detailing the reasons for denial and explains the individual'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 individual'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 Division of Aging 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

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 Division of Aging.

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 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 Program Integrity/Service Utilization Review, 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 calendar days
- a hold (up to 60 calendar 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 Division of Aging 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 in a 24/7 or day setting

A residence that compromises the health and safety of a participant

Suspected or observed criminal activity by

(a) providers staff when it affects or has the potential to affect the participants care;

(b) a family member of a participant receiving services when it affects or has the potential to affect the participants 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, e-mail or fax. 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 number is also inside the front cover of all telephone books in the state. This information will be reviewed formally at 90 day face-to-face updates and informally during monthly telephone contacts with the participant and/or guardian.

- 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. Incident reporting contract staff process the incidents within 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) calendar 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.

FSSA DA staff are responsible for conducting formal critical events or incidents investigations.

Investigations are typically conducted by reviewing the information and evaluating the critical incidents with the enrollee or legal guardian.

Cases related to Abuse, Neglect and Exploitation are processed with 3 workdays and investigated by FSSA DA staff.

Our policy is to complete the investigations within 30 days. Other Incidents and critical reports are processed within 1 workday and are investigated by FSSA DA staff. Our policy is to complete the investigations within 60 days.

DA staff collaborates with the participant's Care Manager to conduct a follow up investigation to the incident report as necessary and then works to close the incident report. Remediation of a critical incident often includes changing services or providers. Care Managers use a person-centered planning approach with enrollees when suggesting and selecting various options to ensure the health and welfare of enrollees.

The Care Manager is responsible for informing participants of the results of the investigation when the incident report has been closed. When an incident report involves a participant death, or an allegation or suspicion of A-N-E, APS conducts an investigation and completes follow up as appropriate.

The state uses preponderance of evidence as the standard FSSA uses for the burden of proof for investigations.

Aggregated incident data is reviewed by the Division of Aging and the quality assurance (QA) committee 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 care management entity to aid them in tracking unresolved incident reports. Unresolved reports are monitored weekly by the DA.

All participants' deaths are required to be reported to the Department of Child Services (DCS) as applicable. 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 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 Division of Aging. The web-based incident reporting system is augmented with e-mail tracking. DA staff are notified daily of all reports of A-N-E and death.

Additional reports track:

- “Non-resolved” Reports – generated weekly to DA staff with area-specific reports to the AAAs and independent care managers
- “Incidents by Type” report – reviewed by 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 on-demand by DA Staff.

DA Staff reviews incident reporting data at each meeting.

As defined in the Indiana Health Coverage Programs (IHCP) DA Provider Reference Module for Home and Community-Based Services Waivers, TBI waiver providers are required 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 and are submitted through the web-based Incident and Follow-Up Reporting (IFUR) tool. All critical incident reports must include location of incident, provider involved (if applicable), reporting person, information about the enrollee, a description of each incident, action steps, strategies implemented to reduce and prevent future incidents from recurring and follow-up activities conducted through the resolution of each incident. TBI waiver Providers are required to submit an incident report for any reportable unusual occurrence within 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 24 hours of “first knowledge” of the incident.

Providers are required to suspend from duty any staff suspected, alleged, or involved in incidents of abuse, neglect and exploitation (A-N-E) of a participant, pending the provider’s investigation of the incident. If needed, the care manager coordinates replacement services for the participant. If 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.

Incidents are received by the DA via a secure web-based reporting system that links to the electronic incident database. Incident reporting (IR) contract staff process the incidents within 1 workday of receiving 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, if any, is required, and send notifications of required actions to the care manager, DA, and provider.

All TBI waiver service providers, including care managers, with knowledge of a reportable event are required to submit an incident report through the web-based Incident and Follow-Up Reporting (IFUR) tool. If web access is unavailable, incidents can be reported to the DA by telephone, email, or fax and must follow-up with the formal report as required by DA staff. DA staff monitors and reviews report submissions.

Additionally, IHCP requires reporting of known or suspected A-N-E of an adult to Adult Protective Services (APS), and for children reporting child A-N-E, to Child Protective Services (CPS).

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 Division of Aging has responsibility for oversight that these prohibitions are enforced. Care managers are responsible for initial oversight of participant’s care, the thirty (30) calendar day follow up and the ninety (90) calendar 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 will be included as a part of the required care managers' training.

The Division of Aging has responsibility for oversight that these prohibitions are enforced. Care managers are responsible for initial oversight of participant's care, the thirty (30) calendar day follow up by phone and the ninety (90) calendar 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 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 Division of Aging has responsibility for oversight that these prohibitions are enforced. Care Managers are responsible for initial oversight of participant's care, the thirty (30) calendar day follow up and the ninety (90) calendar 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 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.

Medication management and follow up responsibilities resides with the approved waiver providers that provide twenty-four (24) hour services to the waiver participants. For the waiver, this includes the Assisted Living (AL) service and Adult Family Care (AFC) service and may include Adult Day Services (ADS) when participants have medications that must be consumed during the times they are attending the ADS. These providers are responsible for the medication management and all necessary follow ups to ensure the health and welfare of the individuals within their care. Additionally, medication administration / management is allowed only within the scope of the practice for the delivery of the medications. In Indiana, medication management and oversight may include reminders, cues, opening of medication containers or providing assistance to the participant who is competent, but otherwise unable to accomplish the task.

AL, ADS and AFC waiver providers must include in their waiver provider application the procedures and forms they will use to monitor and document medication consumption. These 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 which includes medication errors. All approved waiver providers that are responsible for medication management are required to report specific medication errors as defined in DA's incident reporting policy to the Division of Aging (DA). Additionally, AL providers licensed by the Indiana Department of Health (IDOH) must also report medication errors to the IDOH. Please refer to Appendix G1-b for specific details regarding the IR process.

For approved service providers, medication management 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 provider must receive instructions from a doctor, nurse, or pharmacist on the administration of controlled substances if they are prescribed for the participant and he/she requires assistance in the delivery of such medication. Additionally, the provider must demonstrate an understanding of the medication regimen, including the reason for the medication, medication actions, specific instructions, and common side effects. The providers must assure the security and safety of each participant's specific medications if medications are located in a common area such as kitchen or bathroom of the home.

The care manager conducts a face-to-face visit with the participant at least every ninety (90) calendar days to assure all services, including medication management, 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.

Providers must demonstrate an understanding of each participant's medication regime which includes the reason for the medication, medication actions, specific instructions, and common side effects. The provider must maintain a written medication record for each participant for whom they assist with medication management. Medication records will be reviewed as a part of announced and unannounced provider visits and service reviews by Care Managers, DA staff or their contracted representatives. Any noncompliance issues or concerns are addressed promptly, including a corrective action plan as deemed necessary and appropriate.

Monitoring of medication management is included within the person centered compliance review process for participants selected for random review. Care managers review services, including medication management, during their 90 day participant service plan review. Additionally, non-licensed providers will be surveyed by the DA, or its designee, to assure compliance with applicable rules and regulations.

DA is responsible for monitoring and oversight of medication management 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 individual 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 management 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 the Indiana Department of Health (IDOH) are restricted to medication management services. Waiver providers licensed by IDOH must follow State regulations concerning the administration of medications. All providers must receive instructions from a doctor, nurse, or pharmacist on the administration of controlled substances if they are prescribed for the participant and he/she requires assistance in the delivery of such medication. Additionally, all providers must demonstrate an understanding of the medication regimen, including the reason for the medication, medication actions, specific instructions, and common side effects. The providers must assure the security and safety of each participant's specific medications if medications are located in a common area such as kitchen or bathroom.

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 management are required to report specific medication errors as defined in DA's incident reporting policy to the Division of Aging (DA). AL waiver service providers must also report medication errors to the Indiana State Department of Health (IDOH).

- (b) Specify the types of medication errors that providers are required to *record*:

AL waiver service providers, by IDOH regulation, 410 IAC 16.2-5-4(e)(7), any error in medication shall be noted in the resident's record. All approved waiver providers that are responsible for medication management are required to record medication errors in the participants record as per DAs IR policy.

- (c) Specify the types of medication errors that providers must *report* to the state:

For AL waiver providers, the facilities are required to report to IDOH any unusual occurrences which may include medication errors 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 IDOH policy on unusual occurrences includes the reporting of medication errors to IDOH that caused resident harm or require extensive monitoring for 24-48 hours. Waiver providers that are responsible for medication management 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.

IDOH 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 QA/QI committee. Identified problems with medication administration involving licensed waiver providers are referred to IDOH. The QA/QI committee 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 instances of 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.3 Number and 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 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:

Case management system

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 1025 1264 1111" type="text"/>
Other Specify: <input data-bbox="408 1249 647 1335" type="text"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1249 1264 1335" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1473 1264 1559" type="text"/>
	Other Specify: <input data-bbox="718 1697 954 1783" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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 (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>

Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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.2a Electronic Case Management Database System

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

G.2b Person Centered Compliance Tool (PCCT)

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="95"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text" value="Statistically valid sample was proportioned across AAAs to assure mixture of rural and urban populations. Distribution was based upon each geographic areas percentage of the total waiver population."/>
	Other Specify: <input type="text"/>	

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 (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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:

G.5 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 (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100%

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<input type="text"/>

Performance Measure:

G.6 Number and 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):

Critical events and incident reports

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

G.4 Number and Percent of incidents that were reported within the required time periods. Numerator: Total number of incidents reported within the time periods. 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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other	Annually	Stratified

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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:

G.7 Number and percent of reported uses of restraints. Numerator: Total number of reported incidents without use of restrictive interventions. 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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 1160 1262 1238" type="text"/>
Other Specify: <input data-bbox="408 1384 647 1462" type="text"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1384 1262 1462" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1608 1262 1686" type="text"/>
	Other Specify: <input data-bbox="719 1832 954 1910" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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:

G.11 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:

electronic care management database

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

Agency		
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Specify: <input type="text"/>

Performance Measure:

G.10 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

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

	<input style="width: 80%; height: 20px;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

G.9 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

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

		Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

G.8 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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
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: <div data-bbox="403 517 798 600" style="border: 1px solid black; height: 37px; width: 247px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div data-bbox="866 804 1260 887" style="border: 1px solid black; height: 37px; width: 247px;"></div>

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 databases to determine systemic issues affecting participants and/or community in general.

The state 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 staff to determine if the problem or issue has been resolved. If existing documentation does not indicate resolution, DA staff initiate remediate actions, usually by contacting the waiver care manager. The QA/QI unit is responsible for verifying that corrective actions are completed.

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 members as necessary. DA staff work directly with APS units to reach resolution and/or to determine next steps to safeguard members at risk of abuse, neglect or exploitation.

DA and APS staff assure coordination of response to high risk members and/or settings throughout the state by working directly with local APS units, local LTC Ombudsman, AAA, Care Managers and other providers.

The DA monitors member safeguards using a variety of internal reports and service site reviews conducted by a quality assurance contractor. When a Service Reviewer identifies a negative finding, they implement a formal remediation process which requires a Corrective Action Plan (CAP) be submitted by the appropriate provider within a two-week time period, with approval or denial by the Reviewer under supervision of the DA. If a CAP is denied, the provider is required to re-submit it. Once approved, the Reviewer verifies successful implementation of the CAP. Any provider not successfully completing the CAP process is referred to the DA for handling as a formal complaint. The complaint process can result in sanctions up to and including termination as a provider. Any provider who is de-certified as a result of failing to complete corrective actions will be notified of the decision, and of their right to appeal. If any member's services are directly impacted by the suspension or termination of a provider, the care manager will be directed to assist the member in choosing a new provider and the operating agency will assist in expediting this change.

The State seeks to assure safeguards for all members, but respects individual member's choices regarding lifestyle and tolerance for risk. In some cases, the Care Manager may be encouraged to work with the member to develop a formal acceptable risk agreement. When a member chooses an unacceptable level of risk and there is reason to believe the member's ability to make decisions is compromised, the CM will be directed to contact APS.

G.1: The Division of Aging (DA) has a highly structured system for reporting, reviewing and tracking resolution of critical incidents. All reports of abuse, neglect and exploitation (ANE) are designated as "Sentinel Events" and each member of the DA, including the APS Program Director, is notified. Sentinel incidents are tracked electronically and monitored by the DA staff to ensure that immediate protective measures have been put in place. A separate report monitors this process to assure all critical incidents are appropriately resolved. When negative findings are identified, the DA staff reviews the incident documentation, contacting the care manager (CM) or other entities to ascertain the incident status. If emergency protective measures have not been put in place, DA assists the CM in developing a plan to implement measures within 48 hours. Failure to report or respond to an incident of ANE will result in referral for handling as a formal complaint with the potential of sanctions up to and including termination as a provider.

G.2: In addition to requiring incident reports for ANE, the DA includes monitoring through the 90 Day Review. A 90 Day Review that reflects ANE will result in a review of documentation. Any findings could result in a corrective action up to and including provider termination.

When the review probes reveal negative findings indicating an unresolved environment or occurrence of ANE, or failure of provider to respond appropriately to an ANE allegation or occurrence, the Reviewer implements the formalized CAP process detailed above and requires submission of an incident report, if not already submitted. The Reviewer also notifies the DA and APS if this has not already occurred.

G.3 and G.4: Identification of a member who reports that they have not had primary medical care services or lack care for general health needs results in a review of case notes to determine if corrective actions have been implemented by the CM, family or provider(s). If corrective measures have not been initiated, the DA QIS Program Director will contact the CM to initiate steps toward assuring access to appropriate medical care. When a member chooses not to obtain adequate levels of healthcare, the CM is instructed to fully inform the member of the risks and consequences of this choice.

G.5: When the review reveals findings that a member's acute health needs are not appropriately addressed, the Reviewer implements the formal remediation/CAP process to address the unmet need. When a member chooses not to obtain adequate care for acute health needs, the CM is instructed to fully inform the member of the risks and consequences of this choice.

G.6-G.9: When an incident is reported outside of the required time frames the responsible provider will receive a

notice of the late submission from DA as well as instructions and training on incident reporting. Repeated violations can lead to a corrective action plan or even de-certification.

Sentinel events regarding restraints or medication errors that result in medical treatment are reviewed by DA staff. Follow up questions are sent to the care manager to clarify the events and any potential need for medical treatment. DA may take action up to and include de-certification to address provider compliance, if follow up indicates provider fault.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="317 871 743 954" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="813 1184 1240 1267" type="text"/>

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 de-certification as a waiver provider.
- Indiana Department of Health (IDOH) licensure monitoring— The DA and IDOH 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 de-certification 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;

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 <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify: <input type="text"/>	Other Specify: <input type="text"/>

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 care 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 OMPP 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 both discovery 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 OMPP 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 throughout the DA team and externally to the care management and provider entities at regional training and update meetings conducted by the DA for these groups.

- 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 care 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. 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, in coordination with the Waiver Work Group.

Modifications to the Quality Improvement Strategy will be submitted annually with the 372 report.

Based on language approved in the Appendix K amendment associated with this waiver, due to the COVID pandemic, a quality review report was not completed for the previous waiver cycle. Additionally, 372 reports due during the emergency have not been submitted. Upon expiration of the Appendix K amendment, Indiana will gather data and submit the quality review in addition to any outstanding 372 report (s) as quickly as the required information can be gathered and analyzed. If necessary, the state will submit waiver amendments based on identified deficiencies in the quality review report and/or 372 report(s) within 90 days of receiving the final quality review report and 372 report acceptance decision.

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 AAA with full reporting to the OMPP and the Division of Aging. PI has an agreement with the FSSA Audit Unit to audit allegations of 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

PI receives allegations of provider fraud, waste, and abuse and tracks these in its Care Management system. When it receives an allegation regarding a waiver provider, PI forwards it to FSSA Audit to begin their 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 conduct statistically valid random sample of consumers and then Program Integrity's Fraud Abuse and Detection (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 random sample size is ultimately determined utilizing a tool developed by FADS contractors as well as their 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.
- 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.

If the probe identifies material issues, statistical sampling is used to expand the testing and quantify overpayments. Valid statistical samples and sample results projections are provided by Program Integrity's FADS contractor. FADS audits are initiated based on referrals received from different sources/agencies. The Surveillance and Utilization Review (SUR) Unit 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 SUR Unit's Investigations team 4. Analytics performed by FADS contractors. 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 next steps. In certain instances, the SUR Unit 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 with a special focus on any items identified as potential issues 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. 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 recoveries to the program; however, it may be apparent that the provider as well as the Medicaid Program would benefit from the provider receiving additional education 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, Program Integrity is advised of any systemic issues identified. FSSA Audit Services seeks Program Integrity'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. Analytics focusing on specific areas of concern 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.

FADS contractors utilize federal and state guidelines as well as IHCP guidelines and national coding standards applicable to the date(s) of service being audited when determining whether services were billed appropriately. For medical review audits requiring clinician review, FADS contractors employ registered nurses and certified medical coders to also ensure all services were billed appropriately. When necessary, FADS contractors also rely on their Medical Directors and other medical consultants to help confirm audit findings, including medical necessity, when appropriate.

The FADS contractor is continually creating and running analytics to identify aberrant billing patterns and potential overpayments. The FADS contractor's analytic team does audit based on allegation but often, these are not provider specific allegations. Instead the reviews conducted are targeted at a specific provider type or billing practice. This allows all providers billing that code set or included in that provider peer Services to be included in the analysis.

The FADS contractor runs annual provider profile reports comparing providers to their peers. These reports are run annually. These profiles compare generic measurements such as claims per day or dollars per claim. They allow all providers, regardless of whether they have been included in an allegation, to be measured and audited.

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 DA to identify and conduct audits on providers that have been identified as potentially not billing correctly. Detailed information on this policy can be found in the IHCP Provider and Member Utilization Review module posted at: www.indianamedicaid.com.

Under the provisions of the Single Audit Act as amended by the Single Audit Act Amendments of 1996, the State of Indiana utilizes the Indiana State Board of Accounts to conduct the independent audit of state agencies, including the Indiana FSSA Compliance office. FSSA Compliance routinely monitors audit resolution and provides annual status updates to SBOA. Fee-for-service (FFS) providers do not fall under the Single Audit Requirement. FSSA Audit does receive service of the independent audits, but do not track them for the waiver services. FSSA Audit can pull the 990's for any agency within the State of Indiana if needed. Providers are not required to obtain an independent financial statement audit.

The State has implemented an Electronic Visit Verification (EVV) system, known as the Sandata EVV System, that complies with the requirements of the federal 21st Century Cures Act. The IHCP CoreMMIS claim-processing system has been configured to integrate with the Sandata EVV system. IHCP requires that providers use the EVV system to document the following: Date of the service; Location of service delivery; Individual providing the service; Type of service performed; Individual receiving the service; Time the service begins and ends. Providers may choose to use an EVV system other than Sandata. However, those providers will be required to export data from their alternate system to the Sandata "Aggregator" for integration with CoreMMIS.

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

04/12/2024

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 during the review period according to the published service rate. Numerator: Number of claims paid during the review period according to the published service rate. Denominator: Number of claims submitted during the review period.

Data Source (Select one):

Financial records (including expenditures)

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 = <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
Other Specify:	Annually	Stratified Describe Group:

<input type="text" value="Fiscal Contractor"/>		<input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
Other Specify: <input type="text" value="Fiscal Contractor"/>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	Other Specify: <input type="text"/>

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 claims submitted during the review period.

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

Medicaid Management Information System claims data

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> <i>Specify:</i> <input type="text" value="Fiscal Contractor"/>	<i>Annually</i>

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: <input type="text"/>

Performance Measure:

I.3 Number and percent of claims paid during the review period for services that are specified in the participants 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 claims submitted during the review period.

Data Source (Select one):

Financial records (including expenditures)

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 = <input type="text"/>
Other Specify: <input type="text" value="Fiscal Contractor"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other	

	Specify: <input style="width: 100%;" type="text"/>	
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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):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> Specify: <input style="width: 100%;" type="text" value="Fiscal Contractor"/>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other</i> Specify: <input style="width: 100%; height: 30px;" type="text"/>

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):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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 an individual's plan of care, are processed for reimbursement to providers who are enrolled Medicaid Traumatic Brain Injury 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 followup 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 their 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.

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):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> Specify: <input type="text" value="Fiscal Contractor"/>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other</i> Specify: <input type="text"/>

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).

In state fiscal year (SFY) 2023, Indiana's Family and Social Services Administration (FSSA) completed a rate review (rate study) for all Traumatic Brain Injury (TBI) waiver services. FSSA conducted a provider survey to capture the current provider experience of delivering the applicable waiver services, service specific workgroups, and all provider meetings.

Data sources: To develop revised payment rates, FSSA used the following primary data sources:

Bureau of Labor Statistics (BLS) data – Data elements from the BLS incorporated in the rates include Indiana wage data for applicable occupation codes, healthcare industry benefits, and healthcare wages, which were used to project the costs out to the effective rate period.

Provider survey data – Data collected from providers informed public source gaps and provided corroborating support for key BLS inputs. FSSA collected provider surveys related to provider costs (for employee salaries, benefits, administration and program support), average wages per hour, staffing information (such as number of employees relative to participants served, and the average number of service hours per employee), mileage, and operational structure.

Service specific workgroups – Service specific stakeholder meetings were held to contextualize provider survey information and to further capture the provider experience with hiring/retaining staff, delivering services, and sufficiency of current payment rates.

Other public and proprietary data sources – Other data sources were used to develop assumptions in the rate models, including but not limited to, transportation mileage reimbursement, fleet vehicle costs, and food costs (limited to adult day).

Methodologies: For the purpose of this amendment, there is no change to the rate methodology utilized. To develop prospective payment rate methodologies for the Division of Aging's (DA) 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 of this model is the labor cost per unit, which includes projected 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 "other" cost components for unique requirements such as food for adult day services. All services using this build-up approach have supporting rate models.

Key default rate inputs under this approach were as follows:

Direct care staff and supervisory wages: based on BLS Indiana wages and percentiles, but were also informed by provider surveys and stakeholder feedback

*Wage inflation: based on changes in Consumer Price Index (CPI) for employment earnings of medical professionals
Training and Paid Time Off (PTO) factors: training and PTO ranges between 60 and 70 hours per employee per year
Benefits factor ("employee related expenses" or ERE): varies by wages and is based on BLS national benchmarks for insurance costs as well as federal and state taxes*

Administration and program support factor: 15% combined administration and program support factor

Indirect service time: ranges between 1 minute and 3 minutes per 15-minute unit for timed individual services

Staffing ratios: group services vary by staffing ratios that align with group service standards; group services include structured day program and adult day

Caseload size: case management services reflect a waiver specific caseload size

Transportation: some services include mileage for onsite staff travel or reimbursement for a fleet

Rate composite approach - This approach was used for Assisted Living only, and is based on a composite of rates for service components to reflect the value for the package of services. It includes tiered and bundled rates for Assisted Living, where the tiers are assigned based on the level of service assessment for each participant. The rate composite for each level includes the following components:

Attendant Care

Home Maker

Skilled Nursing

Adult Day Service

Emergency Response

Non-Medical Transportation

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.

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 Modifications, Nutritional Supplements, Personal Emergency Response, Pest Control, Specialized Medical Equipment, and Vehicle Modifications.

The DA fee schedule can be found on the DA's HCBS Waivers webpage at: <https://www.in.gov/fssa/da/medicaid-hcbs/>.

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. Once the changes occur, manuals are regularly updated to reflect the changed rates. Information about payment rates is made available to waiver participants by their Case Manager. Information about payment rates is also available to waiver participants and providers, both verbally and in writing, from FSSA staff.

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 TBI waiver services flow directly from the providers to the Indiana Medicaid Management Information System and payments are made via Medicaid's contracted fiscal agent.

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 Traumatic Brain Injury (TBI) Waiver.

The Waiver Unit, within the operating agency, approves a participant's service plan within the State's Care Management database ensuring that only those services which are necessary and reimbursable under the 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 Care Management system will not allow the addition of services beyond those services offered under the (TBI) Waiver. The Care 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 Notice of Action (NOA), which is sent to each authorized provider of services on the Plan. The NOA 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 Care 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 Office of Medicaid Policy and Planning when executing Surveillance Utilization (SUR) activities. Additional information about these reviews can be found in the Financial Transactions and Remittance Advice provider reference module at the following link:

<http://provider.indianamedicaid.com/media/155457/financial%20transactions%20and%20remittance%20advice.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 Care 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.

- 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 §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 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, ICF/IID

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	42065.73	31430.35	73496.08	102267.04	8519.04	110786.08	37290.00
2	49384.94	32341.83	81726.77	108088.38	8766.43	116854.81	35128.04
3	51241.74	33279.74	84521.48	112195.74	9021.00	121216.74	36695.26
4	53275.59	34244.86	87520.45	116459.18	9282.96	125742.14	38221.69
5	55447.06	35237.96	90685.02	120884.62	9552.53	130437.15	39752.13

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:	Level of Care:
		Nursing Facility	ICF/IID
Year 1	200	100	100
Year 2	200	100	100
Year 3	200	100	100
Year 4	200	100	100
Year 5	200	100	100

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.

Based on historical lapse rates, approximately 6.4% of waiver enrollees are projected to lapse each year. An equal number of new entrants are projected to enter the waiver each year, maintaining the slot count at 200 for each of the waiver years. This in turn will keep the average length of stay on the waiver at the average level of 343 or 344 throughout the waiver renewal period.

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:

Base Year data reflects experience from Waiver Year 4 of the fourth renewal: January 1, 2021 – December 31, 2021. (Although this submission continues to use WY4 as the base period, summaries have been updated to reflect additional claims completion; small changes to projected utilization may be observed). The base year data was projected to WY 1 through WY 5 of the fifth renewal, 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 reflects reimbursement change effective July 1, 2023 and then inflated at an annual rate of 3.8% per year starting with waiver year 3 costs.
 - o For WY1, rate increases were projected to be effective for 6 months, so percentage increases for each service were multiplied by 6/12 and applied to actual cost per unit from the base year (WY4 of the prior renewal)
 - o For WY2, the full percentage rate increase was applied to actual cost per unit from WY4 of the prior renewal.
 - For services without explicit rates (those instead subject to annual or lifetime spending caps), reimbursement was inflated by 3.8% effective July 1, 2023.
 - The base year (WY 4) cost per unit for the Vehicle modification service was \$15,000. This is the maximum permitted under the cap, so cost per unit was projected to remain unchanged at \$15,000 each waiver year.
 - The Integrated Healthcare Coordination (IHCC) service is aligned with the same service for the A&D Waiver as follows:
 - o The reimbursement is the same as on the A&D Waiver - \$10.30 per quarter hour (16 hours per month limit) for January 2023 through June 2023 and increasing by 38% effective July 1, 2023.
 - o The number of users is assumed to ramp up gradually over time, reaching 11.4% of unduplicated users (23 users) by WY 5 of the renewal. Approximately 11.4% of unduplicated users on the A&D Waiver used IHCC during WY 5. The initial assumption for WY 1 is 20% of the A&D level of users (5 users).
 - o Average units per user are calculated based on the estimated WY 5 A&D Waiver average units per user (274.7) adjusted by the average length of stay differential between A&D Waiver (285) and TBI Waiver (343).
- Cost per unit trend of 3.8% 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. Estimates of Factor D for each waiver year are illustrated in the cost neutrality summary.

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 4 of the current renewal: January 1, 2021 – December 31, 2021. (Although this submission continues to use WY4 as the base period, summaries have been updated to reflect additional claims completion; small changes from prior projections may be observed). Based on the historical data, factor D' for WY 4 is much lower than in the beginning of the waiver renewal period due to the impacts of the COVID-19 pandemic. In order to reflect an expected increase for these expenditures in the future years, the filing assumes a bounce back impact of about \$4,300 or half of the difference between factor D' for WY 4 and WY 2 (CY 2019), before the pandemic began.

Adjusted base year data was trended at 2.3% per year to reflect Medical CPI-U over the recent 3 years (rounded).

Estimates of Factor D' for each waiver year are illustrated in the cost neutrality summary.

- 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:*

The current TBI Waiver approved level of care includes two levels of care: Nursing Facility residents with a TBI diagnosis and ICF/ID. Based on the analysis of current enrollees, we have assumed that 50% or 100 of the 200 slots will be eligible for the ICF/ID services, and the remaining slots meet the eligibility for the Nursing Facility services.

The table below demonstrates the weighted average calculation for WY 1 for the first amendment of the fifth renewal. A similar calculation was performed for WY 2 through WY 5.

Base Year data reflects experience from Waiver Year 4 of the current renewal: July 1, 2021 – December 31, 2021. (Although this submission continues to use WY4 as the base period, summaries have been updated to reflect additional claims completion; small changes from prior projections may be observed).

Factor G was developed based on the base year institutional claim experience, weighted by level of care.

To develop factor G for Nursing Home recipients with a TBI diagnosis, nursing facility UPL expenditures were added to nursing facility claims expenditures. During calendar year (CY) 2021, total paid nursing facility UPL expenditures were \$1,134.7 million in the state of Indiana. Divided by 32,471 unique nursing facility recipients, the average nursing facility UPL expenditure per unique recipient was \$34,946. This amount has been added to the nursing home factor G

Reimbursement for Nursing Home facilities and ICF/ID facilities had an increase of approximately 10% effective July 1, 2021 to compensate these providers for the COVID related expenses, such as increased workforce costs and personal protective equipment costs. Since this increase was implemented halfway through the base year, a 5% trend was applied to trend WY 4 forward to WY 5. In addition, there is an increase in the Nursing Home facility reimbursement of approximately 15% that was effective July 1, 2022 (impacting WY 1 and WY 2).

Both base Nursing Facility cost factor and ICF/ID cost factor were trended forward at 3.8% per year starting with WY 1 of the renewal for the ICF/ID costs and WY 3 for the Nursing Facility costs to reflect the expected increases in the absence of the COVID-19 pandemic. This cost trend is consistent with the Factor D assumption. Cost per unit trend of 3.8% was estimated using the average of the Medical CPI-U and CPI-U over the most recent 3 years (rounded) as institutional costs tend to trend midway between medical and non-medical costs.

Estimated of factor G for each waiver year are illustrated in the cost neutrality summary.

- 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 Waiver Year 4 of the current renewal: July 1, 2021 – December 31, 2021. (Although this submission continues to use WY4 as the base period, summaries have been updated to reflect additional claims completion; small changes from prior projections may be observed).

Factor G' was developed based on the base year state plan claim experience, weighted by level of care. Factor G' includes all state plan services received by the respective comparison populations while institutionalized. Based on the historical experience, COVID-19 pandemic did not have a material impact on factor G' for either level of care.

This factor was trended at 2.9% 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.

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 Services	
Attendant Care	
Care Management	
Home and Community Assistance	
Residential Based Habilitation	
Respite	
Structured Day Program	
Supported Employment	
Adult Family Care	
Assisted Living	
Behavior Management/ Behavior Program and Counseling	
Community Transition	
Home Delivered Meals	
Home Modifications	
Integrated Health Care Coordination	
Nutritional Supplements	
Personal Emergency Response System	
Pest Control	
Specialized Medical Equipment and Supplies	
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 Services Total:						274187.70
Adult Day Services	1/4 Hour	18	4402.50	3.46	274187.70	
Attendant Care Total:						5380475.40
Attendant Care	1/4 Hour	120	6359.90	7.05	5380475.40	
Care Management Total:						328414.32
Care Management	Month	195	10.40	161.94	328414.32	
Home and Community Assistance Total:						61341.14
Home and Community Assistance	1/4 Hour	16	598.10	6.41	61341.14	
Residential Based Habilitation Total:						752673.10
Residential Based Habilitation	1/4 Hour	34	2696.40	8.21	752673.10	
Respite Total:						641159.20
Respite	1/4 Hour	37	1788.30	9.69	641159.20	
Structured Day Program Total:						99696.13
Structured Day Program	1/4 Hour	8	2781.70	4.48	99696.13	
Supported Employment Total:						1742.26
Supported Employment	1/4 Hour	1	165.30	10.54	1742.26	
Adult Family Care Total:						133767.70
Adult Family Care	Day	6	303.70	73.41	133767.70	
Assisted Living Total:						89718.96
Assisted Living	Day	5	192.20	93.36	89718.96	
Behavior Management/ Behavior Program and Counseling Total:						180908.00
Behavior Management/ Behavior Program and Counseling	1/4 Hour	40	248.50	18.20	180908.00	
Community Transition Total:						1528.50
Community					1528.50	
GRAND TOTAL:						8413146.99
Total Estimated Unduplicated Participants:						200
Factor D (Divide total by number of participants):						42065.73
Average Length of Stay on the Waiver:						343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transition	Unit	1	1.00	1528.50		
Home Delivered Meals Total:						155061.44
Home Delivered Meals	Meal	59	382.00	6.88	155061.44	
Home Modifications Total:						12852.96
Home Modifications	Unit	2	1.00	6426.48	12852.96	
Integrated Health Care Coordination Total:						20249.25
Integrated Health Care Coordination	month	5	330.60	12.25	20249.25	
Nutritional Supplements Total:						4845.61
Nutritional Supplements	Unit	5	9.80	98.89	4845.61	
Personal Emergency Response System Total:						21967.47
Personal Emergency Response System	Unit	45	11.80	41.37	21967.47	
Pest Control Total:						6881.33
Pest Control	Unit	9	4.80	159.29	6881.33	
Specialized Medical Equipment and Supplies Total:						10198.02
Specialized Medical Equipment and Supplies	Unit	8	9.20	138.56	10198.02	
Transportation Total:						205478.51
Transportation	Trip	21	3409.30	2.87	205478.51	
Vehicle Modifications Total:						30000.00
Vehicle Modifications	Unit	2	1.00	15000.00	30000.00	
GRAND TOTAL:						8413146.99
Total Estimated Unduplicated Participants:						200
Factor D (Divide total by number of participants):						42065.73
Average Length of Stay on the Waiver:						343

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 Services Total:						288495.70
Adult Day Services	1/4 Hour	18	4415.30	3.63	288495.70	
Attendant Care Total:						6429427.20
Attendant Care	1/4 Hour	120	6378.40	8.40	6429427.20	
Care Management Total:						384427.68
Care Management	Month	195	10.40	189.56	384427.68	
Home and Community Assistance Total:						75443.42
Home and Community Assistance	1/4 Hour	16	599.90	7.86	75443.42	
Residential Based Habilitation Total:						867972.13
Residential Based Habilitation	1/4 Hour	34	2704.30	9.44	867972.13	
Respite Total:						753843.92
Respite	1/4 Hour	37	1793.50	11.36	753843.92	
Structured Day Program Total:						111368.82
Structured Day Program	1/4 Hour	8	2789.80	4.99	111368.82	
Supported Employment Total:						1974.68
Supported Employment	1/4 Hour	1	165.80	11.91	1974.68	
Adult Family Care Total:						138879.32
Adult Family Care	Day	6	304.60	75.99	138879.32	
Assisted Living Total:						103518.44
Assisted Living	Day	5	192.70	107.44	103518.44	
Behavior Management/ Behavior Program and Counseling Total:						181517.28
Behavior Management/ Behavior Program and Counseling	1/4 Hour	40	249.20	18.21	181517.28	
Community Transition Total:						1557.00
Community Transition	Unit	1	1.00	1557.00	1557.00	
GRAND TOTAL:						9876987.42
Total Estimated Unduplicated Participants:						200
Factor D (Divide total by number of participants):						49384.94
Average Length of Stay on the Waiver:						344

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Delivered Meals Total:						175398.50
Home Delivered Meals	Meal	59	383.10	7.76	175398.50	
Home Modifications Total:						13092.60
Home Modifications	Unit	2	1.00	6546.30	13092.60	
Integrated Health Care Coordination Total:						42408.32
Integrated Health Care Coordination	Month	9	331.60	14.21	42408.32	
Nutritional Supplements Total:						4936.26
Nutritional Supplements	Unit	5	9.80	100.74	4936.26	
Personal Emergency Response System Total:						21967.47
Personal Emergency Response System	Unit	45	11.80	41.37	21967.47	
Pest Control Total:						7009.63
Pest Control	Unit	9	4.80	162.26	7009.63	
Specialized Medical Equipment and Supplies Total:						10388.64
Specialized Medical Equipment and Supplies	Unit	8	9.20	141.15	10388.64	
Transportation Total:						233360.40
Transportation	Trip	21	3419.20	3.25	233360.40	
Vehicle Modifications Total:						30000.00
Vehicle Modifications	Unit	2	1.00	15000.00	30000.00	
GRAND TOTAL:					9876987.42	
Total Estimated Unduplicated Participants:					200	
Factor D (Divide total by number of participants):					49384.94	
Average Length of Stay on the Waiver:						344

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 Services Total:						298753.65
Adult Day Services	1/4 Hour	18	4402.50	3.77	298753.65	
Attendant Care Total:						6654999.36
Attendant Care	1/4 Hour	120	6359.90	8.72	6654999.36	
Care Management Total:						399029.28
Care Management	Month	195	10.40	196.76	399029.28	
Home and Community Assistance Total:						78087.94
Home and Community Assistance	1/4 Hour	16	598.10	8.16	78087.94	
Residential Based Habilitation Total:						898440.48
Residential Based Habilitation	1/4 Hour	34	2696.40	9.80	898440.48	
Respite Total:						780771.78
Respite	1/4 Hour	37	1788.30	11.80	780771.78	
Structured Day Program Total:						115273.65
Structured Day Program	1/4 Hour	8	2781.70	5.18	115273.65	
Supported Employment Total:						2043.11
Supported Employment	1/4 Hour	1	165.30	12.36	2043.11	
Adult Family Care Total:						143735.14
Adult Family Care	Day	6	303.70	78.88	143735.14	
Assisted Living Total:						107180.33
Assisted Living	Day	5	192.20	111.53	107180.33	
Behavior Management/ Behavior Program and Counseling Total:						187866.00
Behavior Management/ Behavior Program and Counseling	1/4 Hour	40	248.50	18.90	187866.00	
Community Transition Total:						1616.17
Community Transition	Unit	1	1.00	1616.17	1616.17	
GRAND TOTAL:						10248347.34
Total Estimated Unduplicated Participants:						200
Factor D (Divide total by number of participants):						51241.74
Average Length of Stay on the Waiver:						343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Delivered Meals Total:						181430.90
Home Delivered Meals	Meal	59	382.00	8.05	181430.90	
Home Modifications Total:						13590.12
Home Modifications	Unit	2	1.00	6795.06	13590.12	
Integrated Health Care Coordination Total:						68268.90
Integrated Health Care Coordination	Month	14	330.60	14.75	68268.90	
Nutritional Supplements Total:						5123.93
Nutritional Supplements	Unit	5	9.80	104.57	5123.93	
Personal Emergency Response System Total:						22801.14
Personal Emergency Response System	Unit	45	11.80	42.94	22801.14	
Pest Control Total:						7276.18
Pest Control	Unit	9	4.80	168.43	7276.18	
Specialized Medical Equipment and Supplies Total:						10783.14
Specialized Medical Equipment and Supplies	Unit	8	9.20	146.51	10783.14	
Transportation Total:						241276.16
Transportation	Trip/Trip & Mileage	21	3409.30	3.37	241276.16	
Vehicle Modifications Total:						30000.00
Vehicle Modifications	Unit	2	1.00	15000.00	30000.00	
GRAND TOTAL:						10248347.34
Total Estimated Unduplicated Participants:						200
Factor D (Divide total by number of participants):						51241.74
Average Length of Stay on the Waiver:						343

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 Services Total:						309847.95
Adult Day Services	1/4 Hour	18	4402.50	3.91	309847.95	
Attendant Care Total:						6906851.40
Attendant Care	1/4 Hour	120	6359.90	9.05	6906851.40	
Care Management Total:						414198.72
Care Management	Month	195	10.40	204.24	414198.72	
Home and Community Assistance Total:						81054.51
Home and Community Assistance	1/4 Hour	16	598.10	8.47	81054.51	
Residential Based Habilitation Total:						932361.19
Residential Based Habilitation	1/4 Hour	34	2696.40	10.17	932361.19	
Respite Total:						809885.30
Respite	1/4 Hour	37	1788.30	12.24	809885.30	
Structured Day Program Total:						119724.37
Structured Day Program	1/4 Hour	8	2781.70	5.38	119724.37	
Supported Employment Total:						2120.80
Supported Employment	1/4 Hour	1	165.30	12.83	2120.80	
Adult Family Care Total:						149183.51
Adult Family Care	Day	6	303.70	81.87	149183.51	
Assisted Living Total:						111245.36
Assisted Living	Day	5	192.20	115.76	111245.36	
Behavior Management/ Behavior Program and Counseling Total:						195022.80
Behavior Management/ Behavior Program and Counseling	1/4 Hour	40	248.50	19.62	195022.80	
Community Transition Total:						1677.58
Community Transition	Unit	1	1.00	1677.58	1677.58	
GRAND TOTAL:						10655118.89
Total Estimated Unduplicated Participants:						200
Factor D (Divide total by number of participants):						53275.59
Average Length of Stay on the Waiver:						343

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Delivered Meals Total:						188417.68
Home Delivered Meals	Meal	59	382.00	8.36	188417.68	
Home Modifications Total:						14106.54
Home Modifications	Unit	2	1.00	7053.27	14106.54	
Integrated Health Care Coordination Total:						91106.75
Integrated Health Care Coordination	Month	18	330.60	15.31	91106.75	
Nutritional Supplements Total:						5318.46
Nutritional Supplements	Unit	5	9.80	108.54	5318.46	
Personal Emergency Response System Total:						23666.67
Personal Emergency Response System	Unit	45	11.80	44.57	23666.67	
Pest Control Total:						7552.66
Pest Control	Unit	9	4.80	174.83	7552.66	
Specialized Medical Equipment and Supplies Total:						11193.09
Specialized Medical Equipment and Supplies	Unit	8	9.20	152.08	11193.09	
Transportation Total:						250583.55
Transportation	Trip & Mileage	21	3409.30	3.50	250583.55	
Vehicle Modifications Total:						30000.00
Vehicle Modifications	Unit	2	1.00	15000.00	30000.00	
GRAND TOTAL:						10655118.89
Total Estimated Unduplicated Participants:						200
Factor D (Divide total by number of participants):						53275.59
Average Length of Stay on the Waiver:						343

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 Services Total:						321734.70
Adult Day Services	1/4 Hour	18	4402.50	4.06	321734.70	
Attendant Care Total:						7173967.20
Attendant Care	1/4 Hour	120	6359.90	9.40	7173967.20	
Care Management Total:						429936.00
Care Management	Month	195	10.40	212.00	429936.00	
Home and Community Assistance Total:						84116.78
Home and Community Assistance	1/4 Hour	16	598.10	8.79	84116.78	
Residential Based Habilitation Total:						967198.68
Residential Based Habilitation	1/4 Hour	34	2696.40	10.55	967198.68	
Respite Total:						840983.84
Respite	1/4 Hour	37	1788.30	12.71	840983.84	
Structured Day Program Total:						124175.09
Structured Day Program	1/4 Hour	8	2781.70	5.58	124175.09	
Supported Employment Total:						2201.80
Supported Employment	1/4 Hour	1	165.30	13.32	2201.80	
Adult Family Care Total:						154868.78
Adult Family Care	Day	6	303.70	84.99	154868.78	
Assisted Living Total:						115473.76
Assisted Living	Day	5	192.20	120.16	115473.76	
Behavior Management/ Behavior Program and Counseling Total:						202477.80
Behavior Management/ Behavior Program and Counseling	1/4 Hour	40	248.50	20.37	202477.80	
Community Transition Total:						1741.33
Community Transition	Unit	1	1.00	1741.33	1741.33	
GRAND TOTAL:						11089411.23
Total Estimated Unduplicated Participants:						200
Factor D (Divide total by number of participants):						55447.06
Average Length of Stay on the Waiver:						343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Delivered Meals Total:						195629.84
Home Delivered Meals	Unit	59	382.00	8.68	195629.84	
Home Modifications Total:						14642.60
Home Modifications	Unit	2	1.00	7321.30	14642.60	
Integrated Health Care Coordination Total:						120824.38
Integrated Health Care Coordination	Month	23	330.60	15.89	120824.38	
Nutritional Supplements Total:						5520.34
Nutritional Supplements	Unit	5	9.80	112.66	5520.34	
Personal Emergency Response System Total:						24569.37
Personal Emergency Response System	Unit	45	11.80	46.27	24569.37	
Pest Control Total:						7839.50
Pest Control	Unit	9	4.80	181.47	7839.50	
Specialized Medical Equipment and Supplies Total:						11618.50
Specialized Medical Equipment and Supplies	Unit	8	9.20	157.86	11618.50	
Transportation Total:						259890.94
Transportation	Trip & Mileage	21	3409.30	3.63	259890.94	
Vehicle Modifications Total:						30000.00
Vehicle Modifications	Unit	2	1.00	15000.00	30000.00	
GRAND TOTAL:						11089411.23
Total Estimated Unduplicated Participants:						200
Factor D (Divide total by number of participants):						55447.06
Average Length of Stay on the Waiver:						343