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 section 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 waiver's 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.

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 section 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*):

Indiana Assisted Living Services Waiver

C. Type of Request: new

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**

☐ **New to replace waiver**

Replacing Waiver Number:

Base Waiver Number:

Amendment Number (if applicable):

Effective Date: (mm/dd/yy)

Draft ID: **IN.019.00.00**

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

Regular Waiver

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

07/01/26

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: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 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:

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

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

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

1. Request Information (3 of 3)

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

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

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

☑ **Waiver(s) authorized under section 1915(b) of the Act.**

Specify the section 1915(b) waiver program and indicate whether a section 1915(b) waiver application has been submitted or previously approved:

The Indiana PathWays for Aging 1915(b) waiver was approved effective July 1, 2024

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

☑ **section 1915(b)(1) (mandated enrollment to managed care)**

☐ **section 1915(b)(2) (central broker)**

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

☑ **section 1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under section 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 section 1915(i) of the Act.**

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

☐ **A program authorized under section 1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

Indiana operates this 1915(c) waiver concurrent with a 1915(b) waiver to implement Indiana PathWays for Aging (PathWays), a statewide managed long term services and supports (MLTSS) program. PathWays serves Medicaid enrollees who are 60 years of age and older and are eligible for Medicaid on the basis of age, blindness, or disability. Enrollees receive long term services and supports (including hospice, nursing facility, and home and community based services (HCBS)) as well as physical and behavioral health services through managed care entities (MCEs) selected through a competitive procurement process.
The PathWays Assisted Living 1915(c) waiver provides an alternative to nursing facility admission for enrollees 60 years of age. The waiver provides specified benefits to eligible enrollees residing in assisted living facilities. The goal of the waiver is to make available affordable housing with personal and health-related services for eligible enrollees.
The waiver is being submitted in compliance with HEA 1277 enacted by the Indiana General Assembly in 2026. HEA 1277 requires the Family and Social Services Administration (FSSA) to apply to the United States Department of Health and Human Services no later than September 1, 2026, for a Medicaid waiver to provide assisted living services effective July 1, 2026 in a waiver separate from the Medicaid home and community-based services waiver that included assisted living services to individuals who:
1) Are at least sixty (60) years of age; and
2) Meet nursing facility level of care requirements;
as an available service before July 1, 2026. HEA 1277 requires the FSSA to transfer slots from the existing Medicaid home and community based services waiver that include assisted living services to individuals described above to this new assisted living Medicaid waiver application. HEA 1277 prohibits the FSSA from increasing the current number of slots authorized under the current Indiana PathWays for Aging waiver.
The PathWays Assisted Living waiver (ALW) must reimburse for the following services, if included in the individual's home and community-based services plan - assisted living services, integrated health care coordination, and transportation. The FSSA is submitting an amendment for the Indiana PathWays for Aging 1915(c) waiver to transfer waiver slots to this waiver and to sunset assisted living as an available service.
This waiver submission anticipates serving the following unduplicated participants:
Year 1 (July 1, 2026-June 30, 2027) 6,500
Year 2 (July 1, 2027-June 30, 2028) 6,500
Year 3 (July 1, 2028-June 30, 2029) 6,500
Year 4 (July 1, 2029-June 30, 2030) 6,500
Year 5 (July 1, 2030-June 30, 2031) 6,500

The waiver will include a reserved capacity of additional priority slots to support individuals in the following categories:
• Age out of Health and Wellness waiver
• Community Transition of institutionalized person due to "Money Follows the Person" initiative
• Maintains access to assisted living services for those who are newly Medicaid eligible
When there are available reserved capacity slots, eligible individuals who meet the available reserved capacity criteria specified in Appendix B-3-c will be assigned the appropriate reserved capacity slot and invited from the waiting list to the ALW on a first come first served basis by date of application.

In the event there are unavailable slots, individuals seeking the waiver are placed on a single statewide waiting list. When there are available unreserved slots, eligible individuals will be assigned a general slot and invited from the waiting list to the AL Waiver in the following order:
1. Those transitioning from 100% state funded budgets to the waiver, nursing facilities to the waiver, or discharging from inpatient hospital settings receive first priority of targeted waiver invitations on a first come first serve basis by date of application.
2. Individuals on the waiting list without a priority status receive the remaining targeted waiver invitations on a first come first served basis by date of application.

The OMPP is the Medical Assistance Unit of Indiana's Single State Medicaid Agency, the FSSA. OMPP is responsible for operation and oversight of the PathWays 1915(b)/(c) waivers and MCE compliance and performance.

As outlined in the concurrent 1915(b) PathWays waiver, some populations who meet the eligibility criteria for the ALW 1915(c) waiver may voluntarily enroll with an MCE or can opt to remain in fee-for-service (FFS). This includes American Indians/Alaskan Natives (AI/AN) and individuals who are receiving hospice services at the time they become eligible for Indiana PathWays for Aging Medicaid (including upon initial implementation of PathWays on July 1, 2024). 1915(c) waiver services available to those enrollees who opt to remain in FFS are identical to those available to enrollees served by an MCE. Throughout this waiver "service coordinator" is used to reference waiver case management delivered by MCEs and "care manager" is used to reference waiver case management in the FFS delivery system.

Additional waiver services offered under this waiver include the following:

• Caregiver Coaching
• Community Transition
• Nutritional Supplements
• Integrated Health Care Coordination
• Service Coordination
• Specialized Medical Equipment and Supplies
• Vehicle Modifications

This waiver establishes an individual cost limit of not more than the institutional cost of nursing facility services as outline in Appendix J. The cost limit is a requirement outlined in HEA 1277. The cost limit only applies to individuals who enter the ALW waiver at age 60 or older. The cost limit does not include individuals who age into the waiver from another waiver, such as Health & Wellness, Community Integration & Habilitation, or Family Supports.

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 section 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 section 1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select*

one):

- (•) **Not Applicable**
- ( ) **No**
- ( ) **Yes**

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

- (•) **No**
- ( ) **Yes**

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

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

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

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

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

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

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care

specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR § 441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

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

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

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

Appendix C.

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

F. FFP Limitation. In accordance with 42 CFR Part 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. 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 Part 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 public comment period for this waiver is 60 days for tribal comment and 30 days for public. In addition to the public comment period, the state also convened an Assisted Living workgroup as required in Indiana HEA 1277. The group consisted of workgroup members includes three assisted living providers appointed by the Governor of the State of Indiana. FSSA met with the Assisted Living workgroup five times from 5/1/2026-6/12/2026. The Assisted Living Workgroup members offered recommendations and feedback on language and services added to this waiver application.

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:

Cunningham Piggott

First Name:

Holly

Title: Director of Care Programs

Agency: Family and Social Services Administration, Office of Medicaid Policy and Planning

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

Address 2:

City: Indianapolis

State: **Indiana**

Zip: 46204

Phone: (317) 233-6117 **Ext:** ☐ **TTY**

Fax: (317) 234-5076

E-mail: holly.cunninghampiggott@fssa.in.gov

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:

Phone: ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under section 1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name: Frenzel

First Name: Audrey

Title: Indiana Medicaid Director

Agency: Family and Social Services Administration, Office of Medicaid Policy and Planning

Address: 402 W Washington St

Address 2: Room W374

City: Indianapolis

State: **Indiana**

Zip: 46204

Phone: (317) 232-0242 **Ext:** ☐ **TTY**

Fax: (317) 234-5076

E-mail: audrey.frenzel@fssa.in.gov

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

The Indiana Family and Social Services Administration (FSSA) attests that no net reduction in the total unduplicated number of participants being served will result from the split of the previously approved Indiana PathWays for Aging waiver into the two waivers hereafter known as the PathWays Assisted Living waiver (ALW) and PathWays Waiver (PathWays). Indiana has developed a transition plan to facilitate continuity of care as 1915(c) waiver enrollees transition to enrollment from the PathWays waiver to the ALW waiver. This includes a strategy for engagement with interested parties, enrollee outreach, and continuity of care provisions.

As required by HEA 1277, the state also convened an Assisted Living workgroup as required in Indiana HEA 1277. The group consisted of three assisted living providers appointed by the Governor of the State of Indiana. FSSA met with the Assisted Living workgroup five times from 5/1/2026-6/12/2026. The Assisted Living Workgroup members offered recommendations and feedback on language and services added to this waiver application. The workgroup will continue to operate after this waiver is approved. The workgroup is charged with providing feedback to ensure quality services and operational efficiencies upon launch of the new waiver.

Interested Parties Engagement
Pursuant to the requirements established by the Indiana General Assembly in HEA 1277 (2026), the Family and Social Services Administration established a work group of interested stakeholders to assist in the development and implementation of the ALW waiver. The Indiana Governor appointed the members of the work group and included providers of assisted living services as members of the workgroup. The workgroup has an established charter to ensures statutory compliance with HEA 1277 (2026), and defines the purpose, membership, and deliverables to support the waiver submission. The workgroup will advise on waiver framework and review waiver application, policy documents, and communication plan. As part of the transition plan, FSSA will convene enrollees and interested parties to solicit public engagement and provide education on the new ALW waiver. FSSA will use strategies such as direct mail, social media, website content, webinars, and other media platforms to communicate the transition to the new ALW.

Targeted Enrollee Outreach
Four to six months prior to launch, FSSA will identify enrollees impacted by splitting the PathWays waiver into two waivers. Three months prior to the launch of the ALW waiver outreach to current enrollees and stakeholders will begin. For individuals receiving assisted living services, integrated healthcare coordination and transportation services on the current PathWays waiver, the waiver case manager or service coordinator will contact enrollees to develop a service plan authorization under the new ALW waiver and end their service plan under the PathWays waiver. Enrollees and providers will receive updated authorizations prior to the launch of the ALW waiver.

Transition from PathWays Waiver to ALW Waiver
There is no change to eligibility requirements to access the ALW waiver. Enrollees can receive the ALW waiver if they:

- Are at least sixty (60) years of age; and
- Meet nursing facility level of care requirements; and
- Must choose to receive assisted living services in an assisted living setting

Current enrollees should not be impacted by the change in waiver once the new waiver is approved.

Moving current enrollees to the new waiver is a process change. There will be no changes to services, number of units, or frequency during the transition process from one waiver to the new waiver. Once processed the enrollee will have a new service plan authorization for assisted living services under the new waiver.

New enrollees to the ALW waiver will receive a waiver slot based on the enrollees choice to receive assisted living services. At the time of the functional assessment, waiver applicants must choose the assisted living setting to be eligible and receive an ALW waiver slot. When there are no available slots available a single statewide ALW waiver waiting list will be implemented. Invitations will be sent to applicants on the waiting list once slots are available.

Services Transitioning to ALW
Assisted Living - This service will only be offered to individuals outlined above through the new ALW waiver upon approval. This service will no longer be offered on the current PathWays waiver.
The following services will be offered in addition to Assisted Living upon ALW waiver approval.
Caregiver Coaching
Community Transition
Integrated Health Care Coordination
Nutritional Supplements
Service Coordination - Only allowed for individuals who remain in fee-for-service Medicate and who are not enrolled in a

managed care health plan.
Specialized Medical Equipment
Vehicle Modifications
All services must identified as a need through the assessment process and be included on the person centered service plan.

This Waiver will have a cost limit not to exceed the average institutional costs per member per year as stated in HEA 1277. This cost limit will apply to individuals who enter the ALW age 60 and older. This cost limit does not apply to anyone aging onto the ALW waiver when they are on a current waiver, such as an individual currently receiving Health and Wellness waiver services who turns 60 years old and transitions to the AL Waiver. If an individual has a cost that exceeds the cost limit when transition from one waiver to the AL waiver, then the cost limit will not apply.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

This Waiver will have a cost limit not to exceed the average institutional costs per member per year as stated in HEA 1277. This cost limit will apply to individuals who enter the ALW at age 60 and older. This cost limit does not apply to anyone aging onto the ALW waiver when they are on a current waiver, such as an individual currently receiving Health and Wellness waiver services who turns 60 years old and transitions to the AL Waiver. If an individual has a cost limit that exceeds the cost limit when transitioning from one waiver to the AL waiver, then the cost limit will not apply.

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:

   Office of Medicaid Policy and Planning (OMPP)

   (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.

   (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:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the state Medicaid agency. Thus this section does not need to be completed.

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.:*

MANAGED CARE ENTITIES (MCE)
OMPP contracts with MCEs to provide statewide, risk-based managed care services to PathWays enrollees. MCEs meet the definition of a managed care organization under 42 CFR 438.2. MCEs are responsible for coordinating and providing member-driven, accessible, equitable, and high-quality services to enrollees for medical, behavioral, and long-term services and supports, including Assisted Living 1915(c) waiver services. The PathWays 1915(b) waiver defines the full scope of MCE responsibilities. Additionally, MCEs conduct the following 1915(c) waiver operational and administrative functions: - Service planning - Prior authorization of waiver services - Utilization management - Execution of Medicaid provider agreements - Quality assurance and quality improvement activities

FISCAL AGENT
OMPP's Fiscal Agent is responsible for enrolling waiver providers in accordance with Medicaid provider enrollment requirements under 42 CFR 455 Subpart E. The Fiscal Agent also reimburses claims for authorized waiver services submitted by authorized waiver providers for the PathWays FFS population.

ACTUARIAL CONTRACTOR
OMPP contracts with an Actuarial Contractor responsible for developing MCE capitation rates in accordance with 42 CFR 438.5. Additionally, the contractor completes budget planning, forecasts, and cost neutrality calculations for the PathWays 1915(c) waiver. The contractor is also responsible for developing and assessing the rate methodology for waiver services, cost surveys, and calculating rate adjustments.

LEVEL OF CARE ASSESSMENT REPRESENTATIVE (LCAR) CONTRACTOR is responsible for performing Nursing Facility (NF) Level of Care (LOC) evaluations and re-evaluations and routing recommendations to designated staff members within the FSSA for subsequent approval or denial.

EXTERNAL QUALITY REVIEW ORGANIZATION (EQRO) OMPP contracts with an EQRO to evaluate quality, timeliness, and access to services furnished by PathWays MCEs. The EQRO conducts all mandatory external quality review (EQR) functions as required under 42 CFR 438.358(b).

NCI SURVEY CONTRACTOR FSSA contracts with an entity responsible for NCI survey administration.

UTILIZATION MANAGEMENT CONTRACTOR The waiver auditing function is incorporated into the Program Integrity (PI) functions of the contract between the Medicaid agency and Fraud and Abuse Detection System (FADS) contractor. FSSA has expanded its Program Integrity activities by using a multipronged approach to PI activity that includes provider self-audits, contractor desk audits, and full on-site audits. The FADS contractor sifts and analyzes claims data and identifies providers and claims that indicate aberrant billing patterns or other risk factors, such as correcting claims. FSSA or any other legally authorized governmental entity (or their agents) may at any time during the term of the provider agreement and in accordance with Indiana Administrative Code conduct audits for the purposes of assuring the appropriate administration and expenditure of the monies provided to the provider through this provider agreement. Additionally, FSSA may at any time conduct audits to assure appropriate administration and delivery of services under the provider agreement. The Program Integrity activities describe post-payment financial audits to ensure the integrity of IHCP payments. Detailed information on PI policy and procedures is available in the IHCP Provider and Member Utilization Review provider reference module. f Program Integrity receives allegations of Medicaid provider fraud, waste, and abuse and tracks these in its case management system. To begin investigating these allegations, Program Integrity vets the providers with the Medicaid Fraud Control Unit (MFCU). Once it receives MFCU's clearance PI determines how to best validate the accuracy of the allegation. PI conducts its audit activities and develops a findings report for the provider which may include a corrective action plan and request for overpayment. 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 FSSA. 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.

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

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver

operational and administrative functions and, if so, specify the type of entity (*Select One*):

- ○ **Not applicable**
- ◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

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

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

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

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

  Area Agencies on Aging (AAAs), in their role as Indiana's designated Aging and Disability Resource Centers , are responsible for disseminating information regarding PathWays managed Medicaid program, PathWays 1915(c) waiver services program, and Assisted Living 1915(c) waiver services program to potential enrollees, assisting individuals in the waiver enrollment application process, and referring individuals to the Level of Care Assessment Representative (LCAR) contractor for level of care evaluation activities. Additionally, at the time of options counseling, the AAAs provide individuals interested in enrolling in PathWays with support in connecting with the Enrollment Broker for choice counseling in accordance with 42 CFR 438.71(c). AAAs may also develop an initial service plan for newly eligible PathWays enrollees enrolled in the fee-for-service delivery system.

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:

OMPP is responsible for assessing performance of the MCEs, Fiscal Agent, Actuarial Contractor, and EQRO .

The Family and Social Services Administration (FSSA) has oversight responsibility of the NCI-AD Survey Administrator. FSSA is the single state Medicaid agency.

The Division of Disability, Aging, and Rehabilitative Services (DDARS) in collaboration with OMPP is responsible for assessing performance and oversight of operations for the AAAs and LCAR Contractor. The DDARS is a division under FSSA, the single state Medicaid agency.

The oversight of performance of the Fraud and Abuse Detection Systems (FADS) contract is performed by Program Integrity.

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:

MANAGED CARE ENTITIES (MCE)
OMPP has developed a comprehensive oversight strategy to ensure PathWays MCEs are performing in accordance with contractual and waiver requirements. These strategies are described in further detail in the PathWays 1915(b) waiver. For example, OMPP requires MCEs to submit extensive reporting on an ad hoc, weekly, monthly, quarterly, and annual basis in accordance with the PathWays MCE Reporting Manual specifications. OMPP promptly reviews all reports received to ensure alignment with technical specifications, performance against contractual targets, and timely submission. OMPP also conducts bi-monthly onsite reviews of all PathWays MCEs to verify compliance through operational demonstrations and documentation reviews. Additionally, OMPP audits service plans, as further described in Appendix H and Item D-1g. In the event of identified deficiency during these oversight activities, a corrective action plan, liquidated damages, or other contractually agreed upon remedy is required. OMPP provides the MCE written notice of non-compliance with expected remediation action and monitors the corrective actions implemented through to resolution. In the event remediation is not achieved in accordance with the required corrective action plan, OMPP may implement escalating non-compliance remedies, the nature and severity of which is based on the area of non-compliance and programmatic impact. Monitoring results are also utilized to identify issues for performance improvement projects.

FISCAL AGENT
OMPP oversees the Fiscal Agent to ensure waiver providers are enrolled timely and in accordance with requirements under 42 CFR 455 Subpart E. The Fiscal Agent is contractually required to enroll providers within 20 business days for paper applications and 15 business days for electronic portal submissions. OMPP reviews weekly and monthly reports from the Fiscal Agent regarding provider enrollment. Additionally, OMPP conducts onsite weekly meetings to discuss provider enrollment issues, including any quality, timeliness, or policy concerns or updates. In the event of identified deficiencies, OMPP implements a corrective action plan, liquidated damages, or other contractually agreed upon remedy.

ACTUARIAL CONTRACTOR
OMPP is responsible for monitoring the performance of the Actuarial Contractor. 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. On an ongoing basis, OMPP ensures the contractor complies with all requirements, deliverables, and timelines as outlined in its contract. In the event of contract non-compliance or performance deficiency, corrective action is pursued in accordance with contract terms. The actuarial contractor is also under contract to develop and assess rate methodology for HCBS. Rate methodology for PathWays services is assessed and reviewed every five years at renewal. The actuarial contractor completes the cost surveys and calculates rate adjustments. The OMPP reviews and approves the fee schedule to ensure consistency, efficiency, economy, quality of care, and sufficient access to providers for PathWays services. The Actuarial Contractor's contract is not a performance based contract.

LEVEL OF CARE ASSESSMENT REPRESENTATIVE (LCAR) CONTRACTOR
The State Medicaid Agency contracts with a level of care assessment representative contractor, who performs level of care evaluations and re-evaluations for Indiana's Medicaid certified nursing facilities and HCBS waivers. FSSA requires the Level of Care Assessment Representative (LCAR) contractor to report a variety of performance measures on a weekly, monthly, quarterly, and annual basis. The reports capture information regarding level of care outcomes, number of assessments, quality related monitoring outcomes, data on provider training/communication, appeals, complaints, number of level of care assessments completed by non-contractor staff, LCAR contractor compliance and other reports. In addition to regular review of reports, the state and the LCAR contractor will meet regularly and as issues may arise to provide a forum to discuss progress, share updates, and collaborate on projects. As part of this monitoring process, FSSA staff set benchmarks on key performance indicators and regularly track the LCAR contractor progress towards meeting those targets. Targets are set for each key performance indicator and those indicators that fall below the desired target are reviewed and corrective action will be taken as deemed necessary.

EQRO
OMPP is responsible for monitoring the EQRO's performance. On an ongoing basis, OMPP ensures the EQRO follows 42 CFR Part 438, Subpart E, and additional state requirements outlined in its contract with the EQRO. OMPP ensures tasks are completed in a timely manner and in accordance with CMS EQRO protocols, and pursues corrective action plans for failure to meet deliverables.

NCI SURVEY ADMINISTRATOR
Family and Social Services Administration (FSSA) has oversight responsibility of the NCI-AD Survey Administrator. FSSA meets at least monthly with the NCI-AD Survey Administrator to ensure all contractual requirements are met.

AREA AGENCIES ON AGING (AAA)
Performance based agreements are written with the AAAs in their role as Indiana's designated Aging and Disability Resource Centers and are audited by the Indiana State Board of Accounts and the Family and Social Services Administration's (FSSA's) Audit Unit. These audits are performed on a biannual basis.

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

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.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

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 waiver eligibility 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 state's quality improvement strategy, provide information in the following fields to detail the state's 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 percentage of quarterly reports submitted to OMPP by Managed Care Entities (MCE) within the required time period. Numerator: Number of quarterly reports received. Denominator: Number of quarterly reports due.

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

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

☑ **Other** Specify: MCE	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
A.2 Number and percentage of State MCE onsite reviews conducted within the required time period. Numerator: Number of MCE onsite reviews conducted. Denominator: Number of MCE onsite reviews due.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Every 2 months	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify: Every 2 months

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 agent. Numerator: The number of providers assigned a Medicaid provider number by the fiscal agent according to the required timeframe specified in the contract. Denominator: The 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*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

MCEs are contractually required to submit a series of reports in accordance with the PathWays Reporting Manual. OMPP promptly reviews all reports received to ensure alignment with reporting technical specifications, performance against contractual targets, and timely submission.

OMPP also conducts bi-monthly onsite reviews of all PathWays MCEs. Site visits are utilized to review MCE compliance with federal, state, and contract requirements through strategies such as onsite demonstrations of operational procedures, meetings and interviews with MCE personnel, and monitoring helpline calls. In the event an onsite review is not conducted in accordance with the planned bi-monthly cadence, OMPP identifies the cause of the delay and implements remediation accordingly. For example, if it was due to MCE failure to participate, contract non-compliance remedies would be implemented.

OMPP will utilize a three-step process for ensuring compliance with this assurance. The process will include: 1) collecting policies and procedures from the MCE; 2) performing onsite reviews; and 3) conducting system demonstration and verification to ensure implementation of, and adherence to, policies and procedures. The MCE will be required to show the policy, demonstrate how the data is tracked in the system, and then provide the remediation activities (if applicable).

In the event of an identified deficiency, a corrective action plan, liquidated damages, or other contractually agreed upon remedy is required. OMPP provides the MCE written notice of non-compliance with expected remediation action and monitors the corrective actions implemented through to resolution. In the event remediation is not achieved in accordance with the required corrective action plan, OMPP may implement escalating corrective action, the nature and severity of which is based on the area of non-compliance and programmatic impact.

Additionally, depending on the nature of MCE non-compliance, OMPP may determine additional policy guidance or contractual modifications are necessary to clarify expectations and ensure performance in accordance with state expectations. In such cases, OMPP may initiate contract amendment or policy clarification through updates to the MCE

Policy and Procedure Manual. Trends are also monitored for the potential development of new Performance Improvement Projects.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Every 2 months

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 Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☑ **Aged or Disabled, or Both - General**					
	☑	**Aged**	65		☑
	☑	**Disabled (Physical)**	60	64	
	☑	**Disabled (Other)**	60	64	
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Brain Injury			☐
	☐	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:

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

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

- ○ **Not applicable. There is no maximum age limit**
- ● **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

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

Appendix B: Participant Access and Eligibility

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

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

- ○ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

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

Specify the percentage:

○ **Other**

Specify:

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

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

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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:

Face to face assessment and development of the plan of care is used to ensure that all waiver participants' care can be provided within the individual cost limit. All potentially eligible waiver participants who:
• meet nursing facility LOC; and
• have been targeted from the ALW waiting list, or are found to meet reserved waiver capacity (priority) criteria with an available budgeted slot granting entry into ALW; and
• eligible individual service plan does not exceed 100% of the institutional cost limit, except for individuals who age into the AL waiver from another waiver such as the Health and Wellness waiver
are afforded the opportunity to develop a service plan. The initial assessment and development of service plan takes into consideration the applicant's functional needs, level of caregiver support if present, and environmental factors that impact the health and welfare of the applicant. The service plan is based upon results of the Person-Centered Planning process. MCEs are responsible for reviewing the service plan to ensure the member's needs can be met with a plan that does not exceed 100% of institutional cost limit. MCEs are expected to review all other services in combination with waiver services when making the determination that a member's plan can support the member's needs and does not exceed 100% of the institutional cost limit. Individuals who remain in FFS, the State determines whether or not the waiver services, in combination with other sources of coverage including the Medicaid state plan, natural supports and other available community supports and resources, can adequately meet the needs of the individual and ensure his or her health, safety and welfare.

The development of the plan of the care includes planning, with the applicant and/or representative, the type, duration and frequency of services needed to meet the needs of the individual along with the cost of those services. The services as outlined in plan of care are then compared against the cost for level of care as outlined in the waiver per year. Should the need for services exceed the individual cost limit the applicant and/or legal representative is notified of ineligibility in writing including notification of the right to hearing and instructions about how to request a hearing.

This Waiver will have a cost limit not to exceed the average institutional costs per member per year as stated in HEA 1277. This cost limit will apply to individuals who enter the ALW at age 60 and older. This cost limit does not apply to anyone aging onto the ALW waiver when they are on a current waiver, such as an individual currently receiving Health and Wellness waiver services who turns 60 years old and transitions to the AL Waiver. If an individual has a cost that exceeds the cost limit when transitioning from one waiver to the AL waiver, then the cost limit will not apply.

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:

Once services are initiated, the service coordinator conducts monthly conferences with the individual/representative whose average monthly cost of care is expected to exceed the average monthly cost of care at a nursing facility. If additional services above the amount of the individual cost limit are needed, care coordination will document in the service plan the reason for the cost and whether there is an expected reduction in service. Additional services may be offered on a short-term basis if it is anticipated that the cost of services over the period of a year will not exceed the individual cost limit.

Waiver clients whose service cost exceeds 105% of the average monthly nursing home cost for more than two months, may also be offered non-Medicaid community resources as an alternative, or supplement to, waiver services. As the last resort, the member may be transitioned to a nursing facility.

Waiver clients may have authorized waiver services that exceed the cost limit if the waiver authorization is short-term. If total cost of care exceeds institutional cost for more than 6 months, the individual will be transitioned to a nursing facility.

☐ **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	6500
Year 2	6500
Year 3	6500
Year 4	6500
Year 5	6500

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

- ○ **Not applicable. The state does not reserve capacity.**
- ◉ **The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

Purposes
Maintain access to assisted living services for those who are newly Medicaid eligible
Community transition of institutionalized person due to Money Follows the Person program
Age out of the Health & Wellness Waiver

Appendix B: Participant Access and Eligibility

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

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

Maintain access to assisted living services for those who are newly Medicaid eligible

Purpose *(describe):*

Maintain access to assisted living services for those who are newly Medicaid eligible

Describe how the amount of reserved capacity was determined:

Individuals who (i) are currently residing in a Medicaid enrolled assisted living facility, (ii) are determined by the state to newly meet financial eligibility for full Medicaid coverage as a result of change in their income and assets, (iii) do not require the Special Income Limits in order to be Medicaid eligible, and (iv) are relying on Medicaid financial and functional eligibility to continue to reside in the assisted living facility are given priority for the PathWays waiver so long as they meet nursing facility level of care, are Medicaid eligible, and are able to access long-term services and supports (LTSS services).

Priority access by Reserved Waiver Capacity is made available as long as available waiver capacity exists for the current waiver year.

The State does not limit or restrict waiver participant access to waiver services except as provided in Appendix C.

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

Waiver Year	Capacity Reserved
Year 1	300
Year 2	300
Year 3	300
Year 4	300
Year 5	300

Appendix B: Participant Access and Eligibility

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

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

Community transition of institutionalized person due to Money Follows the Person program

Purpose *(describe):*

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

Describe how the amount of reserved capacity was determined:

The State reviewed the number of patients currently receiving institutional care above age 60 and determined, based upon the number of waiver slots, the realistic number of individuals that could be transitioned in year 1 through 5. Indiana plans to continue transitioning persons from the nursing facility to HCBS settings maximizing the MFP program.

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

Waiver Year	Capacity Reserved
Year 1	150
Year 2	150
Year 3	150
Year 4	150
Year 5	150

Appendix B: Participant Access and Eligibility

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

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

Age out of the Health & Wellness Waiver

Purpose *(describe):*

To provide seamless transition of Health & Wellness 1915(c) waiver enrollees to the ALW 1915(c) waiver upon turning age 60.

Describe how the amount of reserved capacity was determined:

The state utilized as baseline data the number of individuals on the Health and Wellness waiver turning 60 during the most recently completed year (SFY 2024) and projected the number to grow proportionately with the number of unique individuals served on the PathWays and Health and Wellness 1915(c) waivers.

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

Waiver Year	Capacity Reserved
Year 1	225
Year 2	225
Year 3	225
Year 4	225
Year 5	225

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:

All individuals seeking the waiver are placed on the waiting list. Eligible individuals who meet reserve capacity criteria will be assigned a reserve capacity slot when available.

Individuals are invited each month from the waiting list in the following order:

1. Those transitioning from 100% state funded budgets to the waiver, nursing facilities to the waiver, or discharging from inpatient hospital settings receive first priority of targeted waiver invitations each month on a first come first serve basis by date of application.

2. Individuals on the waiting list without a priority status receive the remaining targeted waiver invitations on a first come first served basis by date of application.

Upon invitation, individuals are sent an invitation letter which outlines the steps necessary to complete waiver enrollment. If the individual does not accept the waiver invitation to continue the process within 45 days of the date of the invitation letter or does accept the waiver invitation but the individual does not complete the necessary steps for waiver enrollment within 180 days of the date of the invitation letter, FSSA will rescind the invitation. The individual, case manager/service coordinator and legal representative (if any) will be notified in writing of the rescindment with appeal rights. FSSA will re-assign the available slot.

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)*:

- (•) **Section 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)

- [ ] **Parents and Other Caretaker Relatives (42 CFR § 435.110)**
- [ ] **Pregnant Women (42 CFR § 435.116)**
- [ ] **Infants and Children under Age 19 (42 CFR § 435.118)**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR § 435.121**
- [ ] **Optional state supplement recipients**
- [x] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

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

Specify percentage: [ ]

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

Section 1925 of the Act - Transitional Medical Assistance

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- [x] **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, 2027 (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 section 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 section 1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 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 period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

● **Spousal impoverishment rules under section 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 section 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 (Section 1634 State/SSI Criteria 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 section 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 period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

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

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

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

  Select one:

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

    (*select one*):

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

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

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

    Specify percentage: [ ]
  - ( ) **Other standard included under the state plan**

    Specify:

    [ ]
- ( ) **The following dollar amount**

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

  Specify:

  [ ]
- ( ) **Other**

  Specify:

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

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

Specify:

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

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

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

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

Specify:

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

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

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

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

Specify:

- ( ) **Other**

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).

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 period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

The state uses the post-eligibility rules of section 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 section 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 or 42 CFR § 435.735:

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

Select one:

- **Not Applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The state does not establish reasonable limits.**
- **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State - January 1, 2014 through September 30, 2027 (or other date as required by law).

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State - January 1, 2014 through September 30, 2027 (or other date as required by law).

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - January 1, 2014 through September 30, 2027 (or other date as required by law).

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

- (●) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By an entity under contract with the Medicaid agency.**

  Specify the entity:

- ( ) **Other**
  Specify:

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:

The Level of Care Assessment Representative (LCAR) contractor's staff assessors must meet the following qualifications:

a. A registered nurse with one year's experience in human services; or
b. A bachelor's degree in health, social work, or related field; or
c. An associate's degree in nursing; or
d. A master's degree in any field; and
e. Cleared by background checks to ensure the individual applicant does not have a criminal background.

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.

Indiana law allows reimbursement to nursing facilities for eligible persons who require skilled or intermediate nursing care. Skilled nursing services, as ordered by a physician, must be required and provided on a daily basis, essentially 7 days a week. Intermediate nursing care includes care for patients with long term illnesses or disabilities which are relatively stable, or care for patients nearing recovery and discharge who continue to require some professional medical or nursing supervision and attention.

A person is functionally eligible for the PathWays waiver if the need for medical or nursing supervision and attention is determined by any of the following findings from the functional screening:
- Need for direct assistance at least 5 days per week due to unstable, complex medical conditions.
- Need for direct assistance for 3 or more substantial medical conditions including activities of daily living.

All applicants to the PathWays Waiver are screened for nursing facility level of care (NFLOC) to evaluate and reevaluate whether an individual needs services through the waiver.

Nursing Facility Level of Care (NFLOC) The criteria necessary to meet NFLOC are specified in Indiana Administrative Code 405 IAC 1-3-1 through 405 IAC 1-3-3.

The level of care assessment tools are FSSA-approved instruments from the InterRAI suite of instruments. Data elements will be collected in a web-based assessment platform (developed by the Level of Care Assessment Representative (LCAR) contractor and approved by FSSA). LCAR LOC recommendations will not be accepted by the web-based assessment platform unless all data elements have been addressed.

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:

All initial evaluations and subsequent re-evaluations are performed by the Level of Care Assessment Representative (LCAR) contractor with recommendations routed to designated staff members within the Family and Social Services Administration (FSSA) for subsequent approval or denial.

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

In addition to approving or denying all level of care determinations, designated FSSA staff members perform extensive reviews on (1) a sample of all approvals recommended by the LCAR contractor, and (2) all denials recommended by the LCAR contractor. FSSA, as the single state Medicaid agency, retains final authority for all LOC approval and denial decisions. The final functional level of care determination is documented in the web-based assessment platform.

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 12 months or more often if 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 Level of Care Assessment Representative (LCAR) contractor maintains a web-based assessment platform which is capable of generating a report that identifies waiver participants who are due to receive an annual level of care (LOC) reevaluation in the upcoming ninety (90) days (90-Day Re-Evaluation Report). LCAR contractor assessors, advisors and supervisors are able to generate this report on demand to conduct first tier reviews to identify waiver participants requiring annual re-evaluation and monitor timely re-assessment.

The LCAR contractor will send copies of the 90-Day Re-evaluation Report to designated FSSA staff and FSSA state staff will also have access to the web-based platform to generate the 90-Day Re-Evaluation Report on demand. FSSA state staff are responsible for conducting second tier reviews to monitor timely re-evaluations. If reevaluations are not completed in a timely manner, the FSSA state staff will remediate the issue as outlined within the LCAR contract.

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

The evaluation and reevaluation documentation is maintained for a minimum of three years within the electronic database maintained by the LCAR contractor.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's 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 applicants who received a Level of Care (LOC) evaluation prior to waiver enrollment. Numerator: Number of applicants who received an LOC evaluation prior to waiver enrollment. Denominator: Total number of applicants who were eligible for waiver enrollment and completed the application process.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reports from Level of Care Assessment Representative (LCAR) Contractor

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
B.2. Number and percent of individuals whose initial level of care (LOC) assessments were completed in accordance with established LOC criteria. Numerator: The total number of individuals whose initial LOC assessment was completed in accordance with established LOC criteria. Denominator: The total number of individuals with an initial LOC assessment.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reports from Level of Care Assessment Representative (LCAR) Contractor

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

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

Data Aggregation and Analysis:

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

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

Performance Measure:
B.3 Number and percent of individuals whose annual level of care (LOC) assessment was conducted based on requirements for determining LOC in the waiver. Numerator: The total number of individuals whose annual LOC assessment was conducted based on requirements for determining LOC in the waiver. Denominator: The total number of individuals due for an annual LOC assessment.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reports from Level of Care Assessment Representative (LCAR) Contractor

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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.

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 state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The FSSA monitors reports from the Level of Care Assessment Representative (LCAR) Contractor and identifies LOC program non-compliance, which is identified in the performance measures. All documentation of resolution activities will be maintained within the electronic case management database or other electronic tracking system.

If the FSSA, or any other entity, identifies any instance of a new applicant not having received a LOC evaluation prior to enrollment, FSSA will ascertain any related MCE capitation payments that have been made and reconcile and recoup accordingly. The MCE, FSSA, and LCAR Contractor will collaborate to ensure a proper LOC evaluation is conducted immediately. If it is identified that the applicant does not meet the LOC criteria, the service coordinator is required to explore other community or public funded services that may be available to the individual. All LOC decisions are subject to the applicant's rights to appeal and have a Medicaid Fair Hearing.

In any discovery finding where an individual received an evaluation where LOC criteria was not accurately applied, the FSSA will require that a reevaluation be conducted with findings verified by FSSA staff.

If redetermination reveals that the individual does not meet the approved LOC category, any MCE capitation payments will be reconciled and recouped accordingly back to the date of expiration of the prior LOC period. The service coordinator will be advised to refer the individual for any other services which may be available and the individual 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.

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

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Division of Disability, Aging, and Rehabilitative Services	☐ **Annually**

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 service coordinator (or case manager for FFS enrollees) is responsible for explaining all available Assisted Living service options, including choice of institutional or HBCS, through the person-centered service planning process. This includes informing individuals about available LTSS, service alternatives, and service delivery options. The service plan must reflect that this was discussed with the enrollee and signature must be obtained from the member, their designated representative (if applicable), and any others involved in the service planning process.

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.

Documentation from the service planning process is maintained in the MCE systems. For FFS, forms are maintained by the case management entity and within the electronic case management database. Forms are maintained for a minimum of three years.

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):

Access to AL waiver services for individuals with limited English proficiency is assured through a series of activities and requirements from initial LOC assessment, to service planning and delivery. MCEs must make written information available in English, Spanish, and other prevalent non-English languages identified by OMPP, upon OMPP's or the member's request. At the time of enrollment with an MCE, OMPP provides the primary language of each member to the MCE. The MCE must utilize this information to ensure communication materials are distributed in the appropriate language. In accordance with MCE policies to promote health equity, preferred language must be captured and stored by the MCE within its systems to ensure continued communication and interpretation in the appropriate language without the need for repeated request by enrollees. The MCE is also required to identify additional languages that are prevalent among its membership. For purposes of this requirement, prevalent language is defined as any language spoken by at least three percent of the general population in the MCE's service area. Written information shall be provided in any such prevalent languages identified by the MCE.

Further, in accordance with 42 CFR 438.10(d), MCEs are contractually required to arrange for oral interpretation services to its members free of charge for all services it provides. Service plans must be accessible to individuals who are limited English proficient. Additionally, the MCE member services helpline must offer language translation services for members whose primary language is not English and offer automated telephone menu options in English and Spanish. The MCE must also ensure at least one fluent Burmese speaker and one fluent Spanish speaker physically present (i.e., not via a language translation line) to answer member calls.

For FFS enrollees, the needs of participants with limited English proficiency are addressed in a variety of ways. FSSA can assist with referrals for interpreters when interpreter services are not already included on the service plan of the individual. Locally available interpreters associated with community or neighborhood organizations and church groups are utilized. Additionally, some metropolitan communities within Indiana offer access to interpreters of varying languages through local colleges, universities or libraries. Further, the State of Indiana offers a variety of links for potential translation opportunities at https://www.in.gov/health/minority-health/minority-health-resources/language-translation-and-migrant-programs/, a webpage titled Language, Translation, & Migrant Programs.

As outlined within the service plan, providers of services are expected to meet the needs of the individuals they serve, inclusive of effectively and efficiently communicating with each individual by whatever means is preferred by the individual. If the individual is a Limited English Proficient person, the provider is expected to accommodate those needs during the delivery of any and all services they were chosen to provide.

The Level of Care Assessment Representative (LCAR) contractor must provide individuals oral interpreter services and language translation services for individuals whose primary language is not English. All LCAR contractor materials and the consumer-facing website must be available in both English and Spanish. Additionally, the LCAR contractor call center must offer automated telephone menu options in English and Spanish and must ensure access to Spanish speaking call center staff. The LCAR contractor must ensure that bilingual staff are appropriately trained in health care translation services in the languages for which they are translating and must have a State-approved plan for monitoring non-English calls for quality.

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	**Case Management**		
Other Service	**Assisted Living**		
Other Service	**Community Transition**		
Other Service	**Integrated Health Care Coordination**		
Other Service	**Nutritional Supplements**		
Other Service	**Specialized Medical Equipment and Supplies**		
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:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

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

Service Definition *(Scope):*

Case Management provides an array of support to connect people to integrated supports, regardless of the funding source, and to assist individuals in accessing needed waiver and other services available through the Indiana Medicaid State Plan. Case managers advocate alongside the individual to ensure their access and inclusion in their community as well as opportunities for participation in all paid and unpaid services, programs, and settings which allow for building social capital, skill development, and personal fulfillment.

Case Management is a person-centered process of needs assessment, discovery, planning, facilitation, advocacy, collaboration, problem-solving, and monitoring of the holistic needs of each individual, regardless of funding sources. Case Managers are responsible for ensuring compliance with service definitions as a component of monitoring service delivery and individual progress toward outcomes. Case Management is responsible to ensure authorized services commensurate with identified needs and helps connect individuals with additional resources when those needs extend beyond the scope or resource availability of HCBS services.
Case management services include: (1) assessment and evaluation, (2) person-centered service planning and PCISP development and implementation, (3) integrated supports exploration, and (4) ongoing case management and monitoring. Case management services are mandatory for all individuals accessing HCBS waivers. Case Management is delivered to waiver participants receiving ALW 1915(c) waiver services through FFS and is the equivalent of Service Coordination delivered to waiver participants receiving PathWays 1915(c) waiver services through an MCE as identified in Appendix C-1-b.

REIMBURSABLE ACTIVITIES
(1) Assessment and Evaluation
• Informing individuals about the level of care assessment process. For individuals seeking Medicaid Waiver Services for the first time, the CM organization may refer to the Level of Care Assessment Representative (LCAR) vendor directly

within the electronic system. If the individual is actively receiving services and supports from a Medicaid Waiver, the LCAR vendor will make contact with the individual ninety (90) days prior to the NFLOC expiration date. The LCAR vendor will schedule and conduct the assessment to recommend an approval or denial NFLOC.

- Referring individuals to the LCAR vendor to perform the level of care re-evaluation when a significant change in the individual's condition occurs.

(2) Person-Centered Planning and PCISP Development and Implementation.

- Ensuring individuals have the information and support necessary to be present, actively participate, and direct the planning process and make informed choices about services, settings, and providers.
- Facilitating the person-centered planning process to ensure access to integrated supports that foster self-determination and community inclusion while identifying opportunities to build on the strengths and preferences of the individual.
- Appropriately developing and updating the initial and annual written, person-centered, strengths based PCISP that supports the individual's goals, preferences and vision of a good life through meaningful outcomes that offer opportunities for integrated supports.
- Developing, and updating when necessary, an initial and annual budget in support of the PCISP that reflects available resources and fiscal responsibility.
- Convening Individualized Support Team (IST) jointly with the individual (and, if applicable, the individual's authorized representative) to facilitate the development of the PCISP. Supports include inviting people chosen by the individual to be members of the IST, scheduling the IST meetings at times and locations convenient to the individual, using plain language and accessible formats that respect cultural and linguistic needs for IST materials, offering clear conflict-resolution strategies for IST, and maintaining conflict-of-interest guidelines for all members of the IST.
- Providing an approved and agreed upon copy of PCISP to ensure collaboration among all IST members and a shared understanding of the individual's desired outcomes.

Additionally, the case manager must ensure the following service-specific information is properly documented in the individual's PCISP, level of service assessment (if applicable), and/or service record:

(1) Assisted Living. Documentation for AL must include but is not limited to:

- justification of need
- types of ADL and IADL support the individual may require
- level of service as determined by the AL LOS Assessment.
- the activities to be performed and frequency of care that will meet the individual's needs (must also be accurately documented in LOC assessment tool)
- who will be providing AL and their relationship to the individual
- If the individual has skilled LOC (i.e. requires skilled care), CM must document and describe how the skilled need is being met, the frequency of care and activities to be performed.

(2) Caregiver Coaching. Documentation for Caregiver Coaching must include but is not limited to:

- justification of need
- description of how the service will benefit the individual
- permission from the waiver recipient to offer their nonpaid caregiver the service

(3) Community Transition Services. Documentation for CTS must include but is not limited to:

- justification of need
- items/furnishings or set up expenses that will meet the individual's needs
- copies of receipts for all expenditures, showing the amount and what item or deposit was covered
- If case manager requests full $1,500 and not all funds are used, CM must complete a PCISP update to reduce the amount to ensure Medicaid is not over-reimbursing for these services.

(4) Integrated Health Care Coordination. Documentation for Integrated Health Care Coordination must include but is not limited to:

- justification of need
- description of how the service will benefit the individual
- the number and description of services needed to meet the individual's need

(5) Nutritional Supplements. Documentation for Nutritional Supplements must include but is not limited to:

- justification of need
- the number and description of supplements that will meet the individual's needs

(6) Specialized Medical Equipment and Supplies. Documentation for SMES must include but is not limited to:

- justification of need
- description of how the equipment is expected to improve the individuals quality of life
- equipment or supplies that will meet the individual's needs
- copies of bids in compliance with the bid requirements set forth in the service definition
- state plan prior authorization request, denial decision, and reason for denial

(7) Vehicle Modification. Documentation for Vehicle Modification must include but is not limited to:

- justification of need
- description of vehicle modification that will meet the individual's needs

- copies of bids in compliance with the bid requirements set forth in the service definition

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

Case Management will not be reimbursed when provided by the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

Reimbursement is not available through case management services for the following activities or any other activities that do not fall under the previously listed definition:
(2) Services delivered to persons who do not meet eligibility requirements established by FSSA/OMPP.
(3) Counseling services related to legal issues. Such issues shall be directed to the Indiana Disability Rights, the designated Protection and Advocacy agency under the Developmental Disabilities Act and Bill of Rights Act, P.L. 100-146.

ACTIVITIES NOT ALLOWED:
- The case management entity may not own or operate another waiver service agency, nor may the case management entity be an approved provider of any other waiver service or otherwise have a financial investment in any other waiver service.
- The case management entity may not subcontract with another agency or case manager for the provision of direct case management services.
- Case managers may not be contractors of the case management entity.
- Caseload average in excess of forty-seven (47) across the case management entity's active, full-time case managers who carry caseloads.
- The case management entity may not bill in a month for solely non-case management related activities or tasks such as mailing greeting cards or holiday text messages, for example.
- Case managers must not be:
- Related by blood or marriage to the individual;
- Related by blood or marriage to any paid caregiver of the individual;
- Financially responsible for the individual; or
- Authorized to make financial or health-related decisions on behalf of the individual.

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

☐ **Participant-directed as specified in Appendix E**
☑ **Provider managed**
☐ **Remote/via Telehealth**

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/OMPP approved Care Management Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

FSSA/OMPP approved Care Management Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

- Enrolled in an active Medicaid provider
- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
- 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 Protecting Individuals: Procedures for protecting individuals
- 455 IAC 2 Protecting Individuals: Unusual occurrence; reporting
- 455 IAC 2 Protecting Individuals: Transfer of individual's record upon change of provider
- 455 IAC 2 Protecting Individuals: Notice of termination of services
- 455 IAC 2 General Administrative Requirements for Providers: Provider organizational chart
- 455 IAC 2 General Administrative Requirements for Providers: Collaboration and quality control
- 455 IAC 2 General Administrative Requirements for Providers: Resolution of disputes
- 455 IAC 2 General Administrative Requirements for Providers: Data collection and reporting standards
- 455 IAC 2 General Administrative Requirements for Providers: Quality assurance and quality improvement system
- 455 IAC 2 Financial Information: Disclosure of financial information
- 455 IAC 2 Property and Personal Liability Insurance: Liability insurance
- 455 IAC 2 Professional Qualifications and Requirements Documentation of qualifications
- 455 IAC 2 Personnel Records: Maintenance of personnel records
- 455 IAC 2 Personnel Policies and Manuals: Adoption of personnel policies
- 455 IAC 2 Personnel Policies and Manuals: Operations manual
- 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
- 455 IAC 2 Maintenance of Records of Services Provided: Individual's personal file; site of service delivery
- 455 IAC 2 Case Management: Case Management
- 455 IAC 2 Services: Coordination of services and plan of care

- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.

Individuals providing case management services must be employed by the specified agency and must possess the following education and work experience:

- An individual continuously employed as a Care/Case Manager by an Area Agency on Aging (AAA) since June 30, 2018; or
- A registered nurse, a licensed practical nurse, or an associate's degree in nursing with at least one year of experience serving the program population; or
- A Bachelor's Degree in Social Work, Psychology, Counseling, Gerontology, Nursing or Health & Human Services; or
- A Bachelor's Degree in any field with a minimum of two years full-time, direct service experience with older adults or person with disabilities (this experience includes assessment, care plan development, and monitoring); or
- A Master's degree in Social Work, Psychology, Counseling, Gerontology, Nursing or Health & Human Services; or
- An Associate's degree in any field with a minimum four years full-time, direct service experience with older adults or persons with disabilities (this experience includes assessment, care plan development, and monitoring).

Individuals providing case management services must be employed by the specified agency and must demonstrate competency regarding the HCBS settings criteria and person-centered service plan development.

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assisted Living

HCBS Taxonomy:

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

Service Definition *(Scope):*

Assisted living (AL) service is defined as personal care support homemaker support, chore support, companion services, medication oversight (to the extent permitted under state law), non-emergency non-medical transportation and therapeutic social and recreational programming, provided in a congregate residential setting in conjunction with the provision of individual's paid room and board. This service includes 24 hour on-site response staff to meet scheduled and unpredictable needs. The individual receiving services retains the right to assume risk.

SERVICE LEVELS
There are three service levels of Assisted Living each with a unique rate. The applicable rate is determined through completion of the comprehensive health assessment tool (CHAT), known as interRAI, Service Coordinators/Case Managers complete this assessment at least annually to accurately reflect the relative support need of the individual. The CHAT Score determines the reimbursement rate to be utilized in the individual's next PCISP.
The breakdown is as follows:
Level 1 - CHAT Assessment Score of 0 - 35.
Level 2 - CHAT Assessment Score of 36 - 60.
Level 3 - CHAT Assessment Score of 61+.

REIMBURSABLE ACTIVITIES
The following are included in the daily per diem for assisted living services:

- Personal care support
- Homemaker or chore support
- Companion services
- Medication oversight (to the extent permitted under state law)
- Non-emergency non-medical transportation

- Therapeutic social and recreational programming

SERVICE STANDARDS:
- Assisted Living services must be included on the individual's PCISP. Additionally, the PCISP should identify the individual's strengths, goals, support needed to assist the individual in achieving goals, risk and interventions to reduce risk.
- Assisted Living services must address needs identified in the person-centered planning process and the CHAT Assessment.

DOCUMENTATION STANDARDS
Provider must maintain all applicable documentation required under 455 IAC 2 Home and Community Based Services and the FSSA/OMPP policies and the FSSA/OMPP HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:
- The provider must document the following data elements to support daily services rendered:
  - Name of individual served
  - IHCP Member ID (RID) of the individual served
  - Service rendered
  - Date of service (include month, day and year)
  - Number of units of service rendered that day
  - Community engagement activities performed by the individual
  - Individual'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
- The provider must update the individual's plan of care at least once each quarter and provide a copy of the updated plan of care to the individual's service coordinator/case manager each quarter.
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
- Upon request, all documentation must be made available to auditors, quality monitors, MCEs, service coordinators/case managers and any other government entity within any/all timeframes specified by OMPP.
- The provider must maintain individual's personal records that must 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)
- Additionally, the individual's personal records must include copies of the documents listed below, if available, which the assisted living caregiver will also provide to the individual's case 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

NOTE: if applicable, copies of personal record must be placed in a prominent place in the consumer file and sent with the individual when transferred for medical care or upon moving from the residence and in accordance with state law.

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

The Assisted Living service per diem or monthly rate does not include room and board.
Separate payment will not be made for Home and Community Assistance, Skilled Respite, Home Modifications, Transportation, Personal Emergency Response System, Attendant Care, Adult Family Care, Adult Day Services, Home Delivered Meals, Pest Control, or Structured Family Caregiving services furnished to the individual selecting Assisted Living Services as these activities are integral to and inherent in the provision of the Assisted Living Service.

Assisted Living services will not be reimbursed when provided by the spouse of a participant (also known as a Legally

Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED:
Personal care services provided to medically unstable or medically complex individuals as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician or other health professional.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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):*

OMPP (or its designee) approved
410 IAC 16.2-5

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transition

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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

Note: "Own Home" is defined as any living arrangement where the individual has control over their residence - including through ownership, rental, or a legally enforceable lease-and enjoys the same rights and responsibilities as anyone else living in the community.

Items purchased through CTS are the property of the individual receiving the service, and the individual takes the property with them in the event of a move to another residence, even if the residence from which they are moving is owned by a provider agency.

REIMBURSABLE ITEMS
- Security deposits and application fees that are required to obtain a lease on an apartment or a home
- Essential furnishings and moving expenses required to occupy and use a community domicile including but not limited to a bed, table or chairs, assembly of flat-packed furniture, window coverings, one telephone, eating utensils, housekeeping supplies, food preparation items, hygiene products, microwave, and bed or bath linens
- Set-up fees or deposits for utility or service access including telephone, electricity, heating, internet and water
- Health and safety assurances including pest eradication, allergen control, or one time cleaning prior to occupancy

SERVICE STANDARDS
- CTS must be included on the individual's PCISP
- CTS must address needs identified in the person-centered planning process

DOCUMENTATION STANDARDS
Provider must maintain all applicable documentation required under 455 IAC 2 Home and Community Based Services and the FSSA/OMPP policies and the FSSA/OMPP HCBS Waivers module on the IHCP Provider Reference Materials

webpage. Additionally, the provider must comply with the following standards:
- The provider must maintain receipts for all expenditures as well as itemized documentation that details each purchase and its purpose. Each itemization must also include a statement of ownership, affirming the purchased goods belong to the individual and they participated in selection.
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
- Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by OMPP.

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

Reimbursement for CTS is limited to a lifetime cap for set up expenses, up to $2,500.

CTS must be identified, ordered, and delivered within 3 months of the individual's discharge from the qualifying institution.

Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the PCISP development process, clearly identified in the PCISP and the person is unable to meet such expense or when the services cannot be obtained from other sources.

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

Nursing Facilities will not be reimbursed for CTS because those services are part of the provider's per diem. The state will not bill for FFP until after the individual departs the institution and meets waiver eligibility.

CTS will not be reimbursed when provided by the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

This service is not available under the waiver to individuals enrolled with an MCE. Rather, all MCEs provide Community Transition Services as part of their contractual obligations to all individuals who seek to move from an institutional to community-based setting.

ITEMS NOT ALLOWED
- Monthly rental or mortgage expense
- Food
- Regular utility charges
- Large household appliances
- Diversional or recreational items such as hobby supplies
- Cable TV access
- Streaming video services (e.g. Netflix)
- VCRs or DVD players

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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/OMPP 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/OMPP approved Community Transition Service Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

- Enrolled as an active Medicaid provider
- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:

o 455 IAC 2 Provider Qualifications: Becoming an approved provider; maintaining approval
o 455 IAC 2 Provider qualifications: General requirements
o 455 IAC 2 Protecting Individuals: Procedures for protecting individuals
o 455 IAC 2 Protecting Individuals: Unusual occurrence; reporting
o 455 IAC 2 Protecting Individuals: Transfer of individual's record upon change of provider
o 455 IAC 2 Protecting Individuals: Notice of termination of services
o 455 IAC 2 General Administrative Requirements for Providers: Provider organizational chart
o 455 IAC 2 General Administrative Requirements for Providers: Collaboration and quality control
o 455 IAC 2 General Administrative Requirements for Providers: Resolution of disputes
o 455 IAC 2 General Administrative Requirements for Providers: Data collection and reporting standards
o 455 IAC 2 General Administrative Requirements for Providers: Quality assurance and quality improvement system
o 455 IAC 2 Financial Information: Disclosure of financial information
o 455 IAC 2 Property and Personal Liability Insurance: Liability insurance
o 455 IAC 2 Transportation of an Individual: Transportation of an individual
o 455 IAC 2 Professional qualifications and requirements; documentation of qualifications
o 455 IAC 2 Personnel Records: Maintenance of personnel records
o 455 IAC 2 Personnel Policies and Manuals: Adoption of personnel policies
o 455 IAC 2 Personnel Policies and Manuals: Operations manual
o 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
o 455 IAC 2 Maintenance of Records of Services Provided: Individual's personal file; site of service delivery
o 455 IAC 2 Services: Coordination of services and plan of care

• Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Integrated Health Care Coordination

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11010 health monitoring
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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 the individual's provider and support team, and integrate medical and social services when this is unavailable through any other Medicaid authority, including an individual's health coverage provider.

REIMBURSABLE ACTIVITIES

(1) 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.
(2) Skilled nursing services are provided within the scope of the Indiana State Nurse Practice Act.
(3) Collaboration across all service providers: waiver, state plan, mental health, dental, medical.
(4) Collaboration across social supports: housing, food, Medicare/Medicaid system navigation, finances, transportation.
(5) Medication review
(6) Transitional support from hospital or nursing facility to home/assisted living
(7) Advance care planning

SERVICE STANDARDS

- IHCC services must be included on the individual's PCISP
- IHCC services must address needs identified in the person-centered planning process

IHCC services must include:

- Weekly consultations or reviews that include consultations with the individual or members of their care team or review and updates of healthcare support plan and/or updated information from care team as determined necessary through the person centered planning process to ensure effective delivery of service.
- A minimum of one (1) face-to-face visit per month with the individual receiving services.

Provider must maintain all applicable documentation required under 455 IAC 2 Home and Community Based Services and the FSSA/OMPP policies and the FSSA/OMPP HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

• The provider must document the following data elements each uninterrupted period of services rendered (including each consultation, review, and face-to-face visit):

- Name of individual served
- IHCP Member ID (RID) of the individual served
- Service rendered
- Date of service (include month, day and year)
- Time frame of service (include start time, end time and a.m./p.m.)
- Name of person providing service (if the person providing the service is required to be a professional, their title must also be included)
- Primary location of service delivery
- A summary of services rendered (including specific reimbursable activities that were performed and the outcomes realized from those activities)
- A description of any issue or circumstance concerning the individual including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the individual
- Signature of person providing the service that must at least include the person's last name and first initial. (Electronic signatures are permissible when in compliance with the Uniform Electronic Transactions Act [IC 26-2-8])

• For FFS enrollees, each quarter (or more often as determined by the IST), the service provider must prepare a progress report and provide this report to the case manager. Quarterly reports must be completed on state approved templates. The case manager will upload the progress report to the document library of the individual in the state's case management system on or before the 15th day of the month following the end of the reporting period. The first reporting period must align with the start of the service. Failure to timely complete and upload each quarterly report may result in a citation.

• For managed care enrollees, the service provider must prepare and submit quarterly progress report in accordance with MCE requirements.

• The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.

• Upon request, all documentation must be made available to auditors, quality monitors, MCEs, service coordinators/case managers and any other government entity within any/all timeframes specified by OMPP.

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

IHCC services are limited to a maximum of sixteen (16) hours per month.

Services provided under IHCC will not duplicate services provided under the Medicaid State Plan, Medicare or any Medicare plan (e.g. advantage and DSNP), or any other waiver service.

IHCC services will not be reimbursed when provided by the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED
Skilled nursing services available under the Medicaid State Plan.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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/OMPP Approved IHCC Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Integrated Health Care Coordination

Provider Category:

Agency

Provider Type:

FSSA/OMPP Approved IHCC Agency

Provider Qualifications

License *(specify):*

IC 25-23-1 RN
IC 25-23-1 LPN
IC 25.23.6 LSW

Certificate *(specify):*

Other Standard *(specify):*

- Enrolled as an active Medicaid provider
- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
  - 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 Protecting Individuals: Procedures for protecting individuals
  - 455 IAC 2 Protecting Individuals: Unusual occurrence; reporting
  - 455 IAC 2 Protecting Individuals: Transfer of individual's record upon change of provider
  - 455 IAC 2 Protecting Individuals: Notice of termination of services
  - 455 IAC 2 General Administrative Requirements for Providers: Provider organizational chart
  - 455 IAC 2 General Administrative Requirements for Providers: Collaboration and quality control
  - 455 IAC 2 General Administrative Requirements for Providers: Resolution of disputes
  - 455 IAC 2 General Administrative Requirements for Providers: Data collection and reporting standards
  - 455 IAC 2 General Administrative Requirements for Providers: Quality assurance and quality improvement system
  - 455 IAC 2 Financial Information: Disclosure of financial information
  - 455 IAC 2 Property and Personal Liability Insurance: Liability insurance
  - 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
  - 455 IAC 2 Personnel Records: Maintenance of personnel records
  - 455 IAC 2 Personnel Policies and Manuals: Adoption of personnel policies
  - 455 IAC 2 Personnel Policies and Manuals: Operations manual
  - 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
  - 455 IAC 2 Maintenance of Records of Services Provided: Individual's personal file; site of service delivery
  - 455 IAC 2 Services: Coordination of services and plan of care

- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.
- Individuals providing IHCC services must be employed by the specified agency and must be:
  - A Registered Nurse licensed in accordance with IC 25-23-1; or
  - A Licensed Practical Nurse licensed in accordance with IC 25-23-1; or
  - A Licensed Social Worker licensed in accordance with IC 25-23.6, have a master's degree in social work, and have at least two years of experience providing health care coordination.

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Nutritional Supplements

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14032 supplies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Nutritional (Dietary) supplements include liquid supplements, such as "Boost" or "Ensure" to support people in maintaining their health in order to remain in the community.

ALLOWABLE ACTIVITIES
• Enteral Formula, category 1 such as "Boost" or "Ensure"

SERVICE STANDARDS
• Nutritional Supplement services must be included on the individual's PCISP
• Nutritional Supplement services must address needs identified in the person-centered planning process
• Supplements must be ordered by a physician, physician assistant, or nurse practitioner.
• For FFS enrollees, reimbursement for approved Nutritional Supplement expenditures are reimbursed through the local AAA or an approved OMPP provider, who maintains all applicable receipts and verifies the delivery of services.

DOCUMENTATION STANDARDS
Provider must maintain all applicable documentation required under 455 IAC 2 Home and Community Based Services and the FSSA/OMPP policies and the FSSA/OMPP HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

• Provider (or such other entity that reimburses the individual for Nutritional Supplements) is responsible for maintaining receipts for all expenditures, showing the amount and what item(s) were supplied and record of date shipped.
• The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
• Upon request, all documentation must be made available to auditors, quality monitors, MCEs, service coordinators/case managers and any other government entity within any/all timeframes specified by OMPP.

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

Service Coordinators/Care Managers must assure that coverage of services provided under the State Plan or a responsible third-party continues until the plan limitations have been reached or a determination of non-coverage has been established prior to this service's inclusion in the PCISP.

Nutritional Supplement services are limited to a maximum of $1,200.00 per plan year.

Nutritional Supplement services will not duplicate services provided under the Medicaid State Plan or any other waiver service. The services under Nutritional Supplements are limited to additional services not otherwise covered under the state plan but consistent with waiver objectives of avoiding institutionalization.

The meals provided as part of these services shall not constitute a full nutritional regimen.

Nutritional Supplement services will not be reimbursed when provided by the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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/OMPP 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/OMPP approved Nutritional Supplements Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

• Enrolled as an active Medicaid provider
• Must be FSSA/OMPP (or its designee) approved
• Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
- 455 IAC 2 Provider Qualifications: Becoming an approved provider; maintaining approval
- 455 IAC 2 Provider qualifications: General requirements
- 455 IAC 2 Protecting Individuals: Transfer of individual's record upon change of provider
- 455 IAC 2 Property and Personal Liability Insurance: Liability insurance
- 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
- 455 IAC 2 Personnel Records: Maintenance of personnel records - 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
• Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Specialized medical equipment and supplies include:
• Devices, controls, or appliances, specified in the PCISP that enable individuals to increase their ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.
• Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items.
• Other durable and non-durable medical equipment not available under the State plan that is necessary to address the individual's functional limitations.

Professional Evaluation Requirements
• Any individual item expected to cost more than $500 requires an evaluation by a qualified professional such as a physician, nurse, occupational therapist, physical therapist, speech and language therapist, or rehabilitation engineer.
• The evaluation should be signed by the qualified professional and include medical necessity, how the item meets a specific need for the individual, how it assists with any defined goals for the individual, and what device or supply specification is recommended.

Bid Requirements
• At least two (2) bids must be obtained for any individual item expected to exceed $1,000.00. Bids must be the most cost effective or conservative means to meet the individual's specific needs. • If only one bid is obtained the service coordinator/case manager must document the date of contact, the provider name, and why the bid was not obtained from that provider.
• Each bid must be itemized and include:
- Picture of equipment; and
- Written warranty for new products.
• The Provider warrants that any bid, invoice, or charge submitted for specialized medical equipment and supplies delivered under this agreement will not include a markup in excess of thirty percent (30%) above the Provider's documented acquisition cost. Acquisition cost is defined as the Provider's actual paid cost for the item, including shipping and handling, less any discounts, rebates, or allowances received.
• Additional fees are not allowed and will not be approved.

Prior Request for Approval to Authorize Services Requirements
• All Specialized Medical Equipment and Supplies must be approved by the MCE (OMPP or its designee for FFS enrollees) prior to the service being rendered.
• Requests for Specialized Medical Equipment and Supplies may be partially approved or denied in their entirety if the MCE (OMPP or its designee for FFS enrollees) determines that:
- Requestor did not first exhaust eligibility of the desired equipment or supplies through Indiana Medicaid State Plan, which may require Prior Authorization (PA); or
- For requests made to OMPP or its designee for FFS enrollees, the request for Specialized Medical Equipment and Supplies did not include documentation of Indiana Medicaid State Plan PA request and denial decision and reason for denial, if requested item is covered under State Plan; or
- Requested Specialized Medical Equipment and Supplies duplicate equipment or supplies covered under the Indiana Medicaid State Plan; or
- Specialized Medical Equipment and Supplies are being requested because a Medicaid vendor refused to accept the Medicaid reimbursement through the Medicaid State Plan; or
- Specialized Medical Equipment and Supplies are being requested because requestor prefers a specific brand name but the Indiana Medicaid State Plan covers like equipment but does not cover the specific brand requested
- The provider claim did not follow the correct Medicaid billing practices.
• Requests for Specialized Medical Equipment and Supplies may be partially approved or denied in their entirety if the MCE (OMPP or its designee for FFS) determines the documentation does not support the service requested.

REIMBURSABLE ACTIVITIES/ITEMS
• Self-help devices - including over the bed tables, reachers, adaptive plates, bowls, cups, drinking glasses, and eating utensils
• Voice activated smart devices
• Lift chairs -The HCBS program will cover the chair. State Plan should be pursued first for prior approval of the lift mechanism.
• Strollers - when needed because individual's primary mobility device does not fit into the individual's vehicle/mode of transportation, or when the individual does not require the full time use of a mobility device, but a stroller is needed to meet

the mobility needs of the individual outside of the home setting.
• Medication Dispensers
• Toileting and/or incontinence supplies
• Slip resistant socks
• Maintenance and repair of the items provided through a HCBS waiver
• Items requested which are not listed above, will be submitted in the PCISP and will be reviewed and approved by the MCE (or OMPP or its designee for FFS), if the request meets the individual's need.
• Interpreter service - provided in circumstances where the interpreter assists the individual in communication during specified scheduled meetings for service planning (e.g. waiver case conferences, team meetings) and is not available to facilitate communication for other service provision.

SERVICE STANDARDS
• Specialized Medical Equipment and Supplies must be included on the individual's PCISP and authorized on the request for approval and linked to the individual's PCISP.
• Specialized Medical Equipment and Supplies must address needs identified in the person-centered planning process and must be of direct medical or remedial benefit to the participant. The PCISP must also describe how the equipment is expected to improve the individual's quality of ADL.
• All items shall meet applicable standards of manufacture, design and service specifications.

DOCUMENTATION STANDARDS
Provider must maintain all applicable documentation required under 455 IAC 2 Home and Community Based Services and the FSSA/OMPP policies and the FSSA/OMPP HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:
• The provider must document the following data elements for services rendered:
- Name of individual served
- IHCP Member ID (RID) of the individual served
- Service rendered
- Date of installation (include month, day and year)
• State-approved and signed Service Authorization/NOA
• Provider responsible for maintaining receipts for all expenditures, showing the amount and what item(s) were supplied; must be in compliance with FSSA and MCE specific guidelines and/or policies.
• The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
• Upon request, all documentation must be made available to auditors, quality monitors, MCEs, service coordinators/case managers and any other government entity within any/all timeframes specified by OMPP.

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

Up to $1,000.00 is allowable per plan year for the maintenance and repair of previously obtained specialized medical equipment that was funded by a Home and Community Based Services (HCBS) waiver. Requests for maintenance/repair services must detail cost of part(s) and cost of labor. If the need for maintenance exceeds $1000.00, the service coordinator/case manager will work with other available funding streams and community agencies to fulfill the need. If maintenance/repair 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.

If the requested Specialized Medical Equipment or supplies are covered under Medicaid State Plan, the reimbursement amount is limited to the Medicaid State Plan fee schedule.

The services under specialized medical equipment and supplies are limited to additional services not otherwise covered under the Indiana Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

Specialized Medical Equipment and Supplies will not be reimbursed when provided by the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES/ITEMS NOT ALLOWED
• Unallowable items include, but are not limited to the following:
- Hospital beds, air fluidized suspension mattresses/beds
- Therapy mats - Parallel bars - Scales
- Paraffin machines or baths

- Therapy balls
- Books, games, toys
- Electronics - such as CD players, radios, cassette players, tape recorders, television, VCR/DVDs, cameras or film, videotapes and other similar items
- Computers and software
- Exercise equipment such as treadmills or exercise bikes
- Furniture - Appliances
- such as refrigerator, stove, hot water heater
- Indoor and outdoor play equipment such as swing sets, swings, slides, bicycles adaptive tricycles, trampolines, play houses, merry-go-rounds
- Swimming pools, spas, hot tubs, portable whirlpool pumps
- Adjustable mattresses (such as, but not limited to, Tempur-Pedic), positioning devices, pillows
- Motorized scooters
- Barrier creams, lotions, personal cleaning cloths
- Essential oils
- Totally enclosed cribs and barred enclosures used for restraint purposes
- Manual wheelchairs
- Vehicle modifications

• Equipment and services available through Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before reimbursement is available through the Medicaid waiver for this service).
• Equipment and services that are not of direct medical or remedial benefit to the individual
• Any equipment or items purchased or obtained by the individual, their family members, or other non- waiver providers

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

☐ **Participant-directed as specified in Appendix E**
☑ **Provider managed**
☐ **Remote/via Telehealth**

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/ OMPP 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:

FSSA/ OMPP approved Specialized Medical Equipment and Supplies Agency

Provider Qualifications

License *(specify):*

IC 25-26-21 - Home Medical Equipment Services Providers

Certificate *(specify):*

IC 6-2.5-8-1- Registered retail merchant's certificate; application; filing fee

Other Standard *(specify):*

• Enrolled as an active Medicaid provider
• Must be FSSA/OMPP (or its designee) approved
• Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
- 455 IAC 2 Provider Qualifications: Becoming an approved provider; maintaining approval
- 455 IAC 2 Provider qualifications: General requirements
- 455 IAC 2 Property and Personal Liability Insurance: Liability insurance
- 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
- 455 IAC 2 Warranty Required: Warranty required
• Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Vehicle Modifications

HCBS Taxonomy:

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

Service Definition *(Scope):*

Vehicle Modifications (VMOD) are the addition of adaptive equipment or structural changes to a motor vehicle that will

provide the individual with a safe and accessible mode of transportation that increases their ability to access their home and community.

Bid Requirements
• At least two (2) bids must be obtained for any vehicle modification expected to exceed $1,000.00. Bids must be the most cost effective or conservative means to meet the individual's specific needs.
• If only one bid is obtained the case manager must document the date of contact, the provider name, and why the bid was not obtained from that provider.
• Each bid must be itemized and include:
- Picture of equipment; and
- Written warranty for new products.

Prior Request for Approval to Authorize Services Requirements
• All vehicle modifications must be approved by the MCE (OMPP or its designee for FFS enrollees) prior to the service being rendered.
• The vehicle to be modified must meet all of the following:
- The individual or primary caregiver (including a family member with whom the individual lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the individual and is not a paid provider of such services) is the titled owner.
- The vehicle is registered and/or licensed under state law.
- The vehicle has appropriate insurance as required by state law.
- The vehicle is the individual's sole or primary means of transportation.
- The vehicle is less than 10 years old and has less than 100,000 miles on the odometer
- The vehicle is not registered to or titled by an FSSA approved provider
• All vehicle modification shall be authorized only when it is determined to be medically necessary and/or shall have direct medical or remedial benefit for the waiver individual.
• Requests for vehicle modifications may be partially approved or denied in their entirety if the MCE (OMPP or its designee for FFS enrollees) determines that the documentation does not support the service requested.

REIMBURSABLE ACTIVITIES/ITEMS
• Wheelchair lifts • Wheelchair tie-downs (if not included with lift)
• Wheelchair/scooter hoist
• Wheelchair/scooter carrier for roof or back of vehicle
• Raised roof and raised door openings
• Power transfer seat base
• Lowered floor and lowered door openings
• Wheelchair ramp for vehicle
• Maintenance and repair of the items provided through a HCBS waiver

• Items requested which are not listed above, will be reviewed and approved by the MCE (or OMPP or its designee for FFS) if the request meets the medical or social needs of the individual.

SERVICE STANDARDS
• Vehicle modifications must be included on the individual's PCISP, identify the direct medical or remedial benefit for the individual, and authorized on the request for approval and linked to the individual's PCISP.
• Vehicle modifications must address needs identified in the person-centered planning process.
• Pricing must be consistent with the fair market price for such modification(s).

•Many automobile manufacturers offer a rebate for waiver participants purchasing a new vehicle requiring modifications for accessibility. To obtain the rebate the individual 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.
• All products shall meet applicable standards of manufacture, design and installation.

DOCUMENTATION STANDARDS
Provider must maintain all applicable documentation required under 455 IAC 2 Home and Community Based Services and the FSSA/OMPP policies and the FSSA/OMPP HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:
• The provider must document the following data elements for services rendered:
- Name of individual served
- IHCP Member ID (RID) of the individual served

- Service rendered
- Date of installation (include month, day and year)
• State-approved and signed Service Authorization/NOA
• Provider responsible for maintaining receipts for all expenditures, showing the amount and what item(s) were supplied for the vehicle modification; must be in compliance with FSSA and MCE specific guidelines and/or policies.
• The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
• Upon request, all documentation must be made available to auditors, quality monitors, MCEs, service coordinators/case managers and any other government entity within any/all timeframes specified by OMPP.

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

Vehicle Modification services are limited to a 10-year cap of $15,000.00 for one vehicle per every ten year period for an individual's household.

In addition to the applicable 10-year cap for vehicle modifications, up to $1,000.00 is allowable per plan year for the maintenance and repair to an existing vehicle modification that was funded by a Home and Community Based Services (HCBS) waiver. Requests for maintenance/repair services must detail cost of part(s) and cost of labor. If the need for maintenance/repair services exceeds $1000.00, the service coordinator/case manager will work with other available funding streams and community agencies to fulfill the need. If maintenance/repair 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.

Vehicle modifications will not be reimbursed when provided by the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED
• Unallowable items include, but are not limited to the following:
- Repair or replacement of modified equipment damaged or destroyed in an accident
- Alarm systems - Auto loan payments
- Insurance coverage
- Driver's license, title registration, or license plates
- Emergency road service - Routine maintenance and repairs related to the vehicle itself
- Specialized Medical Equipment or Home Modification items
- Leased vehicles
• Vehicle modifications that are available under the Rehabilitation Act of 1973 or PL 94-142.

Payment may not be made to adapt the vehicles that are owned or leased by paid providers of waiver services. The cost of purchasing or leasing of a vehicle is excluded from the service.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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/OMPP 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/OMPP approved Vehicle Modification Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

• Enrolled as an active Medicaid provider • Must be FSSA/OMPP (or its designee) approved
• Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
- 455 IAC 2 Provider Qualifications: Becoming an approved provider; maintaining approval
- 455 IAC 2 Provider Qualifications: General requirements
- 455 IAC 2 Property and Personal Liability Insurance: Liability insurance
- 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
- 455 IAC 2 Personnel Records: Maintenance of personnel records
- 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
- 455 IAC 2 Warranty Required: Warranty required
• Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three 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 section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 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.*

☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *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 and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

MCEs provide service coordination as an administrative function. FFS waiver enrollees receive an equivalent service, case management, as a waiver service as defined in Appendix C-3. All service coordinators must complete "Person-Centered Thinking Training" through a state approved curriculum for person-centered practices or a state approved certified trainer within 90 days of their hire date. A service coordinator who has not yet completed the training must have each PCISP reviewed and signed off on prior to the plan's effective date by a service coordinator supervisor who has completed the training. All service coordinators must complete this training on an annual basis. Additionally, the MCEs are contractually required to provide orientation and training to newly hired service coordinators on a variety of topics, including the HCBS Settings Rule.

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

No services selected for remote delivery

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

○ **No. Criminal history and/or background investigations are not required.**

● **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

All direct care providers must submit a criminal background check as required by 455 IAC 2-15-2. The criminal background check must not show any evidence of acts, offenses, or crimes affecting the applicant's character or fitness to care for waiver participants in their homes or other locations. Additionally, licensed professionals are checked for findings through the Indiana Professional Licensing Agency. OMPP also requires that a current limited criminal history be obtained from the Indiana State Police central repository as prescribed in 455 IAC 2-15-2.

Adoption of personnel policies, for each employee or agent involved in the direct management, administration, or provision of services in order to qualify to provide direct care to individuals receiving services at the time of provider certification. The OMPP verifies receipt of documentation as a part of provider enrollment. Waiver providers are required to submit a policy regarding OIG checks at certification and compliance review.

Providers are not permitted to provide services under the traditional model or self-directed model prior to completion and/or review of their background check.

The Fiscal Agent checks the OIG list of excluded individuals and entities at least monthly in compliance with state regulations. Additional review is also conducted during the provider revalidation and FSSA audits.

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; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. 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):

a) The State of Indiana has a registry of professional licenses that is available online at https://mylicense.in.gov/eVerification/
b) FSSA requires each provider or prospective provider conduct and document the screening against this license verification website.
c) FSSA staff reviews applications for approval to provide waiver services as submitted by the prospective provider. In the absence of the license verification for each direct care staff employed by the provider, the application shall not be approved.

Indiana's abuse registry is hosted by the Indiana Professional Licensing Agency (IPLA) at https://www.in.gov/pla/ but information is maintained by the Indiana Department of Health (IDOH). If a registered aide has an abuse finding, IDOH places a finding on their certification within https://www.in.gov/health/ltc/aide-training-and-certification/ so the aide will not show up as active on the registry.

d) If an individual's waiver provider is added to the registry, the MCE (FSSA staff for FFS) and service coordinator/case manager work together to ensure transition to new provider and continuity or care. Provider agencies are responsible for coordinating new direct care staff with oversight by FSSA.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page 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 or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *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 types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is ***"extraordinary care"***, exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of

services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring 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.*

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 types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures 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:

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 OMPP is dedicated to increasing HCBS providers for the waiver. The OMPP is dedicated to focusing on recruitment, certification, and timely enrollment of providers by the fiscal agent, and retention of waiver providers. Information regarding HCBS services is posted on the FSSA website. The OMPP has open enrollment meaning any provider can apply at any time.

MCEs are responsible for developing and maintaining a comprehensive provider network to serve AL waiver enrollees in compliance with 42 CFR Part 438. MCEs must develop and maintain a Network Development and Management Plan demonstrating adequate provider capacity to meet the needs of each waiver enrollee. The MCE must demonstrate the ability to serve members regardless of the county of residence and to meet contractually required minimum enrollee-to-provider ratios.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one*:

- (●) **No, the state does not choose the option to provide HCBS in acute care hospitals.**
- ( ) **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*
  - ☐ **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**
  - ☐ **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**
  - ☐ **The HCBS must be identified in the individual's person-centered service plan; and**
  - ☐ **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

*And specify:***(a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;(b) How the 1915(c) HCBS will assist the individual in returning to the community; and(c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.**

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's 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.1.a Number and percentage of waiver services providers who met certification standards. Numerator: Number of waiver service providers who were certified by the State. Denominator: Number of waiver services providers who requested certification from the State.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Relations Tracking Database

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

Data Aggregation and Analysis:

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

Performance Measure:
C.1.b Number and percentage of waiver services providers who met recertification standards. Numerator: Number of waiver service providers who were recertified by the State. Denominator: Number of waiver services providers in need of recertification from the State.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Relations Tracking Database

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
C.1.c Number and percentage of waiver service providers who were successfully revalidated through IHCP. Numerator: Number of waiver service providers who were revalidated through IHCP. Denominator: Number of waiver service providers who were due to be revalidated.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Fiscal Agent Reporting

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

Data Aggregation and Analysis:

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

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

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.2 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 Database

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

		Sample Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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.3 Number and percentage of Service Coordinators who completed Person-Centered Planning Training. Numerator: Number of Service Coordinators who have been in their role at least 90 days who have completed person-centered training competencies. Denominator: Number of Service Coordinators who have been in their role at least 90 days.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Before a provider is certified as a waiver provider, they must provide written documentation to OMPP that they meet all applicable state licensing and certification standards and other waiver provider qualifications. OMPP verifies each provider meets the established criteria. If a provider does not meet one or more of the waiver qualifications, OMPP provides written notification including the identified non-compliance and appeal rights. Once a provider has been determined by OMPP to meet the waiver requirements, the individual must submit an application to the State's Fiscal Agent to complete the Indiana Health Coverage (IHCP) provider enrollment process. The Fiscal Agent Provider Enrollment Unit screens and enrolls waiver provider applicants in accordance with requirements under 42 CFR 455 Subpart E. Applicants found ineligible for IHCP enrollment are notified in writing with appeal rights. MCEs may only contract with providers certified by OMPP to meet waiver qualifications, and who have completed the IHCP provider enrollment process. OMPP provides a list of all certified/enrolled waiver providers to MCEs to facilitate the contracting process.

This OMPP provider certification and IHCP provider enrollment process effectively prevents provider-applicants from rendering waiver services prior to approval and enrollment. In the event a provider became IHCP or MCE enrolled and initiated delivery of waiver services prior to approval by OMPP, OMPP would instruct the MCE to deny any claim relating to waiver service provision, and disenroll the provider-applicant until such time as the provider-applicant fully documents they meet all qualifications. OMPP would initiate an investigation of internal, Fiscal Intermediary, and MCE processes to identify deficiencies or vulnerabilities within the certification, enrollment, approval, and MCE contracting processes and undertake appropriate improvements.

Additionally, there are strategies in place to ensure providers continue to comply with waiver requirements following initial certification, enrollment, and MCE contracting. Providers undergo a formal service review at least every three years. For licensed providers, this review is conducted by the Indiana Department of Health (IDOH). Non-licensed providers are reviewed by OMPP. Both IDOH and OMPP have formal review and remediation procedures which utilize corrective action plans (CAPs) submitted by the provider with approval or denial by the reviewing entity. If denied, the provider is required to resubmit 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. Additionally, providers must undergo an IHCP enrollment revalidation from the Fiscal Agent in accordance with 42 CFR 455 Subpart E. Providers who are found to not meet revalidation requirements are disenrolled as an IHCP provider, with appeal rights.

Further, MCEs must have policies and procedures, which are reviewed and approved by OMPP, for altering conditions of a provider's participation with the MCE because of quality of care and service issues. These policies and procedures must include:
- Specific actions the MCE may take before terminating the provider's participation
- Mechanisms for reporting serious quality deficiencies to OMPP that could result in a provider's suspension or termination
- How reporting occurs and the individual staff members responsible for reporting deficiencies
- An appeals process for instances in which the MCE decides to alter the provider's condition of participation because of quality of care or service issues. The MCE must ensure that providers are aware of the appeals process.
- Mechanisms to ensure providers are treated fairly and uniformly.

Additionally, MCEs are contractually required to track, review, and analyze critical incidents to identify and address quality of care and/or health and safety issues. MCEs must regularly review the number and types of incidents (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations (including findings from Adult Protective Service (APS) if available); identify trends and patterns; identify opportunities for improvement; and develop and implement strategies to reduce the occurrence of incidents and improve the quality of HCBS. MCEs provide OMPP analyses, reports, and strategies to address critical incidents. This information is utilized by OMPP to determine on an ongoing basis if specific provider trends exist and whether negative findings require additional remediation. If existing documentation does not indicate resolution, OMPP and/or the MCE will initiate consequences to the provider that may include but are not limited to informal actions, formal warning, corrective action plan, or decertification. Any provider decertified as a result of non-compliance with the provider agreement, and/or failing to complete corrective actions, will be notified of the decision, and of his/her right to appeal. Prior to taking action to suspend or terminate a provider, alternative service options will be provided to any affected participants through their service coordinator.

C.3 MCEs are contractually required to provide orientation and training to all newly hired service coordinators. If OMPP identifies MCE non-compliance with this requirement, written notice of non-compliance is sent to the MCE with expected remediation activities. OMPP then monitors the corrective actions implemented through to resolution. In the event remediation is not achieved in accordance with the required corrective action plan, OMPP may implement escalating corrective action, the nature and severity of which is based on the scope of non-compliance.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 in which 1915(c) HCBS are recieved. *(Specify and describe the types of settings in which waiver services are received.)*

The Indiana Family and Social Services Administration (FSSA) attests that all settings are compliant with the HCBS Settings requirements at 42 CFR 441.301(c)(4)-(5).

Individuals receiving HCBS under the waiver may reside in the following settings:

• Assisted living facilities: Residential services offering an increased level of support in a home or apartment-like setting.

Waiver services are provided in the individual's home and community, based upon their preference. Additionally, Adult Day Services are activities provided in a group setting, outside the individual's home. Settings for service delivery are chosen by the individual during the service planning process, identified in the individual's PCISP, reviewed, and approved by the MCE, and subject to OMPP review. To ensure compliance of all settings, HCBS questions are addressed and recorded in the PCISP.

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 in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

FSSA has developed and utilizes a variety of tools to establish HCBS settings criteria compliance and monitor on-going compliance for all provider-owned or controlled settings as well as any other settings where HCBS services are provided. These tools include the following:
• Provider application/reverification process that is conducted at least every 4 years.
• PCISP development/review process that is conducted at least annually.
• Provider Compliance Review (PCR) process that is conducted at least every 3 years.
• Complaint Investigation Process that is conducted on a continuously and on-going basis.

Provider Application and Reverification Process: The provider application process assesses for compliance by ensuring providers fully embrace person-centered values, practices, and planning by requiring new providers to demonstrate an understanding of the purpose of HCBS by articulating how they will support individuals in a way that complies with the HCBS Settings requirements at 42 CFR 441.301(c)(4)-(5). MCEs may only contract with providers certified by OMPP as a waiver provider and enrolled as a Medicaid provider.

PCISP Development Process: HCBS settings questions are addressed and recorded in the PCISP. For provider owned or controlled residential settings a systemic verification process has been embedded within the service plan development process to ensure ongoing monitoring of HCBS settings compliance.

Provider Compliance Review Process: The oversight process for continuous compliance with HCBS settings requirements is conducted through the Provider Compliance Review. The Provider Compliance Review process includes an assessment tool that includes indicators to support determining if individual outcomes are being achieved as well as the providers compliance with the HCBS Settings requirements. Through this process FSSA reviews providers compliance with state and federal rules as well as speaks directly to individuals to make sure they are receiving person-centered quality services.

Complaint Investigation Process: Individuals can report any instances of non-compliance directly to their service coordinator/case manager, MCE, or OMPP. FSSA provides an online complaint form as well as a complaint hotline to submit reports of non-compliance.

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

☑ **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.**

☑ **The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. *(see Appendix D-1-d-ii)***

☑ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**

☑ **Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.**

☑ **Facilitates individual choice regarding services and supports, and who provides them.**

☑ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.**

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings*.)

○ **No, the waiver does not include provider-owned or controlled settings.**

● **Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):

☑ **The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally**

enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

☑ **Each individual has privacy in their sleeping or living unit:**

- ☑ **Units have entrance doors lockable by the individual.**
- ☑ **Only appropriate staff have keys to unit entrance doors.**
- ☑ **Individuals sharing units have a choice of roommates in that setting.**
- ☑ **Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.**

☑ **Individuals have the freedom and support to control their own schedules and activities.**

☑ **Individuals have access to food at any time.**

☑ **Individuals are able to have visitors of their choosing at any time.**

☑ **The setting is physically accessible to the individual.**

☑ **Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan*(see Appendix D-1-d-ii of this waiver application).***

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person-Centered Individualized Support Plan (PCISP)

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. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(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:

MCEs must employ service coordinators experienced in meeting the needs of people with disabilities regardless of age and vulnerable populations with chronic and/or complex conditions. A service coordinator must have an undergraduate and/or graduate degree in social work or a related field, or be a Registered Nurse, Licensed Practical Nurse, Advanced Nurse Practitioner, or a Physician Assistant. All service coordinators must complete "Person-Centered Thinking Training" through a state approved curriculum for person-centered practices or a state approved certified trainer within 90 days of their hire date. A service coordinator who has not yet completed the training must have each PCISP reviewed and signed off on prior to the plan's effective date by a service coordinator supervisor who has completed the training. All service coordinators must complete this training on an annual basis. Additionally, the MCEs are contractually required to provide orientation and training to newly hired service coordinators on a variety of topics, including the HCBS Settings Rule.

☐ **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. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *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.** ***Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☐ **Direct oversight of the process or periodic evaluation by a state agency;**

☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

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.

All MCE PCISP processes must comply with 42 CFR 438.208(c)(3) and 42 CFR 441.301(c). PCISP development is guided by a strengths-based person-centered process. MCEs/service coordinators/case managers are required to provide the necessary level of support to ensure that the member directs the person-centered planning process to the maximum extent possible and is enabled to make informed choices and decisions. MCEs/service coordinators/case managers are also required to provide comprehensive information to enrollees and/or their representatives on available services and supports and the service planning process. OMPP reviews and approves all MCE member information materials, and ensures they are accurate and current, culturally appropriate, written for understanding at a fifth-grade reading level, in plain language, and available in English, Spanish, other prevalent languages, and alternative formats.

Person-centered planning begins during the assessment process. The MCE/service coordinator/case manager informs members that they may request the assessment be conducted in alternative modes, such as by phone or virtual visit, or settings, besides at the member's place of residence or service location. Upon request and to the extent possible, the MCE/service coordinator/case manager must coordinate with the member and/or the member's family member, informal caregiver, supported decision maker(s), legal guardian, and/or designated representative to conduct assessments in a mode or setting convenient to the member and member's support team and reflective of the member's expressed preferences. For members in need of services provided by the LTC Ombudsman, the MCE/service coordinator/case manager shall, as appropriate, invite an LTC Ombudsman staff person to participate in the member's assessment process.

The participant has the authority to include members from their support team in the service planning process. The person-centered service planning process helps to identify outcomes based on the participant's goals, interests, strengths, abilities, and preferences. The process assists the participant to articulate a plan for the future and helps determine the supports and services that the participant needs to achieve these outcomes. The service coordinator/case manager is responsible to include all of those elements in the PCISP. The service coordinator/case manager must obtain the electronic or written signatures of the member, member's designated representative (if applicable) and any others involved in the service planning process, indicating they participated in the process, they approve and understand the services outlined in the PCISP, and that services are adequate and appropriate to the member's needs. The PCISP is not considered complete until all of the required signatures are received. A member may also sign indicating disapproval. When this occurs, the service coordinator/care manager must provide the member with a denial notice within two business days that includes their right to file a grievance and assist the member through the process as appropriate. A copy of the signed PCISP is given to the member as well as all interdisciplinary care team (ICT) participants. Service coordinators/case managers must ensure that the member or guardian, providers, caregivers, and involved agencies have a copy of relevant documentation, including instructions on how to request an appeal.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. i. 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; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. 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):

a. Who develops the plan, who participates in the process, and the timing of the plan

The service coordinator/case manager facilitates a face-to-face visit with the member to complete and approve a PCISP within five business days of receiving the member's nursing facility level of care (NFLOC) determination notification. The person-centered planning process includes the member and the member's chosen participants identified in their support team. As applicable, the member's legal guardian, designated representative, and informal caregivers also participate. For members in need of services provided by the LTC Ombudsman, the MCE/service coordinator/case manager shall, as appropriate, invite an LTC Ombudsman staff person to participate. In accordance with 42 CFR 431.301, the PCISP must 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. FSSA requires that providers receive a copy of the PCISP initially, annually, and when there is a change or revision to the plan.

b. The types of assessments that are conducted to support the PCISP development process

The results of the comprehensive self-assessment tool (CHAT) and LOC assessment are the foundation of the strengths-based service planning process. The CHAT is a functional assessment based on the interRAI and a social determinants of health (SDOH) questionnaire based on the Accountable Health Communities (AHC) Model. The CHAT also includes an assessment of vulnerability and risk factors for abuse and neglect in the member's personal life or finances. MCEs may augment the CHAT with condition specific and/or MCE specific elements upon review and approval of OMPP.

Unless otherwise assessed as part of the MCE's care coordination processes or included in the member's CHAT results, the MCE's LTSS-specific assessment process may also include, but is not limited to, the following explorations and assessments based on the member's specific health and social needs:
- An exploration with the member of their understanding of self-directed supports and any desire to self-manage the allowable portions of their PCISP.
- An exploration with the member of their preferences in regard to privacy, services, caregivers, and daily routine, including, if appropriate, an evaluation of the member's need and interest in acquiring skills to perform activities of daily living to increase their capacity to live independently in the most integrated setting.
- An assessment of mental health and alcohol and other drug abuse (AODA) issues, including risk assessments of mental health and AODA status as indicated.
- An assessment of the member's overall cognition and evaluation of risk of memory impairment.
- An assessment of the availability and stability of natural supports and community supports for any part of the member's life. This includes an assessment of what it will take to sustain, maintain and/or enhance the member's existing supports and how the services the member receives from such supports can best be coordinated with the services provided by the MCE.
- An exploration with the member of their preferences and opportunities for community integration including opportunities to engage in community life, control personal resources, and receive services in the community.
- An exploration with the member of their preferred living situation and a risk assessment for the stability of housing and finances to sustain housing as indicated.
- An exploration with the member of their preferences for educational and vocational activities.
- An assessment of the member's understanding of their rights, preferences for executing advance directives, and whether the member has a guardian, protective order, durable power of attorney or activated power of attorney for health care.

With member and informal caregiver consent, an informal caregiver assessment is also conducted. At minimum, the informal caregiver assessment includes: (1) an overall assessment of the informal caregiver(s) providing services to the member to determine the willingness and ability of the informal caregiver(s) to contribute effectively to the needs of the member, including employment status and schedule, and other caregiving responsibilities; (2) an assessment of the informal caregiver's own health and well-being, including medical, behavioral, physical, social, or environmental limitations, such as any food, utility, housing, and healthcare insecurities, as it relates to the informal caregiver's ability to support the member; (3) an assessment of the informal caregiver's level of stress related to caregiving responsibilities and any feelings of being overwhelmed; (4) identification of the informal caregiver's needs for training in knowledge and skills in assisting the person needing care; and (5) identification of any service and support needs for training in knowledge and skills to be better prepared for their caregiving role. Additionally, an SDOH assessment for informal caregivers is included to identify needs such as current or potential lack of healthcare, food insecurity, utility instability, housing insecurity, or transportation issues.

c. How the participant is informed of the services that are available under the waiver

The PCISP is established to identify services based on the participant's needs and preferences, and availability and appropriateness of services. The person-centered service planning process includes informing members about available services to address their assessed needs. This includes information on 1915(c) waiver services, Medicaid covered non-waiver services, and noncovered medical, social, housing, educational, financial assistance, and other services and supports, including services provided by other community resources. The service coordinator/case manager also provides detailed information (described further in Appendix E) regarding opportunities for participant-directed services and responsibilities for directing those services.

d. How the plan development process ensures that the PCISP addresses participant goals, needs (including health care needs), and preferences

The person-centered planning process includes the following components to assist the participant in identifying waiver and non-waiver services that will best meet their goals, needs, and preferences:
- Identifying, coordinating, and supporting members in gaining access to LTSS and other covered services.
- Identifying, coordinating, and assisting members in gaining access to noncovered medical, social, housing, educational, financial assistance, and other services and supports, including services provided by other community resources.
- Informing members about available LTSS, required assessments, the PCISP, service alternatives, service delivery options including participant-direction, risks, responsibilities.
- Protecting a member's health, welfare, and safety including developing an emergency plan.
- Facilitating member access to, locating, coordination, and monitoring needed services and supports.
- Collecting member preferences, strengths, and goals.
- Assisting in identifying and choosing willing and qualified providers.
- Coordinating efforts and prompting the member to complete activities necessary to maintain LTSS eligibility.
- Exploring coverage of services to address member-identified needs through Medicaid and other services such as Medicare, private insurance, VA services, and other informal unpaid supports.
- Actively coordinating with other individuals and entities essential in the physical and social care delivered for the member to provide for seamless coordination.

e. How waiver and other services are coordinated

The PathWays program has been designed to coordinate care across the delivery system and care continuum, considering physical health, behavioral health, social services, and LTSS. All 1915(c) waiver enrollees in managed care receive Complex Case Management from their MCE, including assignment of a Care Coordinator who works with the Service Coordinator to ensure cohesive, holistic service delivery.

The Care Coordinator has primary responsibility for coordination of the member's physical and behavioral health. The member's Service Coordinator collaborates with the member's Care Coordinator and is a core participant in the member's Interdisciplinary Care Team (ICT). The ICT also includes any member-selected supports, including informal caregivers and incorporates additional expertise as needed based on the member's medical and behavioral health conditions, disabilities, pharmacy, environmental needs, and other urgent management needs. Through a person-centered planning approach, MCEs assist the member, their family, and physician to develop a strengths-based Individualized Care Plan (ICP) with specific objectives, goals, and action protocols to meet identified needs. The PCISP is a component of the ICP. Additionally, MCEs must engage the member's PMP or other significant practitioner(s) in care coordination activities through ongoing, direct interaction between the practitioner and the ICT. This involvement includes semi-annual care conferences based on the member's assessment and evaluation.

In the FFS delivery system, case managers are responsible for the implementation and monitoring of the PCISP, and for monitoring the individual's health and welfare on an on-going basis. Coordination of waiver services and other services is completed by the case manager. Within 30 calendar days of implementation of the plan, the case manager is responsible for ensuring that all identified services and supports have been implemented as identified in the PCISP. The case manager is responsible for monitoring and coordinating services on an ongoing basis and is required to record at least one monthly case note for each individual. At least once every 90 calendar days, a review is completed by the case manager with the individual. The IST is advised of any concerns or needs for updates that may require

scheduling of additional team meetings by the case manager. Each waiver provider is required to submit a quarterly report summarizing the level of support provided to the individual based upon the identified supports and services in the PCISP. The case manager reviews these reports for consistency with the PCISP and works with providers as needed to address findings from this review.

f. How the plan development process provides for the assignment of responsibilities to implement and monitor the plan

MCEs must ensure services outlined on the PCISP are initiated within 20 business days of receiving the NFLOC determination. When the initial PCISP is activated, the service coordinator/case manager must either call or visit the member within 30 days from initial PCISP activation to ensure implementation of services. Additionally, service coordinators/case managers are responsible for monitoring and assessing the quality and effectiveness of the member's PCISP in a face-to-face contact every 90 days. At least two of these face-to-face contacts per year will be in the member's home setting, consistent with the member's preference. Additionally, members are contacted by their service coordinator/case manager at least monthly either in person or by telephone, unless the member specifically requests to opt out or otherwise reduce the frequency of these monthly contacts. The service coordinator/case manager may also meet more frequently with the member when appropriate based on the member's needs and/or request.

g. How and when the plan is updated, including when the participant's needs change

PCISPs must be updated when there is a change in the member's condition or recommended services. The service coordinator/case manager must monitor and assess the quality and effectiveness of the PCISP during each 90 day visit and initiate updates as needed. MCEs are contractually required to establish a process, subject to OMPP review and approval, for identifying and addressing the following events that trigger reassessment of the member as expeditiously as possible in accordance with the circumstances, and as clinically indicated by the member's health status and needs, but in no case more than five business days after the occurrence of any of the following:
- A significant healthcare event, including but not limited to, hospital admission, transition between healthcare settings, or hospital discharge.
- A change or loss of informal caregiver.
- A decline in social status (e.g., increased isolation/loneliness).
- A change in the home setting or environment if the change impacts one or more areas of health or functional status.
- A change in diagnosis that is not temporary or episodic and that impacts one or more area of health status or functioning.
- As requested by the member or member's designee, caregiver, provider, the member's ICT, or OMPP.

Additionally, the member's Care Coordinator, Service Coordinator, and ICT meet together with the member in-person at least once per year to conduct an annual reassessment, and review and update the member's ICP and PCISP.

Case managers and supervisors monitor PCISPs that are due to expire through the case management system. In addition, supervisors run monthly reports of the number of PCISPs that are about to expire for case management monitoring and quality assurance purposes.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

☑ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**

☑ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**

- ☑ **A specific and individualized assessed need for the modification.**
- ☑ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
- ☑ **Less intrusive methods of meeting the need that have been tried but did not work.**
- ☑ **A clear description of the condition that is directly proportionate to the specific assessed need.**
- ☑ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**

☑ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**

☑ **Informed consent of the individual.**

☑ **An assurance that interventions and supports will cause no harm to the individual.**

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 during both the NFLOC and service planning processes. During the initial and renewal NFLOC processes, the level of care assessment tool is used to identify potential risks and vulnerabilities. PCISP development takes into account risks identified during the assessment. The person-centered service planning process must include protecting a member's health, welfare, and safety, including developing an emergency plan. PCISPs must address member's assessed needs, including health and safety risks factors and documentation of appropriate interventions to mitigate risk while balancing the member's overall quality of life and individual choice. The PCISP will clearly identify any activities that pose a significant level of risk which require restricting the person's ability to engage in the activity. Such restrictions will have a targeted modification plan, proportional to the risk itself, including support necessary for the person to engage in the activity, and a plan to restore the person's unrestricted right to that activity. The service provider must document the assessed risk, including when and how often the risk occurs, and develop a strategic plan to attempt to restore the person's right to that activity. The State recognizes that risk tolerance varies greatly from participant to participant and encourages service coordinators/case managers to recognize and respect the participant's participant desires and preferences when formulating risk mitigation strategies.

Additionally, the Service Coordinator works with the informal caregiver and Informal Caregiver Coach, as applicable, on the creation of a crisis management/emergency plan to support unplanned events that could impact the member and environment. The plan is reviewed and updated at the time of reassessment, or as needed, and provided to the MCE and listed entities on the plan. Permissions from the member to share this information is necessary. The plan includes but is not limited to the following:
- Health conditions
- Advance Care Planning: advance directives, will planning, physician orders for life sustaining treatment (POST) form, etc.
- Medications and/or medication management/assistance to prevent medication errors, if part of the PCISP - Fall prevention interventions, as necessary
- Healthcare providers including contact information
- Emergency contacts
- Identification and contact information for back-up informal caregiver(s)
- Contact information for Informal Caregiver Coach and MCE Care Team
- Informal caregiver resources available within the caregiver's/member's community of choice

As part of the MCE's annual Care Coordination Program Plan, subject to OMPP review and approval, the MCE must describe its mechanism(s) to monitor, evaluate and improve its performance in the area of safety and risk issues. These mechanisms shall ensure that the MCE offers individualized supports to facilitate a safe environment for each member. The MCE must assure its performance is consistent with understanding of the desired member outcomes and preferences. The MCE must include family members and other natural and community supports when addressing safety concerns per the member's preference.

Additionally, the MCE is responsible for establishing a network of contracted providers adequate to ensure that critical services are provided without gaps in care. Critical services include attendant care, personal care, homemaker, and respite care, and includes, but is not limited to, tasks such as bathing, toileting, dressing, feeding, transferring to or from bed or wheelchair, and assistance with similar daily activities. In instances where an unforeseeable gap in critical services occurs, the MCE must ensure services are provided within four hours of the report of the gap. If the provider agency or Service Coordinator is able to contact the member or member representative before the scheduled service to advise him/her that the regular provider/employee will be unavailable, the member or member representative may choose to receive the service from a back-up substitute provider/employee, at an alternative time from the regular provider/employee or from an alternate provider/employee from the member's informal support system. The member or member representative has the final say in how (informal versus paid) and when care to replace a scheduled provider/employee who is unavailable will be delivered. When the provider or the MCE is notified of a gap in critical services, the member or member representative must receive a response acknowledging the gap and providing a detailed explanation as to the reason for the gap, and the alternative plan being created to resolve the particular gap and any possible future gaps. The MCE must implement policies and procedures to identify, correct, track, and report gaps in critical services. These policies must be described in the MCE's annual Care Coordination Program Plan, which is reviewed and approved by OMPP.

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.

MCEs are tasked with providing comprehensive communication and outreach to its enrollees to ensure understanding of the PathWays program, how to access services, and available choice of providers. For example, MCEs are contractually required to provide an enrollment packet to all members within five days of enrollment. The enrollment packet includes a welcome letter that includes education confirming the member's enrollment with the PathWays MCE and an explanation as to how to access information. It also includes specific information on coordination of care with current providers and how members can receive care coordination assistance. Additionally, the enrollment packet includes information on where to find information about the provider's network. The MCE must provide a current provider directory and/or information on how to find a provider near the member's residence online and via the MCE Member Helpline. The provider directory must meet the requirements of 42 CFR 438.10(h), which delineates minimum required content for listing all 1915(c) waiver providers. The Member Handbook also provides detailed information on how to access 1915(c) waiver services. All MCE member communication materials are reviewed and approved by OMPP prior to distribution. Additionally, in accordance with 42 CFR 441.301(c), as part of the person-centered service planning process, the Service Coordinator/Case Manager is responsible for ensuring participants are fully informed of their right to choose service providers before services begin, at each reevaluation, and at any time during the year when a participant requests a change of providers.

For FFS, an electronic database is maintained by FSSA that contains information regarding all qualified waiver providers for each service on the waiver. Case managers are able to generate a list of all qualified providers for each service on the waiver for the participants' use. As a service is identified, participant or guardian with the support team are encouraged to call and interview potential service providers and make their own choice. The participant's person centered service plan must document the provider-choice process. Case managers can assist the participant with interviewing potential providers and obtaining references on potential providers, if desired by the participant. The participant can request a change of any service provider at any time while receiving waiver services. The case manager will assist the participant with obtaining information about any and all providers available for a given service.

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):

When receiving PathWays enrollees with an existing PCISP, the MCE must honor such plan for a minimum of 90 days, unless the enrollee would like to modify services and/or providers or the MCE or FSSA identifies a need for reassessment. Modifications to the PCISP can be made based on the reassessment supporting the change. Following the 90-day minimum continuity-of-care period, services may not be reduced or terminated in the absence of an up-to-date assessment of needs that supports reduction or termination. MCEs submit monthly aggregate and participant-level reports to OMPP on PCISPs. OMPP utilizes these reports to monitor PCISP changes, MCE compliance with continuity of care requirements, and appropriateness of PCISP modifications. OMPP reviews plans that have proposed reductions that exceed an OMPP-defined threshold. Additionally, OMPP may review, question, and request revision to any PCISP.

Additionally, OMPP's care management team conducts monthly audits of PCISPs, based on a statistically significant random sample, developed in accordance with the National Committee for Quality Assurance (NCQA) "8-30 methodology" for file review. OMPP has developed a standardized audit template to ensure consistent application of review standards. To be considered compliant, the following elements must be included:
- Developed by a person trained in person-centered planning using a person-centered process
- Identifies the setting where the member lives
- Addresses member's strengths and preferences
- Identifies member's specific individualized assessed needs including clinical and support needs as identified through an assessment of functional need
- Individually identified goals and outcomes
- Services and supports (paid and unpaid) that will assist the member to achieve the goals
- Identifies the individual and/or entity who is responsible for monitoring the plans
- Identifies services for which the individual elects to self-direct, meeting the requirements of 42 CFR 441.740
- Reflects risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed
- Contains the electronic or written signature of the member, member's designated representative (if applicable) and any others involved in the service planning process
- Is written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b)

Additionally, the audit confirms MCE compliance with contractually required PCISP development and update timelines, and continuity of care provisions.

In addition to OMPP conducted audits, MCEs are required to develop an internal PCISP audit policy and procedure for OMPP review and approval. OMPP reviews the results of the MCE internal PCISP audits.

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, when the individual's circumstances or needs change significantly, or at the request of the individual, 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:

Service coordinators/case managers must review and update PCISPs with members on an as-needed basis, including upon reassessment of functional need, when the member's circumstances or needs change significantly, or at the request of the member, but no less often than annually per 42 CFR 441.301(c)(3).

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:

Electronic documents of FFS PCISPs are maintained in FSSA's case management data system. Managed care PCISPs are maintained by the MCE.

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, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

MCEs must ensure services outlined on the PCISP are initiated within 20 business days of receiving the NFLOC determination. When the initial PCISP is activated, the Service Coordinator/Case Manager must either call or visit the member within 30 days to ensure implementation of services. Additionally, Service Coordinators/Case Managers are responsible for monitoring and assessing the quality and effectiveness of the member's PCISP in a face-to-face contact every 90 days. At least two of these face-to-face contacts per year will be in the member's home setting, consistent with the member's preference. Additionally, members are contacted by their Service Coordinator/Case Manager at least monthly either in person or by telephone, unless the member specifically requests to opt out or otherwise reduce the frequency of these monthly contacts. The Service Coordinator/Case Manager may also meet more frequently with the member when appropriate based on the member's needs and/or request. MCEs must use the OMPP-developed person-centered monitoring tool (PCMT), or OMPP-approved equivalent tool, which supports monitoring to ensure participants can exercise free choice of provider, services meet participants' needs, effectiveness of back-up plans, participant health and welfare, and access to non-waiver services.

OMPP also oversees PCISP implementation through a comprehensive oversight process. For example, as further described in Item D-1-g, OMPP conducts monthly audits of PCISPs. MCEs are also required to develop an internal PCISP audit policy and procedure for OMPP review and approval. The results of these MCE audits are reviewed by OMPP. Additionally, OMPP receives monthly data at the individual member level containing key PCISP data such as date of activation, authorized units by service, and confirmation of in-person contact status.

b. Monitoring Safeguard. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☐ **Direct oversight of the process or periodic evaluation by a state agency;**

☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's 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.a Number and percentage of PCISPs that address the participants needs and personal goals. Numerator: Number of PCISPs that address the participants needs and personal goals. Denominator: Number of PCISPs audited by the State.

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

Responsible Party for	Frequency of data	Sampling Approach

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

Data Aggregation and Analysis:

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

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

Performance Measure:
D.1.b Number and percent of sampled individuals who report that their long-term services meet all of their current needs and goals. Numerator: Number of sampled individuals who report that their long-term services meet all of their current needs and goals. Denominator: Total number of sampled individuals who responded.

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators Aging and Disabilities (NCI-AD)

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

		Representative Sample; Confidence Interval = 95%; Proportional and stratified across state districts
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D.1.c Number and percent of sampled individuals who responded that the service coordinator/CM talked to them about services/resources that may help their unmet needs/goals. Numerator: Number of sampled individuals who responded the service coordinator/CM talked to them about services/resources that may help their unmet needs/goals. Denominator: Total number of sampled individuals who responded

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators Aging and Disabilities (NCI-AD)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: NCI-AD Survey Contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Representative Sample: Confidence Interval = 95%; Proportional and stratified across state districts
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: NCI-AD Survey Contractor	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.***

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 percentage of PCISPs audited that were developed in accordance with policies and procedures. Numerator: Number of audited PCISPs compliant with PCISP policies and procedures. Denominator: Number of PCISPs audited.

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

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

		Sample Confidence Interval =
☑ **Other** Specify: MCE	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-assurance: 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.3.a Number and percentage of PCISPs audited that were updated or revised annually. Numerator: Number of PCISPs that were updated annually. Denominator: Number of PCISPs that were due for annual update.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D.3.b Number and percentage of PCISPs with evidence the plan was updated in response to a participant's needs. Numerator: Number of PCISPs audited that include evidence that the plan was updated in response to a participant's needs. Denominator: Number of PCISPs audited for participants who had a change in condition or change in needs.

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

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

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

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: Participants are afforded choice between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
D.4 Number and percentage of PCISP audits where services are delivered in accordance with the PCISP. Numerator: Number of PCISPs submitted with proof of service documentation that demonstrates service provided at the type, scope, amount, duration, and frequency as specified in the PCISP. Denominator: Number of PCISPs audited.

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

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

MCE		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

e. ***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.5.a Number and percentage of PCISP audits that reflect participant choice between/among waiver services. Numerator: Number of PCISPs audited that reflect choice between/among waiver services. Denominator: Number of PCISPs audited.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
D.5.b Number and percentage of PCISPs audited that reflect participant choice between waiver providers. Numerator: Number of PCISPs audited that reflect participant choice between waiver providers. Denominator: Number of PCISPs audited.

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

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

☑ **Other** Specify: MCE	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D.5.c Number and percentage of PCISP audits that reflect participant choice between waiver services and institutional care. Numerator: Number of PCISP audits that reflect participant choice between waiver services and institutional care. Denominator: Number of PCISPs audited.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Audit Reports

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

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The OMPP Care Management team will conduct audits of MCE PCISPs on a monthly basis. The MCEs will provide requested copies of services plans to the Care Management Manager monthly. Each PCISP will be scored using a standardized template. OMPP developed this audit review checklist to include all of the elements in 42 CFR §441.301(c)(1) and (2). In order to be considered a compliant PCISP it must include all of the checklist elements.

In addition, PCISPs are reviewed to confirm compliance with the following timeliness requirements:
- Members who are newly determined to meet NFLOC: A PCISP needs to be completed within five business days of receiving the member's NFLOC determination
- Members entering into the program with existing NFLOC and receiving HCBS prior to enrollment in the MCE will be visited by the service coordinator within 90 days.

The results of the audit will be sent to the Service Coordinator leader for the MCE by the last working day of the month. The MCE must provide a plan to correct any deficiencies identified by the 15th business day of the following month. The OMPP care management team will plan for a repeat audit, if needed.

In addition to OMPP conducted audits, the MCE will be required to provide their internal audit policy and procedure (P&P). Based upon this P&P, OMPP will develop a process for reviewing the results of the MCE internal PCISP audit. In the event of an identified deficiency, a corrective action plan, liquidated damages, or other contractually agreed upon remedy is required. OMPP provides the MCE written notice of non-compliance with expected remediation action and monitors the corrective actions implemented through to resolution. In the event remediation is not achieved in accordance with the required corrective action plan, OMPP may implement escalating corrective action.

Additionally, depending on the nature of MCE non-compliance, OMPP may determine additional policy guidance or contractual modifications are necessary to clarify expectations and ensure performance in accordance with state expectations. In such cases, OMPP may initiate contract amendment or policy clarification through updates to the MCE Policy and Procedure Manual. Trends are also monitored for the potential development of new Performance Improvement Projects.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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.

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.

MCEs operate a grievance and appeal system in accordance with 42 CFR 438 Subpart F and as detailed in the Grievance System section of the 1915(b) Waiver. Enrollees are notified in writing, by their MCE, of all adverse benefit determinations, as defined in 42 CFR 438.400(b). The MCE notice must meet the requirements of 42 CFR 438.404 and explain the:
- Adverse benefit determination the MCE has taken or intends to take
- Reason for the adverse benefit determination
- Right of the enrollee to be provided access to all information relevant to the determination - Right to request an appeal
- Procedures for requesting an appeal, including an external review by an Independent Review Organization (IRO) and Fair Hearing following exhaustion of the MCE appeals process
- Circumstances under which an appeal process may be expedited, and how to request
- Right to have benefits continue pending resolution of the appeal, how to request continuation of benefits, and any circumstances under which the enrollee may be required to pay for the cost of such services

MCEs must maintain records of all grievance and appeals in accordance with 42 CFR 438.416. Within 120 days of exhausting the MCE grievance and appeal process, in accordance with 42 CFR 438.408, enrollees may access the State Fair Hearing process. This may run concurrent to an external review by an IRO.

MCEs must provide enrollees any reasonable assistance in completing forms and taking other procedural steps related to appeals. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. Oral interpretation services do not substitute for written translation of vital materials in accordance with 42 CFR 438.408(d)(1) and 42 CFR 438.10. In addition to MCE assistance, OMPP contracts with a Member Support Services Contractor to provide beneficiary support system services per 42 CFR 438.71(d). They are an access point for enrollee grievances and appeals, and provide education on grievance, appeal, and State Fair Hearing rights. The Contractor also provides assistance in navigating the process and appealing MCE adverse benefit determinations.

Additionally, MCEs are contractually required to annually provide enrollees written information including a description of grievance, appeal, external review by an IRO, and State Fair Hearing procedures and timeframes. Information must also be included in the Member Handbook, in accordance with 42 CFR 438.10(g)(2)(xi). All MCE generated enrollee materials are subject to advanced OMPP review and approval.

For Waiver participants receiving services through the FFS delivery system, the following processes apply: Waiver applicants and their legal representatives are provided oral explanations of the Medicaid Fair Hearing process (including an explanation of the types of decisions they may appeal) at the time of the waiver participant's initial eligibility assessment by the Level of Care Assessment Representative (LCAR) contractor.

The LCAR contractor will send formal notification to waiver applicants and participants regarding the following adverse actions:

• Denying functional level of care

Case managers will send formal notification to waiver applicants and participants of any action that affects the individual's Medicaid benefits related to service delivery, or participant-directed budget amount, including the following adverse actions:
• Not providing an individual the choice of home and community-based services as an alternative to institutional care;
• Reducing participant-directed budget allocation amount;
• Denying an individual the service(s) of their choice or the provider(s) of their choice; and
• Denying, suspending, reducing or terminating previously authorized services.

This formal notification of action will be provided in writing to the waiver applicant or participant and their legal representatives within 10 business days of the issue date specified on the formal notification and in advance of the effective date of the action. The notice will include the following information:
• Description of the decision that was made;
• Description of the waiver participant's appeal rights;
• Instructions for how the waiver applicant or participant may appeal the decision/action by requesting a Fair Hearing;
• Timeliness requirements for an appeal - within 33 days of the issue date specified on the formal notification;
• Description of the appeal process and procedures; and
• Option for waiver applicants and participants to have representation by an attorney, relative or other spokesperson.

Additionally, whenever an action is taken that adversely affects a waiver participant post-enrollment (e.g., services are denied, reduced or terminated), the notice will inform the participant that, if they file an appeal in a timely manner, their services will be continued during the period the appeal is under consideration by the Office of Administrative Law Proceedings.

Each formal notification is generated from and stored within the electronic eligibility systems. The case manager documents the request for an appeal in a case note. Additionally, the request for an appeal and a fair hearing is also recorded at the Office of Administrative Law Proceedings.

Upon request, the case manager assists the waiver participant in preparing the written request for an appeal. The case manager advises the waiver participant of the required timeframes for submission of an appeal, the address for submission of the appeal, and provides an opportunity to discuss the issue being appealed.

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**

• **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.

The MCE grievance and appeals process operates in accordance with 42 CFR Part 438 Subpart F and is described in the PathWays 1915(b) Waiver.

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**

• **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

Do not complete this item.

• **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).

Do not complete this item.

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).

All individuals with direct monitoring responsibilities for enrollees (including, but not limited to MCEs, providers, Service Coordinators/Case Managers, and FSSA staff) are responsible for reporting incidents. Incident reports are submitted through the FSSA web-based incident reporting system. If web access is unavailable, incidents can be reported by telephone and e-mail. Additionally, all cases of suspected abuse, neglect, or exploitation (ANE), and unexpected death of a member, must be reported to an Adult Protective Services (APS) unit or law enforcement. APS reports can be made via a 24-hour hotline, online reporting system, or to an APS field office. Providers are also required to notify the member's service coordinator/case manager of all incident reports.

In accordance with 455-IAC-2, incidents are unusual occurrences affecting the health and safety of enrollees and include the following:
1. Alleged, suspected, reported, observed, or actual abuse/battery, assault, neglect, or exploitation of a member
2. The unexpected death of a member
3. Significant injuries to the member requiring emergent medical intervention, including, but not limited to, the following:(a) fracture; (b) a burn greater than first degree; (c) choking that requires intervention; or (d) contusions or lacerations.
4. Injuries of unknown origin
5. Any threat or attempt of suicide made by the member
6. Any unusual hospitalization due to significant change in health and/or mental status may require a change in service provision OR admission of an individual to a nursing facility, excluding respite stays
7. Member elopement or missing person
8. Inadequate formal or informal support for a member, including inadequate supervision which endangers the member
9. Medication errors resulting in outcomes that require medical treatment beyond an ER/physician evaluation or monitoring vital signs
10. A residence that compromises the health and safety of a member due to any of the following: (a) a significant interruption of a major utility; or (b) an environmental, structural, or other significant problem.
11. Environmental or structural problems associated with a dwelling where individuals reside that compromise the health and safety of the individuals
12. A residential fire resulting in any of the following: (a) relocation; (b) personal injury; or (c) property loss.
13. Suspected or observed criminal activity by: (a) provider's staff when it affects or has the potential to affect the member's care; (b) a family member of a member receiving services when it affects or has the potential to affect the member's care or services; or (c) the member receiving services.
14. Police arrest of a member or any person responsible for the care of the member
15. A major disturbance or threat to public safety created by the member. The threat can be toward anyone, including staff, and in an internal setting, and need not be outside the individual's residence.
16. Any instance of restrictive intervention (including chemical or physical restraints, or seclusion)
17. Falls with injury, in accordance with the U.S. Center for Disease Control's (CDC) Behavioral Risk Factor Surveillance System (BRFSS)

Reports regarding an incident, allegation, or suspicion of ANE, or the death of a member must be submitted within 24 hours of the occurrence or knowledge of the occurrence (whichever is sooner). All other incidents must be reported within 48 hours of the occurrence or knowledge of the occurrence (whichever is sooner).

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.

Information pertaining to protections from abuse, neglect, and exploitation (including how to notify the appropriate authorities) is shared with participants annually. MCEs are contractually required to provide educational materials and training opportunities to members, families, informal caregivers, and guardians which cover the prevention, identification, reporting, management, and mitigation of abuse, neglect, and exploitation. MCEs must communicate this information via a variety of mechanisms such as alerts and messages via member portals, websites, text messaging, social media campaigns, and online videos.

At minimum, MCEs must also include in its member welcome packet, member handbook, and member website the following information:
- A detailed description of critical incidents and instructions about how to report an incident
- A description of what the member should expect if they submit a critical incident report to the MCE and if one is submitted on their behalf
- Member rights related to the reporting, management, and mitigation of all critical incident types
- Information about where at-risk members and caregivers can find education, support, and strategies to reduce member and informal caregiver isolation
- A description of the member's role in mitigating future critical incidents

All MCE materials are reviewed and approved by OMPP.

Additionally, as part of the person-centered service planning process, the service coordinator/case manager provides information on who to contact, when to contact, and how to report incidents with all persons involved in PCISP development. Information is regularly reviewed during each 90 day visit.

For FFS enrollees, as a part of the PCISP process, participants, family members and/or legal guardians are advised by the case manager via written materials of OMPP's abuse, neglect, and exploitation reporting procedures. The case manager will discuss the information concerning who to contact, when to contact and how to report incidents with all persons involved in PCISP 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.

Additionally, case managers are required to provide each waiver participant with a link to the Indiana Health Coverage Programs (IHCP) Office of Medicaid Policy and Planning (OMPP) HCBS Module, a resource document for participants and support teams. When requested by the participant, guardian and/or family, a paper/hard copy of the IHCP OMPP HCBS Module will be provided by the case manager. Participants are required to sign and date that they received the grievance procedure and a link and/or copy of the above mentioned IHCP OMPP HCBS Module.

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 reported to the FSSA web-based incident reporting system. Additionally, all cases of suspected abuse, neglect, or exploitation (ANE) are reported to an Adult Protective Services (APS) unit or law enforcement. Upon receipt of a report through the web-based system, OMPP routes it to the participant's MCE. The MCE must intake the report into its critical incident tracking system as soon as possible, but no later than four business hours after receipt. Then, the MCE must review and triage all reports within one business day of receipt to:
- Determine if ANE has occurred. If ANE is reasonably suspected, the MCE must file a critical incident report with APS if one has not already been submitted.
- Assess and address any immediate potential threats to member health, safety, and welfare. If the MCE identifies a risk of harm or potential harm, the MCE must take immediate action to ensure the safety of the member. These steps may include communication with service coordinators, other providers, family members and informal caregivers to verify or ensure that immediate threats to the individual's health and welfare are addressed and resolved. The MCE must document the actions taken as part of their weekly report to OMPP until the critical incident investigation is closed.
- Determine whether additional information is required from the provider.
- Notify the member and, as needed, other service providers about the critical incident report and related issues and concerns, about what to expect, and, as appropriate, how to mitigate future risk.

If the MCE determines that additional information is required from the provider or other reporter, the MCE must notify them within no more than 24-hours and provide guidance and technical assistance to support them in successfully completing the report. After returning the report to the provider or other reporter, the MCE must follow up with them within one business day to obtain confirmation that they are submitting the necessary updates to the MCE.

The MCE is responsible for analyzing each critical incident report (except for ANE reports investigated by APS, as described further below) and determining how to proceed. The MCE must analyze each report to determine if the report meets the threshold to be a critical incident as defined in Appendix G-1-b. If a report meets the defined criteria to be a critical incident, the MCE must take the following steps:

1. Conduct a full investigation. The MCE shall ensure that the investigation and resolution of critical incidents are conducted timely based on the nature and severity of each case. All investigations must be completed within 30 days, and:
a. Incidents not resolved within 21 days of the date of the initial incident must be referred to the MCE's Quality Manager or designee for additional action. The MCE must have the ability to flag such incidents in its incident management system. Follow-up reporting must continue every seven days until the incident is deemed resolved.
b. For incidents that occurred when the member was enrolled with a different MCE, the member's prior MCE must cooperate with the investigating MCE.
c. The MCE must clearly define responsibilities for implementation of its critical incident policies and procedures, to assure that a thorough investigation is completed timely. These policies are reviewed and approved by OMPP.
2. Submit to the member or the member's legal guardian as well as to the individual's case manager and service coordinator all information required by the MCE's investigator to be submitted.
3. Submit required reports to FSSA.

If a report does not meet the threshold to be a critical incident, the MCE must:
1. Respond to the reporter and route the complaint through the MCE's complaints, grievances, and appeals process.
2. Follow its quality of care and/or quality of service investigation process.

If a critical incident has been confirmed (i.e., a substantiated critical incident), the MCE is responsible for ensuring follow-up care is in place for the impacted member. The MCE must require all staff and contracted providers to document updates regarding initiated action(s) taken for the member and all follow-up activities related to the intervention(s) implemented as a result of the incident. Such follow-up may include updating the member's PCISP to reflect enhanced care needs and conducting necessary follow up visits. The MCE's process must include a holistic review of the circumstances of the critical incident and preventing future occurrences. For example, if multiple critical incidents are filed for a network provider, the MCE must evaluate the implications for inclusion of that provider in its network or the application of additional oversight and reporting requirements, sanctions, or other requirements. The MCE is required to align its response with 455 IAC 2-6 and take comparable actions with providers who have egregious or repeated violations.

The MCE is responsible for implementing corrective actions to ensure that the conditions that led to the critical incident

no longer exist. These may include but are not limited to:
- Enhancing provider oversight activities for a single provider, a group of providers, or all providers
- Establishing corrective action plans with network providers, within the MCE itself, or in other areas
- Modifying or terminating contracts with providers or vendors
- Transferring all or subgroups of members to be served by other providers

The MCE must document its corrective action process including steps taken to address the conditions that led to the critical incident, timeframe for resolution, staff members involved, member perspective, and plan for continuous monitoring. Upon a determination that the report does not need further documentation or review, the MCE shall mark the report as closed.

For reports of ANE, after the report is submitted to APS, it is sent to the director of the local APS unit who determines appropriate next steps. If APS conducts an investigation, an investigator may contact the MCE and/or other reporter for additional information. Once a report of an ANE critical incident has been made, the MCE must proactively provide interventions to members regarding the ANE. For cases where APS may need to be involved, the MCE must:
1. Invite APS to participate in the member-centered planning process, including plan development and updates, comprehensive assessment, and reassessment.
2. Invite APS to participate on the interdisciplinary team to the extent that the staff person makes recommendations as necessary to fulfill their APS responsibilities.
3. Designate a staff person to serve as a member advocate and liaison between APS and the member to assist in developing service options.

The MCE must ensure that members are immediately separated from an alleged abuser. This transition must uphold continuity of care and connect the individual with appropriate providers and other services in their community. The MCE will consult with human services agencies, as needed, to identify appropriate providers in the community. The MCE must then follow up to ensure that member needs are addressed on an ongoing basis. Follow-up on the success of an intervention must be completed within a week and reported to OMPP. All follow- up activities and referrals must be documented in the MCE's tracking systems.

Additionally, the OMPP Mortality Review Committee will review all participant deaths that:
- Are due to alleged, suspected or known abuse or neglect - Are from trauma or accident
- Are alleged or known suicide or homicide
- Occur unexpectedly following transition from a nursing facility
- Occurs when participant has gone missing from normal care setting

The OMPP 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 service coordinator/case manager, a referral to another entity, or a systemic recommendation; or
- Close a case with no recommendation(s).

MCEs are required to participate in the OMPP Mortality Review Committee.

OMPP is responsible for review and response to critical incidents or events for FFS enrollees in accordance with the methods and timeframes implemented by MCEs for managed care enrollees.

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 critical incidents is the responsibility of OMPP. To assist in this oversight, MCEs are required to submit weekly critical incident reports to OMPP. These reports document data such as:
- Date the critical incident occurred
- Date the critical incident was identified
- Confirmation of report made to APS for incidents involving ANE - Date initial action was taken - Incident type
- Relevant provider information
- Current status of the investigation
- Closure information (e.g., date closed, final disposition, PCISP updates made, provider changes initiated, education provided, other actions taken, etc.)

OMPP reviews the MCE reports against incidents reported to the FSSA web-based incident reporting system to validate all reported incidents are being investigated by the MCE. Data is also monitored to ensure the MCEs are closing cases timely. As applicable, corrective action is implemented with the MCE when performance or non-compliance issues are identified.

MCEs are also subject to semi-annual audits by OMPP of their critical incident processes. OMPP collects a sample of reports received by the MCE to confirm whether critical incidents were accurately identified and reported timely; whether appropriate investigations and/or follow-up actions were conducted; and whether corrective actions were implemented where necessary. OMPP may obtain feedback from members who experienced a critical incident, and the providers involved in the incident, to assure appropriate follow-up occurred. OMPP may also review the MCE's internal policies and procedures and related documents and data and to observe the MCE's workflows related to critical incidents as part of the audit process.

Additionally, OMPP has a critical incident workgroup that reviews data provided by the MCEs, refers cases to the OMPP Mortality Review Committee, and aggregates data across the MCEs to identify programmatic trends and necessary remediation. For example, the workgroup reviews the number and types of incidents for patterns such as across and within settings, provider, or provider type.

The MCEs, with oversight of OMPP, have an obligation to implement and maintain systems to prevent and mitigate critical incidents from occurring, such as:
- Conducting screenings to identify members who are at risk of experiencing a critical incident, as well as follow-up protocols to implement interventions for those members who are at risk.
- Making reasonable efforts through member interactions, education, and interventions to ensure that members are free from ANE.
- Referring members at risk to the appropriate resource including the LTC Ombudsman or other appropriate agency, such as the Area Agency on Aging.
- Processes to develop and update members' care plans and/or PCISPs, as needed, to balance member needs for safety, protection, physical health and freedom from harm with overall quality of life and individual choice.
- Using trend reports to identify potentially vulnerable members and develop systemic or operational interventions. This includes developing a screening or algorithm to identify individuals at higher risk of incidents. This also includes identifying areas where critical incidents are underreported.

- In cases where a participant has more than three critical incidents in a 12-month period, the MCE must perform an analysis of that participant's situation and take action as necessary to prevent or mitigate further incidents.
-Identifying, remediating, and resolving systemic issues based on a review of program data including:
o Developing and implementing initiatives to mitigate critical incident risks.
o Developing and implementing initiatives to reduce levels of underreporting.
o Imposing corrective actions with network providers, within the MCE itself, or in other areas, as needed.
o Terminating contracts with providers or vendors that, based on MCE analysis, pose risks that cannot be mitigated or that the provider has failed to mitigate.
o Other MCE actions, as needed.

- Using coordinated, creative, and effective methods for conducting outreach and education for all parties involved in critical incident reporting, management and mitigation, for example:
o Providing outreach and educational information about critical incidents to members and their family, guardian, and informal or unpaid caregivers to address particular trends or issues.
o Communicating timely with MCE staff and contractors about trends and issues, and updating the MCE's training

materials.
o Communicating with providers about trends and issues identified through critical incident data analysis.

- Implementing policies and processes to assist in identifying unreported incidents.

OMPP also works in collaboration with the Bureau of Disability Services (BDS), the FSSA agency responsible for administration and operation of Indiana's other four 1915(c) waivers. OMPP and BDS meet to identify cross-waiver issues such as provider trends requiring system-wide remediation across waiver programs. These meetings occur on a bi-annual basis, and ad hoc as needed to respond to identified issues.

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:

  OMPP prohibits the use of restraints in the provision of services regardless of the waiver setting. Reporting of prohibited restraint usage by a provider is reported through the FSSA web-based incident reporting system.

  Service coordinators/case managers are responsible for monitoring and assessing the quality and effectiveness of the member's PCISP through monthly contact, including face-to-face contact every 90 days. These reviews are utilized as opportunities to monitor for any prohibited restraint usage. MCEs are responsible for tracking, reviewing, and analyzing all incidents of prohibited use of restraints and reporting incidents to OMPP. OMPP has ultimate responsibility for oversight that these prohibitions are enforced.

- ( ) **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:

  OMPP prohibits the use of restrictive interventions in the provision of services regardless of the waiver setting. Reporting of prohibited usage of restrictive interventions by a provider is reported through the FSSA web-based incident reporting system.

  Service coordinators/case managers are responsible for monitoring and assessing the quality and effectiveness of the member's PCISP through monthly contact, including face-to-face contact every 90 days. These reviews are utilized as opportunities to monitor for any prohibited usage of restrictive interventions. MCEs are responsible for tracking, reviewing, and analyzing all incidents of prohibited use of restrictive interventions and reporting incidents to OMPP. OMPP has ultimate responsibility for oversight that these prohibitions are enforced.

- ( ) **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:

OMPP prohibits the use of seclusion in the provision of services regardless of the waiver setting. Reporting of prohibited usage of seclusion by a provider is reported through the FSSA web-based incident reporting system.

Service coordinators/case managers are responsible for monitoring and assessing the quality and effectiveness of the member's PCISP through monthly contact, including face-to-face contact every 90 days. These reviews are utilized as opportunities to monitor for any prohibited usage of seclusion. MCEs are responsible for tracking, reviewing, and analyzing all incidents of prohibited use of seclusion and reporting incidents to OMPP. OMPP has ultimate responsibility for oversight that these prohibitions are enforced.

- **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)*

- **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 in this waiver 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 when individuals 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. For some individuals, the family or legal guardian provide medication management and follow up. As natural and unpaid providers of care, families are not required to monitor and document medication consumption.

In Indiana, medication management may include reminders, cues, opening of medication containers or providing assistance to the individual who is competent, but otherwise unable to accomplish the task. 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 management of controlled substances if they are prescribed for the individual 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 individual's specific medications if medications are located in a common area such as kitchen or bathroom of the home.

AL 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 OMPP 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 OMPP's Incident Reporting (IR) policies and procedures related to unusual occurrences. All approved waiver providers that are responsible for medication assistance are required to report specific medication errors as defined in OMPP's incident reporting policy as outlined in Appendix G1-b of this application. Additionally, providers licensed by the Indiana Department of Health (IDOH) must also report medication errors to the IDOH.

The service coordinator/case manager conducts a face-to-face visit with the individual at least every ninety (90) days to assure all services, including medication assistance, are within the expectations of the waiver program. Additionally, non-licensed providers will be surveyed by the OMPP, 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 individual'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 individual 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 service coordinators/case managers, MCEs, OMPP 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 individuals selected for random review. Service coordinators/case managers review services, including medication management, during their 90 day individual PCISP review. Additionally, non-licensed providers will be surveyed by FSSA, or its designee, to assure compliance with applicable rules and regulations.

OMPP is responsible for monitoring and oversight of medication assistance practices and conduct analysis of medication errors and potentially harmful practices as discovered through incident reporting, provider compliance review process, mortality review, and the complaint process. Data is analyzed at the 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)*

• **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).

Medication administration is restricted within this waiver to waiver providers who are licensed by the Indiana Department of Health (IDOH) and are authorized to perform medication administration within the scope of their license. These IDOH-licensed waiver providers 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 individual 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 individual's specific medications if medications are located in a common area such as kitchen or bathroom.

• **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 administration are required to report specific medication errors as defined in OMPP's incident reporting policy. Licensed AL waiver service providers must also report medication errors to the Indiana 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), are required to record any error in medication shall be noted in the resident's record. All approved waiver providers that are responsible for medication administration are required to record medication errors, including refusal to take medications, in the individual's record as per OMPP's IR policy. This includes the following:
a) Medication given that was not prescribed or ordered for the individual;
b) Failure to administer medication as prescribed, including:
• Incorrect dosage;
• Medication administered incorrectly;
• Missed medication; and
• Failure to give medication at the appropriate time.

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

For licensed AL waiver providers, the facilities are required to report to IDOH any unusual occurrences if it directly threatens the welfare, safety or health of a resident as per 410 IAC 16.2-5-1.3(g)(1). The current 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 administration must report medication errors in accordance with the OMPP's IR policy.

Any medication error, except for refusal to take medications, must be reported to the state via the incident reporting process detailed within Appendix G-1-a of this application. Such errors including the following:
a) Medication given that was not prescribed or ordered for the individual;
b) Failure to administer medication as prescribed, including:
• Incorrect dosage; • Medication administered incorrectly;
• Missed medication; and
• Failure to give medication at the appropriate time

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:

- **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.

The IDOH has responsibility for monitoring licensed providers through the survey and compliance review processes. Additionally, OMPP gathers data through incident reporting, complaints, provider surveys, and mortality review. Identified problems with medication administration involving licensed waiver providers are referred to IDOH. OMPP staff reviews and reports medication administration error trends to the OMPP executive staff for further remedial action as deemed necessary.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's 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.

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

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.1.a Number and percentage of Critical Incident Reports received from MCEs within the stipulated timeframe. Numerator: Number of Critical Incident Reports received. Denominator: Number of Critical Incident Reports due.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
G.1.b Number and percentage of instances of abuse, neglect, exploitation, and unexplained death. Numerator: Number of Critical Incidents reflecting instances of abuse, neglect, exploitation or unexplained death. Denominator: Number of Critical Incidents reports received.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

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

Data Aggregation and Analysis:

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

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

Performance Measure:
G.1.c Number and percent of sampled individuals who reported that paid staff are respectful. Numerator: Number of sampled individuals who reported paid staff are respectful. Denominator: Total number of sampled individuals who responded.

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators Aging and Disabilities (NCI-AD)

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

		Representative Sample; Confidence Interval = 95%; Proportional and stratified across state districts
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
G.1.d Number and percent of sampled individuals who reported they feel safe around their paid support staff. Numerator: Number of sampled individuals who reported they feel safe around their paid support staff. Denominator: Total number of sampled individuals who responded.

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators Aging and Disabilities (NCI-AD)

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: NCI-AD Survey Contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Representative Sample; Confidence Interval = 95%; Proportional and stratified across state districts
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **Other** Specify: NCI-AD Survey Contractor	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.2.a Number and percentage of Critical Incident Reports reviewed by Critical Incident team that included cases sent to Mortality Review Committee. Numerator: Number of Critical Incident reports reviewed with recommendation to send to Mortality Review Committee. Denominator: Number of Critical Incident reports received.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

		Sample Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
G.2.b Number and percentage of waiver individuals (or families/legal guardians) who received information on how to report abuse, neglect, and/or exploitation (ANE) via the service planning process. Numerator: Number of participants, family members, or legal guardians who received information on reporting ANE as part of the PCISP. Denominator: Number of PCISPs audited.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
G.2.c Number and percentage of incidents of abuse, neglect and exploitation individually remediated. Numerator: Number of incidents of abuse, neglect and exploitation remediated. Denominator: Number of incidents of abuse, neglect and exploitation.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Specify: MCE		Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
G.2.d Number and percentage of unexpected deaths reviewed by the mortality review committee according to policy. Numerator: Number of unexpected deaths reviewed by the mortality review committee according to policy. Denominator: Total number of unexpected deaths.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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:

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.3 Number and percentage of Critical Incident Reports that include instances of restrictive interventions. Numerator: Number of Critical Incident reports that include usage of restrictive intervention (seclusion and restraints). Denominator: Number of Critical Incident reports received.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

☑ **Other** Specify: MCE	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
G.4.a Number & percentage of members with a care plan that was transmitted to their PCP or other documented medical care practitioner identified by the member within 30 days of its development (HEDIS MEASURE). Numerator: Number of members whose care plan was transmitted to practitioner within 30 days Denominator: Number of care plans reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Annual LTSS HEDIS Audit

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

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
G.4.b Number and percentage of sampled individuals having a complete physical exam or wellness visit in the past year. Numerator: Number of sampled individuals who report having a complete physical exam or wellness visit in the past year. Denominator: Total number of sampled individuals who responded.

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators Aging and Disabilities (NCI-AD)

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

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: NCI-AD Survey Contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Representative Sample; Confidence Interval = 95%; Proportional and stratified across state districts
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
G.4.c Number and percentage of HCBS participants who received an ambulatory or preventive health visit during the year. Numerator: Number of HCBS participants who received an ambulatory or preventive health visit during the measurement year. Denominator: Number of HCBS participants.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
G.4.d Number and percent of sampled individuals who report the ability to get an appointment to see their primary care doctor when they need to. Numerator: Number of sampled individuals who report the ability to get an appointment to see their primary care doctor when they need to. Denominator: Total number of sampled individuals.

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators Aging and Disabilities (NCI-AD)

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

☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: NCI-AD Survey Contractor Annually Stratified Describe Group: Continuously	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Representative Sample; Confidence Interval = 95%; Proportional and stratified across state districts
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

All HCBS providers are required to report critical incidents (CI) to the FSSA web-based incident reporting system (and APS as applicable). The MCE must include CI reporting requirements for providers in all network provider agreements. The MCEs receive CI reports from the web-based incident reporting system and are responsible for reviewing/remediating the CI. The MCEs are also responsible for logging all reported incidents on the CI report that goes to OMPP weekly. OMPP is responsible for verifying that all web-based incident reporting system reported incidents appear on the MCE reports.

The MCEs must have a system for accepting and analyzing CI reports. They are responsible for remediating the CIs and sending status updates to OMPP via the weekly CI report. In the web-based incident reporting system, there is a field for providers to indicate if an incident was reported to APS; providers are required to report to APS, but the MCE is responsible for identifying and reporting instances when the provider did not report to APS.

OMPP's CI Team reviews all CI reports and performs data analysis to identify trends and cases to send to the Mortality Review Committee. Part of the PCISP review will include whether information on reporting A-N-E was included in the service planning process. Data is also monitored to ensure the MCEs are closing cases timely. Corrective action is implemented when performance or non-compliance issues are identified.

If a report meets the defined criteria to be a CI, the MCE must follow the steps identified in the CI Management section of the MCE Policy and Procedure Manual. If a CI has been confirmed (i.e., a substantiated critical incident), the MCE is responsible for ensuring follow-up care is in place for the impacted member. The MCE shall require all staff and contracted providers to document updates regarding initiated action(s) taken for the member and all follow-up activities related to the intervention(s) implemented as a result of the incident. Such follow-up may include updating the member's PCISP to reflect enhanced care needs and conducting necessary follow up visits. The MCE's process must include a holistic review of the circumstances of the CI and preventing future occurrences. For example, if multiple CIs are filed for a network provider, the MCE should evaluate the implications for inclusion of that provider in its network or the application of additional oversight and reporting requirements, sanctions, or other requirements. The MCE must also report to OMPP decisions to exclude the provider from network participation based on founded allegations. The MCE should align its response with 455 IAC 2-6, Provider Qualifications, and take comparable actions with providers who have egregious or repeated violations. The MCE is also responsible for implementing corrective actions to ensure that the conditions that led to the CI no longer exist.

The MCE must document its corrective action process including steps taken to address the conditions that led to the CI, time frame for resolution, staff members involved, member perspective, and plan for continuous monitoring. Upon a determination that the report does not need further documentation or review, the MCE shall mark the report as closed.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 Section 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 (QIS) 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 QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, 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 QIS 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 QIS. 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 OMPP will utilize the information gathered during the discovery and remediation efforts identified throughout this waiver application in conjunction with the information gathered through Indiana's other 1915(c) waivers to ensure a seamless approach to system improvement. In support of these activities, FSSA will convene a quality team comprised of representatives from OMPP, BDS, each MCE, and others as appropriate. This team will assist OMPP in identifying areas requiring system improvements through the review of information gathered through the discovery and remediation processes. Systems improvement strategies used by OMPP will be tailored to address the specific issues identified through discovery and remediation data, and can include targeted technical assistance and training with the MCEs (and, as needed with their provider panels), data system improvements, or contract clarifications or adjustments.

The 1915(c) waiver data sources identified throughout the appendices in this application will form the basis of information upon which systems improvement will be undertaken. Initial analysis of discovery data is conducted by the appropriate OMPP staff as part of their day-to-day activities. This discovery data is obtained from the following activities and sources:
• Regular reporting - OMPP conducts regular reporting activities to include the collection of the following information: claims, encounters, member grievances and appeals, independent external reviews, translation and interpretation services, provider helpline performance, provider claims, credentialing, outcome measures, utilization, service authorizations, administrative, financial, network development and access, quality management and improvement, program integrity, and critical incidents.
• Electronic Database queries-OMPP utilizes several electronic 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.
• On site reviews - OMPP conducts bi-monthly onsite reviews of all MCEs. Site visits are utilized to review MCE compliance with federal, state, and contract requirements through strategies such as onsite demonstrations of operational procedures, meetings and interviews with MCE personnel, and monitoring helpline calls.
• Incident Review- OMPP requires all waiver service providers to report critical incidents via a web-based submission tool. All reports are processed by incident review staff within the time period stipulated in the MCE manual. All reports of actual or alleged ANE are designated as critical incidents and forwarded to OMPP for additional review in addition to any submission to APS.
o Mortality Review- All incident reports of waiver participants' deaths are forwarded to OMPP 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.

Reporting and management of critical incidents will be an area of heightened focus during the early implementation of the program. The state expects a high degree of collaboration to reduce the risk of critical incidents as members transition into the MCE and transition to new Service Coordinators. This period may involve activities such as increased reporting frequency and detail, ad hoc workgroups to identify trends, and required interventions to address those trends. The state may also require the submission of the MCE's methodology for identifying individuals at high risk for critical incidents.
• Provider Compliance/Licensure Monitoring -The Provider Compliance Tool (PCT) review involves a service review visit to each non-licensed/noncertified provider at least one time every three years to establish that the provider continues to meet all provider requirements contained in 455 IAC 2. If found deficient the provider will be required to submit and fulfill the requirements of an acceptable CAP. Failure to successfully complete the CAP process may result in corrective action up to and including decertification as a waiver provider. IDOH is responsible for assuring licensed providers continue to meet license requirements. If found deficient the provider will be required to submit and fulfill the requirements of an acceptable CAP. Failure to successfully complete the CAP process may result in corrective action up to and including decertification as a waiver provider.

COMPILATION and TRENDING OF PERFORMANCE MEASURES
OMPP 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 waiver application.

Data obtained from all of these sources, as well as data generated through remediation processes, is disseminated to the appropriate agency staff. Remediation of participant findings is initiated immediately at the program and service level.

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. OMPP also reviews reports and descriptions of best-practice quality improvement approaches from other states. OMPP recommendations for system improvements will be researched and developed into proposals for consideration by the Quality Strategy Committee.

SYSTEM IMPROVEMENT and DESIGN
OMPP can include upper management personnel from MCES, other FSSA agencies, and other areas within OMPP, and it may also include legal representation. The purpose 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.

OMPP may assign research, design or implementation activities back to appropriate agencies, MCE staff, other OMPP 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; and
- ability to measure results and outcomes of system improvements.

OMPP is sensitive to the complexities of the service delivery system and the 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; and
- abide by existing State protocols for approval, development and implementation of new policies, technologies and general practices.

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. In addition to the data and information related to the measures specifically identified in this waiver, OMPP will utilize information from the following sources to achieve a coordinated, effective system improvement strategy: external quality review (EQR) reports, managed care quality strategy, and performance improvement projects (PIPs).

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Quality Improvement Committee**	☐ **Annually**
☑ **Other** Specify:	☐ **Other** Specify:

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
MCEs	

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.

OMPP is committed to making sound, data driven design changes based upon information gathered from discovery and remediation, and from the waiver monitoring activities. OMPP utilizes several electronic database applications and MCE reports which provide routine reports on various performance indicators in addition to allowing for on-demand report generation. These reports provide key data and allow OMPP to monitor and assess the outcome and effects of system design changes. OMPP 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 OMPP. This information is disseminated throughout the agency and is provided to other areas within OMPP as well as other agencies and MCE staff for review and analysis. These entities assess the outcome of system design changes through a comparison of current and past performance measure results. Findings are then used to assess the need for additional changes or refinement, in the continuation of the quality improvement cycle.

The State will use this data to inform future QIS considerations. The State will utilize formalized processes, including solicitation of input from CMS, to monitor the efficacy of the intervention to ensure that the areas targeted for improvement are positively impacted. Areas of non-compliance are addressed through a progressive sanctioning process that may include corrective action plans developed by the MCEs or by the LCAR contractor, as appropriate, and such interventions will further inform overall system design changes to prevent future issues. Lessons learned from these activities will be communicated internally by the OMPP, and externally to MCEs and provider entities.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

While the QIS is designed to identify opportunities for improvement in the service delivery system, the QIS itself must be monitored and improved upon. Improvements in the QIS will be necessary to keep up with changes in the regulatory and service delivery environments, and due to data or tools which the operators find to be inconsistent, incomplete or not conducive to obtaining desired measures or outcomes.

As many of the data collection and analysis tools are electronic in nature, OMPP will review opportunities to integrate new technology into the QIS. OMPP 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 OMPP staff. OMPP staff will formally review the QIS at least annually and make recommendations for changes or improvements.

OMPP has engaged with stakeholders and advocates throughout the design and development phases of the waiver. In order to ensure success and maintain a truly collaborative process, the state will continue reaching out to providers, advocates, and individuals throughout the implementation and operational phases of the demonstration.

In addition to the ongoing incorporation of a continuous quality improvement process for the quality and oversight process as a whole, OMPP will, at least once during the initial term of the waiver engage in a critical assessment of the performance of both the system improvement and the QIS and revise it as necessary and appropriate. Modifications to the Quality Improvement Strategy will also be submitted annually with the 372 report.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ◉ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

Waiver services are furnished through MCEs; therefore, 1915(b) waiver financial accountability requirements apply. MCEs are contractually required to reconcile eligibility and capitation payments on a monthly basis and return overpayments within 45 days.

For services delivered via FFS, FSSA's Audit Unit is responsible for annual review of services/billing performed by AAAs with reporting to OMPP. FSSA PI has an agreement with FSSA Audit to investigate allegations of fraud, waste and abuse (FWA). PI receives allegations of provider FWA, tracks in its case management system, and forwards to FSSA Audit to begin research/audit. FSSA Audit works with PI to vet 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 conduct a statistically valid random sample of consumers and then PI's Fraud & Abuse Detection System (FADS) vendor will pull a sample for their audit. The size of a random sample audit is dependent upon the universe(s) size, claim/claim line payments, and other statistical criteria. The sample size is ultimately determined utilizing a FADS contractor tool that 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, timeframes or other scenarios identified as higher risk for FWA to determine potential outcomes of audit findings or payment error issues. If the probe identifies material issues, statistical sampling is used to expand testing and quantify overpayments.
• Random Sample Audit - Identify potential payment errors and extrapolate those to the entire universe of claims. FSSA Audit conducts its audit activities, develops a findings report for the provider which may include a CAP and request for overpayment, and shares findings with PI. Audits are performed onsite utilizing a probe test that includes a review of:
• Providers' source documents. This includes 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 HR files, are reviewed, including background checks, licenses, and search of the HHS/OIG exclusions list.

The FSSA PI section regularly utilizes random-sampling and extrapolation in conducting audits of IHCP providers. If the focus of the audit is narrow, and the number of potentially erroneous claims is manageable, the review will be conducted on all identified claims. In the event the issue involves a large number of claims, or if the review is a provider-focused, comprehensive review, PI has the ability to utilize statistically-valid random sampling and extrapolation to determine any potential overpayments from the IHCP. The frequency of utilizing this approach is fluid, based upon the providers in queue for audit as well as the proposed audits included in the yearly FADS Audit Workplans. On-going monitoring of IHCP providers is supported by utilization of Truven Health Analytic's Provider Peer Comparison Tool, J-SURS, which compares providers to peers of like specialty to identify outliers. All provider types are profiled at least yearly, while higher-risk provider types are profiled quarterly. The results of the profiles are reviewed by PI staff to determine which providers may need further investigation and these results are discussed in weekly FADS team meetings.

Provider records are reviewed to ensure compliance with applicable state and federal guidelines, as well as policies published by the IHCP. Review scope may vary depending on provider type/specialty and/or concerns identified through pre-audit activities (e.g., data mining, complaints, etc.). Review scopes typically include (at a minimum) procedures to determine provider compliance with applicable documentation requirements and review of provider credentials/qualifications to ensure they are practicing within the scope of their licensure or certification (if applicable). When appropriate, these reviews may include reconciliation of the records to timesheet and/or other payroll records, as well as vehicle insurance and/or health records of servicing providers (e.g., TB test records for waiver and home health providers). A detailed claim-level review checklist is prepared for each review that lists all claims included in the review, outlines the scope of the review, and identifies all findings or educational items noted during the review.

FADS investigations/audits can be initiated based on referrals received from different sources/agencies. PI receives information from the following sources which could potentially lead to additional action including audit action:
1. IHCP Provider and Member Concerns Line
2. Other agencies (MFCU)
3. Analyses/Analytics performed by the PI Investigations team
4. Analytics performed by FADS contractors
Depending on the allegations/information received regarding the provider(s), PI may conduct a Preliminary Investigation, utilizing the Credible Allegation of Fraud (CAF) tool developed by FADS contractors to determine next steps.

In certain instances, PI refers the provider in question to FADS contractors for additional analysis which may include

performing a Risk Assessment. The Risk Assessment tool, developed by FADS contractors, is utilized to gather information on a specific provider's background as well as billing patterns utilizing claims data and other research databases, focusing on any potential issues identified during the referral process. FADS contractors utilize this tool to assist in the decision making process when recommending the next appropriate action to be taken for the provider(s) in question.

There are differences in post-payment review methods, scope and frequency based upon audit type, provider type/specialty, background information, and state rules/regulations. PI can audit IHCP providers through either an algorithmic approach or a provider-specific full review. Algorithms processed by the PI FADS contractor, focus on specific codes, diagnoses, or program limitations to identify potentially erroneous claims across the IHCP. These reviews can involve hundreds of IHCP providers, but are limited in scope. The providers are notified of the potential errors upon receipt of the Draft Audit Findings letter, where no medical records are reviewed prior to identification of the claims. If PI decides to conduct a more comprehensive review of a provider, PI request a full medical record review. The audit can be conducted through a medical record request desk audit, or as an on-site review. The on-site audit can be announced or unannounced, based upon the circumstances.

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 issues identified that would result in patient harm or overpayments; however, it may be apparent that the provider as well as the Medicaid Program would benefit from additional education for the provider on proper/best billing practices.
• Provider self-audit: Specific concern(s) were identified resulting in a recommended limited-scope audit; however, the concern(s) are in an area which the State is comfortable with the provider conducting the audit to ensure compliance. FADS contractors 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 (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 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) of the pending on-site audit. If notice is provided, it can range from a few days to a few weeks depending on several factors (type of facility, audit concerns, etc.). Requested information is collected on-site. A facility tour as well as provider/staff interviews are also conducted during on-site reviews. FADS contractors, including clinical staff, are included in on-site reviews and assist with conducting interviews. State Program Integrity personnel often also participate in on-site reviews.
• Referral to MFCU: Payment suspension recommended as the potential intent of fraudulent behavior was identified. Depending on the allegations/information received regarding the provider(s), the SUR Unit may conduct a Preliminary Investigation, utilizing the Credible Allegation of Fraud (CAF) tool developed by FADS contractors to determine the appropriate next steps, if any.

**Audit reports containing accuracy-related issues, missing documentation, internal control deficiencies, and training issues are prepared. Providers submit corrective action plans. Any overpayments are set up for recoupment. Audit reports are distributed to provider leadership and appropriate FSSA executives. Periodically, PI is advised of any systemic issues identified. FSSA Audit Services seeks PI's advice on audit reporting and direction on technical questions. For audits performed based on referrals such as incorrect billing, the reporting varies. If the audit finds the provider made unintentional errors, the typical audit reporting process is followed. However, if the referred audit identifies potential, intentional errors that may be credible allegations of fraud, the provider is referred to Program Integrity for further action. Select analytics are periodically rerun in an attempt to identify if provider billing patterns have changed/improved based on previous audit and/or provider education. Additional audit action may be taken for providers who continue to be identified as potential issues in these algorithms. If providers are again selected for audit, a similar audit process as previously described would occur.*

The State 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 state's quality improvement strategy, provide information in the following fields to detail the state's 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.

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

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 percentage of claims paid for services that have a matching EVV record. Numerator: Number of claims paid for services that have a matching EVV record. Denominator: Number of claims submitted subject to EVV.

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

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

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

Data Aggregation and Analysis:

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the state to

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

Performance Measure:
I.2.Number and percentage of claims per MCE which are not paid at the State minimum fee schedule. Numerator: Number of waiver claims which were not paid at the State minimum fee schedule. Denominator: Number of waiver claims paid.

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.*

For PM I.1: MCEs provide quarterly reports to OMPP documenting claims adjudication for services subject to EVV. This reporting allows OMPP and the MCEs to monitor the volume of claims for which an associated EVV record is not present. MCEs are expected to monitor provider compliance with EVV requirements and to conduct outreach and education as necessary to resolve claims non-compliance and ensure provider understanding of submission requirements. OMPP monitors MCE reports to identify any trends that require remediation. For example, OMPP would outreach to MCEs with high EVV denial rates to understand MCE processes for provider education and resolution. In the event of an identified deficiency in MCE remediation process, a corrective action plan, liquidated damages, or other contractually agreed upon remedy is required. OMPP provides the MCE written notice of non-compliance with expected remediation action and monitors the corrective actions implemented through to resolution. In the event remediation is not achieved in accordance with the required corrective action plan, OMPP may implement escalating corrective action.

Additionally, OMPP may determine additional policy guidance or contractual modifications are necessary to clarify expectations and ensure performance in accordance with state expectations. In such cases, OMPP may initiate contract amendment or policy clarification through updates to the MCE Policy and Procedure Manual. Trends are also monitored for the potential development of new Performance Improvement Projects.

For PM I.2: The Fiscal Agent runs all encounter claims through an adjudication process that calculates the amount that should be paid under the state fee schedule. The process also captures the amount paid by the MCE, and the data is placed in the Electronic Data Warehouse (EDW). OMPP will compare the two amounts to verify for each MCE the number of waiver claims that were not paid at the state minimum fee schedule. If it is determined that an MCE is paying less than the state minimum fee schedule, OMPP will investigate the root cause(s) and develop a remediation plan as appropriate. MCEs will be required to identify reasons why the minimum fee schedule was not paid and adjust their systems to correct and re-adjudicate prior claims as needed.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The method of determining capitation rates for the PathWays program is subject to the 1915(b) requirements and criteria. FSSA has contracted with an actuarial firm to develop the actuarially sound capitation payment rates on an annual basis.

For FFS rate setting, a rate review occurs at least every five years.

In state fiscal year (SFY) 2023, FSSA completed a rate review (rate study) for all 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 waiver participants served, and the average number of service hours per employee), mileage, and operational structure.

Service specific workgroups - Service specific interested party 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: To develop prospective payment rate methodologies for this waiver's 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. Self-directed and non-agency service rates follow the cost model build-up but do not include a supervisory 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 interested party 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 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 CHAT assessment for each individual. 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 CHAT assessment. 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 interested parties, provider survey results, and the state'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.

This waiver's fee schedule can be found on the FSSA webpages.

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 FSSA and distributed by FSSA's fiscal agent. 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.

FSSA will continue to collaborate with the 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 waiver 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:*

Waiver services are reimbursed by MCEs. Providers bill the MCE with whom a member is enrolled. Claims are reimbursed in accordance with the terms of the provider's contract with the MCE. Providers may not bill FSSA directly for services provided to MCE enrollees. MCE billings to the State are made in accordance with the provisions of the 1915(b) PathWays Waiver.

For FFS, claims for waiver services flow directly from the providers to the Indiana Medicaid Management Information System (MMIS) and payments are made via FSSA's contracted fiscal agent.

The State 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.

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:*

Waiver services are reimbursed by MCEs. Providers bill the MCE with whom a member is enrolled. Claims are reimbursed in accordance with the terms of the provider's contract with the MCE. Providers may not bill FSSA directly for services provided to MCE enrollees. MCE billings to the State are made in accordance with the provisions of the 1915(b) PathWays Waiver. The MMIS includes system edits to ensure that prior to issuing a capitation payment, the enrollee is eligible for the 1915(c) waiver and is enrolled with the MCE. MCEs must implement system edits to ensure that claim payments are made only when the individual is eligible for 1915(c) waiver services on the date of service. FSSA monitors MCE compliance and system capability through pre-implementation readiness review and ongoing monitoring (e.g., encounter data audit and validation). The MCEs are also responsible for program integrity functions with OMPP review and oversight.

For FFS enrollees, OMPP approves an individual's PCISP within the State's case management database ensuring only services which are necessary and reimbursable under the Waiver. The PCISP is sent to the fiscal agent, via systems interface with the MMIS, serving as the authorization for the individual's approved Waiver services. The case management system will not allow the addition of services beyond those services offered under the Waiver. The case management data system has been programmed to alert OMPP staff when a PCISP is being reviewed for an individual 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 PCISP will be approved, and the system will generate the Individual Service Authorization, which is sent to each authorized provider of services on the PCISP. The Individual Service Authorization identifies the waiver participant, the service that each provider is approved to deliver, and the rate at which the provider may bill for the service.

The case management database transmits data daily containing all new or modified service plans to the Indiana MMIS. The PCISP data is utilized by the MMIS as the basis to create or modify Prior Authorization fields to bump against the billing of services for each individual waiver participant.

Providers submit electronic (or paper) claims directly to the MMIS. Claims are submitted with date(s) of service, service code, and billing amount. Reimbursements are only authorized and made in accordance with the Prior Authorization data on file. The MMIS also confirms that the waiver participant had the necessary level of care and Medicaid eligibility for all dates of service being claimed against.

Documentation and verification of service delivery consistent with paid claims is reviewed during the post payment review of the operating agency as well as by the OMPP when executing SUR activities. Additional information about these reviews can be found in the Provider and Member Utilization Review provider reference module at the following link: http://provider.indianamedicaid.com/media/155481/provider%20and%20member%20utilization%20review.pdf

RECOUPMENT If a payment to a provider is identified as paid in error due to error, fraud, policy, system issues, etc., the State can recoup that payment by any of the ways listed below:
1. Create a non-claim specific accounts receivable
2. Claim adjustment
3. Remit payment via check
Non-Claim Specific Accounts Receivable (AR):
When this method is used to recoup payment, an AR is setup under the Medicaid Provider's identification number. Each AR is assigned a reason code. The reason code describes the purpose for the AR. The reason code also maps to various lines on the CMS 64.
Once the AR is setup, a provider's future Medicaid payments will be reduced until the AR is fully satisfied. Claim Adjustments:
Under this process, a claim specific AR will be created when a claim is adjusted. Either the provider or the State may adjust claims. With claim specific ARs, the AR is attached to a specific claim that was previously paid.

The process is the same; however, as non-claim specific ARs, in that a reason code will also be assign to a claim specific AR, and a provider's future Medicaid payments will be reduced until the AR is satisfied. With claim specific ARs, the CMS 64 line on which the original payment was made, is reduced to reflect returning the federal share. For, example, if an inpatient claim is adjusted to recoup payment, once the recoupment happens, the adjustment would be reflected in line 1A of the CMS 64.9.

Remit Payment Via Check:

Providers may repay overpayments in the form of a check. If a provider remits payment via check, an AR is still necessary to process the check. Under this method, instead of reducing a providers future Medicaid payments until the AR is satisfied, the AR is satisfied with the check.

In summary, the waiver participant's eligibility for Medicaid Waiver services is controlled through the electronic case management system which is linked to the Medicaid claims system. All services are approved within these systems by the operating agency. As part of the 90 day review, the case manager verifies with the individual the appropriateness of services and monitors for delivery of service as prescribed in the plan of care. Modifications to the plan of care are made as necessary.

The State is offering an Open Choice Model for Electronic Visit Verification (EVV). The State is contracting with an EVV vendor that allows providers with existing EVV vendors to continue to use those systems. Existing EVV vendors will report standardized aggregate data to the State operated EVV system. The PathWays waiver services that utilize EVV are all forms of attendant care, unskilled respite care, Home and Community Assistance, and specialized medical equipment.

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 for FFS enrollees are made through the MMIS. Capitation payments to MCEs are made by the MMIS. The MMIS contains recipient eligibility and MCE assignment information. When a 1915(c) waiver recipient is enrolled in an MCE, this is reflected on the eligibility file and monthly payment flows from the MMIS to the MCE via an 837 transaction. FSSA will recover capitation payments for enrollees who were later determined to be ineligible for PathWays and/or waiver services.
- ***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.

N/A - For enrollees receiving PathWays services via managed care, no 1915(c) waiver services are paid outside the MCE capitation rate.

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.

The capitation payment to MCEs is reduced by a performance withhold amount as outlined in the contracts between FSSA and the MCEs, and approved by CMS. The MCEs are eligible to receive some or all of the withheld funds based on their performance against contractual requirements. FSSA also recoups excess capitation paid to the MCE in the event its medical loss ratio (MLR) falls below the contractual requirement. Additionally, the MCE contracts and capitation rate certification outline applicable capitation risk mitigation strategies such as risk corridors and risk adjustments. For FFS enrollees, providers receive and retain 100% of the amount claimed to CMS for waiver services.

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 section 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 section 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 section 1915(b)/section 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 section 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 section 1115/section 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 section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 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 section 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:*

In accordance with 42 CFR 441.310(a)(2), FSSA does not pay the cost of room and board and did not include costs associated with room and board in the capitation rate development process. The MCEs are contractually required to comply with federal provisions regarding reimbursement prohibitions for the cost of room and board services in residential settings.

For FFS enrollees, 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. Waiver 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:

MEDWorks members with income between 150% - 350% FPL are responsible for paying a premium based on family size and income; the income standard includes a 50% earned income disregard for all MEDWorks members. Premiums vary from $0 to $254.
The included groups are the MEDWorks members with HCBS waivers with income over 150% FPL.

For 2024, the MEDWorks premiums are:
Family Size 1:
Income standard $1216 - $1822: Premium $0
Income standard $1823 - $2127: Premium $48
Income standard $2128 - $2430: Premium $69
Income standard $2431 - $3038: Premium $107
Income standard $3039 - $3645: Premium $134
Income standard $3646 - $4253: Premium $161
Income standard: $4254 and over: Premium $187

Family size 2:
Income standard $1644 - $2465: Premium $0
Income standard $2465 - $2876: Premium $65
Income standard $2877 - $3287: Premium $93
Income standard $3288 - $4109: Premium $145
Income standard $4110 - $4930: Premium $182
Income standard $4931 - $5752: Premium $218
Income standard $5753 and over: Premium $254

**Income of the non-MEDWorks member is not budgeted in the eligibility determination but does apply to the premium calculation.*

Every month, the Premium Vendor sends a bill to MEDWorks members with a premium. The member has 60 days to pay the premium; failure to pay within 60 days can result in the closure of the MEDWorks Medicaid. This results in a 2 year lock out for MEDWorks members. If the member pays the premium in full, the lock out is removed.
MEDWorks members between 101-149% FPL are excluded as are other Medicaid categories with HCBS waivers.

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	33511.66	9060.60	42572.26	91154.59	3132.77	94287.36	51715.10
2	39657.60	9060.60	48718.20	93980.38	3201.69	97182.07	48463.87
3	39657.60	9060.60	48718.20	96893.77	3272.13	100165.90	51447.70
4	39657.60	9060.60	48718.20	96893.77	3272.13	100165.90	51447.70
5	39657.60	9060.60	48718.20	96896.77	3272.13	100168.90	51450.70

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	6500	6500
Year 2	6500	6500
Year 3	6500	6500
Year 4	6500	6500
Year 5	6500	6500

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.*

Projected average length of stay was developed based on slot projections. Slot projections reflect actual experience through June 30, 2025 in WY 1 of the actual expenditures.

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 for members 60 and over from Waiver Year 1 of the PathWays 1915(c) waiver services: July 1, 2024-June 30, 2025. he base year data was projected in the following manner:
• The number of users of each service was adjusted proportionally, based on projected slots and assumptions about the number of slots as described in the section J-2-b.
• Average units per user were projected to vary with average length of stay.
• It is assumed that those in the managed care program will be receiving Case Management services through integrated case management with the managed care entities (MCEs), since it will be part of administrative function performed by the MCEs under the PathWays program. Only those receiving services through the FFS delivery system will receive waiver Case Management services through the Assisted Living waiver.

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 1 of the PathWays 1915(c) waiver services: July 1, 2024-June 30, 2025.for enrollees age 60 and above.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Base Year data reflects experience from Waiver Year 1 of the PathWays 1915(c) waiver services: July 1, 2024-June 30, 2025.for enrollees age 60 and above Factor G for WY1 also includes $810.3 million in Nursing Facility Upper Payment Limit (UPL) expenditures, contributing to the base year Factor G. Starting with Waiver Year 1, costs are trended at 3.1% per year. The 3.1% trend was estimated using the average of the Medical CPI-U and CPI-U over the most recent 5 complete years (rounded) as institutional costs tend to trend midway between medical and non-medical costs.

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 1 of the PathWays 1915(c) waiver services: July 1, 2024-June 30, 2025.for enrollees age 60 and above. Base year data was trended at 2.2% per year to reflect Medical CPI-U over the recent 5 complete years (rounded).

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	
Case Management	
Assisted Living	
Community Transition	
Integrated Health Care Coordination	
Nutritional Supplements	
Specialized Medical Equipment and Supplies	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							**0.00**
Case Management	☐	Monthly	0	0.00	189.56	**0.00**	
Assisted Living Total:							**207458155.62**
Assisted Living FFS Daily	☐	Daily	0	0.00	115.58	**0.00**	
Assisted Living Daily	☑	Daily	2117	267.57	115.58	**65469792.85**	
Assisted Living FFS Monthly	☐	Monthly	0	0.00	3432.58	**0.00**	
Assisted Living Monthly	☑	Monthly	4591	9.01	3432.58	**141988362.77**	
Community Transition Total:							**0.00**
Community Transition FFS	☐	Lifetime Cap	0	0.00	2500.00	**0.00**	
Community Transition	☑	Lifetime Cap	0	0.00	2500.00	**0.00**	
Integrated Health Care Coordination Total:							**10367616.00**
Integrated Health Care Coordination FFS	☐	1/4 unit	0	0.00	14.21	**0.00**	
Integrated Health Care Coordination	☑	1/4 unit	950	768.00	14.21	**10367616.00**	
Nutritional Supplements Total:							**0.00**
Nutritional Supplements FFS	☐	Unit	0	0.00	23.56	**0.00**	

GRAND TOTAL: **217825771.62**

Total: Services included in capitation: 217825771.62

Total: Services not included in capitation: 0.00

Total Estimated Unduplicated Participants: **6500**

Factor D (Divide total by number of participants): **33511.66**

Services included in capitation: 33511.66

Services not included in capitation: 0.00

Average Length of Stay on the Waiver: 274

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nutritional Supplements	☑	Unit	0	0.00	23.56	0.00	
Specialized Medical Equipment and Supplies Total:							0.00
Specialized Medicaid Equipment and Supplies FFS	☐	Unit	0	0.00	207.38	0.00	
Specialized Medical Equipment and Supplies	☑	Unit	0	0.00	207.38	0.00	
Vehicle Modifications Total:							0.00
Vehicle Modifications FFS	☐	Unit	0	0.00	1000.00	0.00	
Vehicle Modifications	☑	Unit	0	0.00	1000.00	0.00	

GRAND TOTAL: 217825771.62
Total: Services included in capitation: 217825771.62
Total: Services not included in capitation: 0.00
Total Estimated Unduplicated Participants: 6500
Factor D (Divide total by number of participants): 33511.66
Services included in capitation: 33511.66
Services not included in capitation: 0.00
Average Length of Stay on the Waiver: 274

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							0.00

GRAND TOTAL: 257774401.23
Total: Services included in capitation: 257774401.23
Total: Services not included in capitation: 0.00
Total Estimated Unduplicated Participants: 6500
Factor D (Divide total by number of participants): 39657.60
Services included in capitation: 39657.60
Services not included in capitation: 0.00
Average Length of Stay on the Waiver: 274

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management	☐	Monthly	0	0.00	189.56	0.00	
Assisted Living Total:							201025345.23
Assisted Living FFS Daily	☐	Daily	0	0.00	115.58	0.00	
Assisted Living Daily	☑	Daily	2051	267.57	115.58	63428693.97	
Assisted Living FFS Monthly	☐	Monthly	0	0.00	3432.58	0.00	
Assisted Living Monthly	☑	Monthly	4449	9.01	3432.58	137596651.26	
Community Transition Total:							0.00
Community Transition FFS	☐	Lifetime Cap	0	0.00	2500.00	0.00	
Community Transition	☑	Lifetime Cap	0	0.00	2500.00	0.00	
Integrated Health Care Coordination Total:							56749056.00
Integrated Health Care Coordination FFS	☐	1/4 unit	0	0.00	14.21	0.00	
Integrated Health Care Coordination	☑	1/4 unit	5200	768.00	14.21	56749056.00	
Nutritional Supplements Total:							0.00
Nutritional Supplements FFS	☐	Unit	0	0.00	23.56	0.00	
Nutritional Supplements	☑	Unit	0	0.00	23.56	0.00	
Specialized Medical Equipment and Supplies Total:							0.00
Specialized Medicaid Equipment and Supplies FFS	☐	Unit	0	0.00	207.38	0.00	
Specialized Medical	☑	Unit	0	0.00	207.38	0.00	

GRAND TOTAL: 257774401.23

Total: Services included in capitation: 257774401.23

Total: Services not included in capitation: 0.00

Total Estimated Unduplicated Participants: 6500

Factor D (Divide total by number of participants): 39657.60

Services included in capitation: 39657.60

Services not included in capitation: 0.00

Average Length of Stay on the Waiver: 274

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Equipment and Supplies							
Vehicle Modifications Total:							**0.00**
Vehicle Modifications FFS	☐	Unit	0	0.00	1000.00	**0.00**	
Vehicle Modifications	☑	Unit	0	0.00	1000.00	**0.00**	

GRAND TOTAL: **257774401.23**
Total: Services included in capitation: 257774401.23
Total: Services not included in capitation: 0.00
Total Estimated Unduplicated Participants: **6500**
Factor D (Divide total by number of participants): **39657.60**
Services included in capitation: 39657.60
Services not included in capitation: 0.00
Average Length of Stay on the Waiver: 274

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							**0.00**
Case Management	☐	Monthly	0	0.00	189.56	**0.00**	
Assisted Living Total:							**201025345.23**
Assisted Living FFS Daily	☐	Daily	0	0.00	115.58	**0.00**	
Assisted Living Daily	☑	Daily	2051	267.57	115.58	**63428693.97**	
Assisted Living FFS	☐	Monthly	0	0.00	3432.58	**0.00**	

GRAND TOTAL: **257774401.23**
Total: Services included in capitation: 257774401.23
Total: Services not included in capitation: 0.00
Total Estimated Unduplicated Participants: **6500**
Factor D (Divide total by number of participants): **39657.60**
Services included in capitation: 39657.60
Services not included in capitation: 0.00
Average Length of Stay on the Waiver: 274

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Monthly							
Assisted Living Monthly	☑	Monthly	4449	9.01	3432.58	137596651.26	
Community Transition Total:							0.00
Community Transition FFS	☐	Lifetime Cap	0	0.00	2500.00	0.00	
Community Transition	☑	Lifetime Cap	0	0.00	2500.00	0.00	
Integrated Health Care Coordination Total:							56749056.00
Integrated Health Care Coordination FFS	☐	1/4 unit	0	0.00	14.21	0.00	
Integrated Health Care Coordination	☑	1/4 unit	5200	768.00	14.21	56749056.00	
Nutritional Supplements Total:							0.00
Nutritional Supplements FFS	☐	Unit	0	0.00	23.56	0.00	
Nutritional Supplements	☑	Unit	0	0.00	23.56	0.00	
Specialized Medical Equipment and Supplies Total:							0.00
Specialized Medicaid Equipment and Supplies FFS	☐	Unit	0	0.00	207.38	0.00	
Specialized Medical Equipment and Supplies	☑	Unit	0	0.00	207.38	0.00	
Vehicle Modifications Total:							0.00
Vehicle Modifications FFS	☐	Unit	0	0.00	1000.00	0.00	
Vehicle Modifications	☑	Unit	0	0.00	1000.00	0.00	

GRAND TOTAL: 257774401.23

Total: Services included in capitation: 257774401.23

Total: Services not included in capitation: 0.00

Total Estimated Unduplicated Participants: 6500

Factor D (Divide total by number of participants): 39657.60

Services included in capitation: 39657.60

Services not included in capitation: 0.00

Average Length of Stay on the Waiver: 274

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							**0.00**
Case Management	☐	Monthly	0	0.00	189.56	**0.00**	
Assisted Living Total:							**201025345.23**
Assisted Living FFS Daily	☐	Daily	0	0.00	115.58	**0.00**	
Assisted Living Daily	☑	Daily	2051	267.57	115.58	**63428693.97**	
Assisted Living FFS Monthly	☐	Monthly	0	0.00	3432.58	**0.00**	
Assisted Living Monthly	☑	Monthly	4449	9.01	3432.58	**137596651.26**	
Community Transition Total:							**0.00**
Community Transition FFS	☐	Lifetime Cap	0	0.00	2500.00	**0.00**	
Community Transition	☑	Lifetime Cap	0	0.00	2500.00	**0.00**	
Integrated Health Care Coordination Total:							**56749056.00**
Integrated Health Care Coordination FFS	☐	1/4 unit	0	0.00	14.21	**0.00**	
Integrated Health Care Coordination	☑	1/4 unit	5200	768.00	14.21	**56749056.00**	

GRAND TOTAL: **257774401.23**

Total: Services included in capitation: 257774401.23

Total: Services not included in capitation: 0.00

Total Estimated Unduplicated Participants: **6500**

Factor D (Divide total by number of participants): **39657.60**

Services included in capitation: 39657.60

Services not included in capitation: 0.00

Average Length of Stay on the Waiver: 274

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nutritional Supplements Total:							**0.00**
Nutritional Supplements FFS	☐	Unit	0	0.00	23.56	**0.00**	
Nutritional Supplements	☑	Unit	0	0.00	23.56	**0.00**	
Specialized Medical Equipment and Supplies Total:							**0.00**
Specialized Medicaid Equipment and Supplies FFS	☐	Unit	0	0.00	207.38	**0.00**	
Specialized Medical Equipment and Supplies	☑	Unit	0	0.00	207.38	**0.00**	
Vehicle Modifications Total:							**0.00**
Vehicle Modifications FFS	☐	Unit	0	0.00	1000.00	**0.00**	
Vehicle Modifications	☑	Unit	0	0.00	1000.00	**0.00**	

GRAND TOTAL: **257774401.23**
Total: Services included in capitation: 257774401.23
Total: Services not included in capitation: 0.00
Total Estimated Unduplicated Participants: **6500**
Factor D (Divide total by number of participants): **39657.60**
Services included in capitation: 39657.60
Services not included in capitation: 0.00
Average Length of Stay on the Waiver: 274

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							**0.00**
Case Management	☐	Monthly	0	0.00	189.56	**0.00**	
Assisted Living Total:							**201025345.23**
Assisted Living FFS Daily	☐	Daily	0	0.00	115.58	**0.00**	
Assisted Living Daily	☑	Daily	2051	267.57	115.58	**63428693.97**	
Assisted Living FFS Monthly	☐	Monthly	0	0.00	3432.58	**0.00**	
Assisted Living Monthly	☑	Monthly	4449	9.01	3432.58	**137596651.26**	
Community Transition Total:							**0.00**
Community Transition FFS	☐	Lifetime Cap	0	0.00	2500.00	**0.00**	
Community Transition	☑	Lifetime Cap	0	0.00	2500.00	**0.00**	
Integrated Health Care Coordination Total:							**56749056.00**
Integrated Health Care Coordination FFS	☐	1/4 unit	0	0.00	14.21	**0.00**	
Integrated Health Care Coordination	☑	1/4 unit	5200	768.00	14.21	**56749056.00**	
Nutritional Supplements Total:							**0.00**
Nutritional Supplements FFS	☐	Unit	0	0.00	23.56	**0.00**	
Nutritional Supplements	☑	Unit	0	0.00	23.56	**0.00**	
Specialized Medical Equipment and Supplies Total:							**0.00**
Specialized Medicaid Equipment and Supplies	☐	Unit	0	0.00	207.38	**0.00**	

GRAND TOTAL: **257774401.23**

Total: Services included in capitation: 257774401.23

Total: Services not included in capitation: 0.00

Total Estimated Unduplicated Participants: **6500**

Factor D (Divide total by number of participants): **39657.60**

Services included in capitation: 39657.60

Services not included in capitation: 0.00

Average Length of Stay on the Waiver: 274

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
FFS							
Specialized Medical Equipment and Supplies	☑	Unit	0	0.00	207.38	0.00	
Vehicle Modifications Total:							0.00
Vehicle Modifications FFS	☐	Unit	0	0.00	1000.00	0.00	
Vehicle Modifications	☑	Unit	0	0.00	1000.00	0.00	

GRAND TOTAL: 257774401.23

Total: Services included in capitation: 257774401.23

Total: Services not included in capitation: 0.00

Total Estimated Unduplicated Participants: 6500

Factor D (Divide total by number of participants): 39657.60

Services included in capitation: 39657.60

Services not included in capitation: 0.00

Average Length of Stay on the Waiver: 274