INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Division of Aging

Home and Community-Based Services Waivers

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Version	Date	Reason for Revision	Completed By
		• Added references to Incident and Follow-Up Reporting (IFUR) tool • Updated *Section 1: Introduction* • Created and updated *Section 2: Waiver Provider Requirements* with information previously in Section 1 • Updated the *Verifying Eligibility for HCBS Waiver Services* section • Updated the *Billing Instructions* section, including adding the *Assisted Living Billing Instructions* subsection • Added the *Electronic Visit Verification System Required for Personal Care Services* section • Updated the *Claim Voids and Replacements* section • Updated the *Division of Aging HCBS Waiver Rates* section • Updated the *Provider Compliance Reviews* section • In *Section 6: Care Management*, added that care managers need to be cleared by background checks • Updated *Section 7: Service Definitions and Requirements* • Updated *Section 8: Provider Help*	

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Section 1: Introduction

Section 1915(c) of the *Social Security Act* permits states to offer, under a waiver of statutory requirements, an array of home and community-based services (HCBS) that an individual needs to avoid institutionalization. These waiver programs allow the Indiana Health Coverage Programs (IHCP), state of Indiana's Medicaid program, to provide services in an individual's home or other community setting that would ordinarily be provided only in an institution. The term "waiver" refers to waiving of certain federal requirements that otherwise apply to Medicaid program services. HCBS waivers are not Medicaid entitlement programs. Waiver services complement and supplement the services available to participants through the Medicaid State Plan and other federal, state, and local public programs, as well as the support that families and communities provide.

The Indiana Family and Social Services Administration (FSSA) has overall responsibility for the waiver programs. Day-to-day administration and operation of individual waiver programs are delegated to divisions within the FSSA.

The Division of Aging (DA) offers two HCBS waiver programs:

- Aged and Disabled (A&D) Waiver
- Traumatic Brain Injury (TBI) Waiver

Information about these two waivers is available on the *Medicaid HCBS* page of the DA website at in.gov/fssa/da. Individuals and their families may find additional information courtesy of the Indiana *Governor's Council for People with Disabilities* website at in.gov/gpcpd.

Eligibility for HCBS Waiver Services

Individuals must qualify for institutional care and must be enrolled in the IHCP to be eligible for HCBS waiver coverage. Additional requirements apply, based on the specific waiver program.

Level of Care (LOC)

Level-of-care (LOC) requirements for the A&D and TBI waivers are as follows:

- Persons must meet the criteria for nursing facility (NF) LOC as a key component of eligibility for the A&D Waiver.
- Persons seeking eligibility for the TBI Waiver must meet either NF LOC criteria or intermediate care facility for individuals with intellectual disabilities (ICF/IID) LOC criteria.

The criteria necessary to meet NF LOC or ICF/IID LOC are outlined in *405 IAC 1-3-1*.

Indiana has established the Eligibility Screen (E-Screen), a tool that is used to determine whether an individual meets the basic criteria for NF LOC. The E-Screen must be completed by the care manager from the Area Agency on Aging (AAA), as part of the LOC packet. An E-Screen will not be accepted by the computer system if all the pages of the E-Screen have not been addressed.

The final LOC determination is documented in the bottom section of the *Transmittal for Medicaid Level of Care Eligibility* form (*State Form 46018-HCBS 0007*).

All initial evaluations for the A&D waiver are completed by the AAA care manager, and determinations are rendered by the care manager supervisor, unless the participant has been in a nursing facility for at least 90 days. In that instance, if a participant has already received a long-term LOC designation for a nursing

facility stay, then that determination will serve as the initial evaluation. All initial LOC approvals are reviewed and verified by the DA staff before service implementation.

Medicaid Eligibility and Disability Determinations

To receive A&D or TBI Waiver services, an individual must be enrolled in the IHCP Traditional Medicaid (full State Plan benefits with a fee-for-service delivery system).

Additionally, enrollment in Traditional Medicaid may require a member to have a disability determination from the Social Security Administration (SSA).

If an individual has a disability determination from the SSA, the State uses the SSA determination for Medicaid eligibility purposes. Individuals considered disabled by the SSA are considered disabled IHCP However, by law, IHCP determines eligibility for individuals who apply to Indiana Medicaid without having received SSA disability determination. The following conditions apply:

- IHCP may require application to the SSA as part of the eligibility process.
- Individuals who are found eligible for Indiana Medicaid may be required to have an SSA disability determination by their next regularly scheduled Medical Review Team (MRT) progress report.
- If the SSA's disability determination differs from IHCP's, the SSA determination is considered final. As a 1634 state, Indiana is required to defer to all SSA disability determinations. For example, if the Medicaid agency's MRT deemed an individual to be nondisabled but the SSA later determined that same individual to be disabled and eligible for Supplemental Security Income (SSI), IHCP would automatically enroll the individual. Individuals later found eligible for Social Security Disability Income (SSDI) would need to reapply, but the SSA disability determination would be accepted, and the member would be eligible if he or she met the other eligibility requirements.

Aged and Disabled Waiver

The A&D waiver is designed to provide an alternative to NF admission for Medicaid-eligible persons age 65 and older and persons of all ages with disabilities by providing supports to complement and supplement informal supports for persons who would require care in an NF if waiver services or other supports were not available. Indiana's 16 Area Agencies on Aging (AAAs) act as the entry points for this waiver. The services available through this waiver are designed to help members remain in their own homes, as well as to help individuals residing in nursing facilities to return to community settings, such as their own homes, apartments, assisted living, or adult family care.

Member Eligibility for the A&D Waiver

In addition to meeting NF LOC and Medicaid eligibility requirements, individuals must also meet at least one of the following criteria to receive services through the A&D Waiver:

- Age 65 or older
- Have a substantial physical disability

Services Available under the A&D Waiver

The following services are available under the A&D Waiver (see *Section 7* for service definitions):

- Adult day services
- Adult family care
- Assisted living

- Attendant care
- Care management
- Community transition
- Home and community assistance
- Home-delivered meals
- Home modification assessment
- Home modifications
- Integrated healthcare coordination
- Nonmedical transportation
- Nutritional supplements
- Participant-directed home care service (PDHCS)
- Personal emergency response system (PERS)
- Pest control
- Respite services
- Specialized medical equipment and supplies
- Structured family caregiving
- Vehicle modifications

By March 17, 2022, all services will be compliant with the Centers for Medicare & Medicaid Services (CMS) HCBS Final Rule settings requirements as outlined in Indiana's Statewide Transition Plan (STP).

Traumatic Brain Injury Waiver (TBI)

The TBI Waiver's goal is to ensure that individuals with a traumatic brain injury receive appropriate services based on their needs and the needs of their families. The TBI waiver provides HCBS to individuals who, but for the provision of such services, would require institutional care.

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

Member Eligibility for the TBI Waiver

Individuals must meet the minimal NF or ICF/IID LOC requirements and Medicaid eligibility requirements, and must have a diagnosis of traumatic brain injury to be eligible for TBI Waiver services.

Entry to the waiver may be delayed due to the existence of a waiting list.

Priority admittance to the waiver may be made based on criteria outlined in the approved waiver.

Services Available under the TBI Waiver

The following services are available under the TBI Waiver (see *Section 7* for service definitions):

- Adult day services
- Adult family care
- Assisted living
- Attendant care
- Behavior management/behavior program and counseling
- Care management
- Community transition
- Home and community assistance
- Home-delivered meals
- Home modifications
- Nonmedical transportation
- Nutritional supplements
- Personal emergency response system (PERS)
- Pest control
- Residential-based habilitation
- Respite services
- Specialized medical equipment and supplies
- Structured day program
- Supported employment
- Vehicle modifications

By March 17, 2022, all services will be compliant with the Centers for Medicare & Medicaid Services (CMS) HCBS Final Rule settings requirements as outlined in Indiana's Statewide Transition Plan (STP).

Section 2: Waiver Provider Requirements

The following sections describe the process for becoming a provider of home and community-based services (HCBS) for the Aged and Disabled (A&D) Waiver or Traumatic Brain Injury (TBI) Waiver, as well as related requirements.

Waiver Provider Certification and Enrollment Process

Becoming a waiver provider for A&D or TBI Waiver services begins with the Family and Social Services Agency (FSSA) Division of Aging (DA) certification process and is finalized with the Indiana Health Coverage Programs (IHCP) provider enrollment process. Applicants must complete the certification process through the DA, and then the IHCP enrollment process through the IHCP fiscal agent, DXC.

> *Note: On October 1, 2020, the name of the IHCP fiscal agent changed from DXC Technology to Gainwell Technologies.*

DA-certified providers may begin providing services when they:

- Receive their IHCP Provider ID
- Are activated in the waiver provider database
- Receive a notice of action (NOA) authorizing the provision of services to a particular member

DA Application and Certification

The DA must certify providers of the A&D and TBI waivers. An information and application packet (with accompanying required documents) is available on the *Medicaid Waivers* page of the DA website at in.gov/fssa/da.

Prospective applicants are encouraged to submit application packets via email; however, paper applications continue to be accepted. Please submit certification applications, updates, or terminations to the following email or postal address:

Email: DAproviderapp@fssa.in.gov
Mail: **MS 21**
Waiver/Provider Analyst
Family and Social Services Administration
Indiana Health Coverage Programs (IHCP)
DA Home and Community-Based Services
402 West Washington Street, Room W454
P.O. Box 7083
Indianapolis, Indiana 46204-7083

Phone: **(317) 232-4650**

> *Note: Applicants and current providers are encouraged to contact their local Area Agency on Aging (AAA) for questions concerning FSSA DA waiver services. A list of current AAAs is located on the Area Agencies on Aging page at in.gov/fssa/da.*

When a completed application is received, the following steps occur:

- The application is date stamped and reviewed by the waiver/provider analyst and the DA staff.
- If additional information is needed, applicants may be contacted via email or telephone with a request for additional information. A 30-calendar day time frame is given for submission of

additional information. If the necessary documentation is not submitted in a timely manner, the application may be returned with the request to resubmit.

- If information is sufficient and meets the requirements for specific services, the provider is certified for those requested services.
- Preliminary information is entered into the waiver provider database and the waiver/provider analyst sends the provider a *Waiver Service Certification Letter*.
- The *Waiver Service Certification Letter* directs the provider to contact the fiscal agent, DXC, to complete the IHCP provider enrollment process. The applicant is instructed to attach a copy of the DA waiver certification to the IHCP application for processing.

> *Note: On October 1, 2020, the name of the IHCP fiscal agent changed from DXC Technology to Gainwell Technologies.*

IHCP Enrollment as a Waiver Provider

After a prospective provider receives the DA *Waiver Service Certification Letter*, the enrollment process with the IHCP begins. **The enrollment application MUST be submitted within 90 calendar days of certification.**

The prospective provider can enroll online or by mail:

- Prospective providers may enroll online through the Provider Healthcare Portal, accessible from the home page at in.gov/medicaid/providers. Click the Provider Enrollment link to begin the enrollment process.
- To enroll by mail, a prospective provider may obtain an IHCP Provider Enrollment Packet by downloading it from the *Complete an IHCP Provider Enrollment Application* page at in.gov/medicaid/providers, or by contacting 1-800-457-4584 (Option 2) to request an application by mail.

> *Note: All applications for enrollment as an A&D or TBI waiver provider must include the DA Waiver Service Certification Letter.*

For detailed enrollment instructions, see the *Provider Enrollment* provider reference module at in.gov/medicaid/providers.

IHCP Provider Classification

When applying for enrollment in the IHCP, providers must select a provider classification based on their business structure. HCBS waiver providers must be enrolled under one of the following classifications:

- Billing provider (sole practitioner)
- Group provider (must have members linked to the group)
- Rendering provider (must be linked to a group)

Rendering providers cannot bill for services; the group bills for services, identifying the rendering provider as the performer of the service. For group enrollments, all rendering providers linked to the group must be certified by the DA.

When applying by mail rather than online, the provider classification determines which enrollment packet the waiver provider should complete:

- IHCP Waiver Billing Provider Enrollment and Profile Maintenance Packet

- IHCP Waiver Group and Clinic Provider Enrollment and Profile Maintenance Packet
- IHCP Waiver Rendering Provider Enrollment and Profile Maintenance Packet

IHCP Provider Type and Specialty

Each prospective provider must designate a "type" and "specialty." Specialties and subspecialties are assigned based on the FSSA waiver program certification. See the *IHCP Provider Enrollment Type and Specialty Matrix* for list of waiver specialties and subspecialties.

The IHCP provider type for HCBS waiver providers is 32 – *Waiver*. The specialties the provider chooses must be those it is certified (by the appropriate FSSA division) to provide. The DA certifies services for the following provider specialties:

- 350 – Aged and Disabled (A&D) Waiver
- 356 – Traumatic Brain Injury (TBI) Waiver

IHCP Application Submission and Processing

The enrollment application must be signed and submitted with the requested documentation, including form *W-9*, electronic funds transfer (EFT) form, and a copy of the HCBS *Waiver Service Certification Letter*. An *IHCP Provider Agreement* is also included in the enrollment application. Enrollments submitted via the Portal allow electronic signatures and electronic attachments.

All paper enrollment forms and attachments must be sent to the following address, to ensure proper processing.

IHCP Provider Enrollment
P.O. Box 7263
Indianapolis, IN 46207-7263

Enrollment documents are logged into a document tracking system and issued an application tracking number (ATN).

The IHCP Provider Enrollment Unit has dedicated staff members assigned to coordinate and handle all HCBS waiver provider enrollments and updates. These staff members work closely with the DA to ensure timely and accurate maintenance of HCBS waiver provider enrollment processes.

The IHCP staff members review the IHCP provider enrollment packet to ensure completeness according to the Provider Enrollment guidelines:

- If the information is completed accurately and approved, the IHCP Provider Enrollment team then enters the provider's information into the IHCP Core Medicaid Management Information System (*Core*MMIS). For enrollment applications submitted via the Portal, the provider's information transfers automatically into *Core*MMIS. A provider letter is generated from the IHCP notifying the provider agency that it is now a Medicaid-enrolled HCBS waiver provider. This letter is sent to the provider detailing the assigned IHCP Provider ID and enrollment information entered into *Core*MMIS. Providers are encouraged to review this letter to ensure enrollment accuracy.
- If a provider enrollment packet needs correcting or is missing required documentation, the IHCP Provider Enrollment Unit will contact the applicant by telephone, email, or mail. This contact is intended to communicate what needs to be corrected, completed, and submitted before the IHCP can process the enrollment transaction. If an application is rejected for missing or incomplete information, the entire packet will be returned to the applicant with a letter indicating what needs to be corrected or attached. The applicant ***must*** return the entire packet, as well as a copy of the provider letter, when submitting the correction or missing information.

IHCP Provider Responsibilities

Complete information on IHCP provider enrollment, eligibility, and responsibilities is available in the *Provider Enrollment* module.

IHCP Provider Agreement

Medicaid-enrolled HCBS waiver providers are enrolled in the Indiana Health Coverage Programs (IHCP) and have executed an *IHCP Provider Agreement* with the FSSA. This agreement states that the provider will comply, on a continuing basis, with all the federal and State statutes and regulations pertaining to the IHCP, including the waiver programs' rules and regulations. The *IHCP Provider Agreement* is included in the IHCP enrollment application; see the *IHCP Enrollment as a Waiver Provider* section for details. By signing the agreement, the provider agrees to follow the information provided in the IHCP provider reference modules (including this module), as amended periodically, as well as all provider bulletins, banner pages, and notices. All amendments to the IHCP provider reference modules (including this module), and all applicable Indiana Administrative Codes (IACs), rules, and regulations are binding on publication. This module and all IHCP publications are accessible online from the *Provider References* page at in.gov/medicaid/providers.

The information is made available to assist all those who administer, manage, and participate in the A&D and TBI waiver programs. The information and direction in this module replaces all previous HCBS waiver documents. Current HCBS waiver requirements can be found in the Centers for Medicare & Medicaid Services (CMS) approved applications and the *Aging Rule, 455 IAC 2*.

Office of Inspector General Exclusionary List

The U.S. Health and Human Services Office of Inspector General (HHS-OIG) excludes certain providers (both individuals and entities) from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and all federal healthcare programs (as defined in Section 1128B(f) of the *Social Security Act* – the Act). When the HHS-OIG has excluded a provider, federal healthcare programs – including Medicaid and SCHIP programs – are generally prohibited from paying for any items or services furnished, ordered, or prescribed by the excluded individual or entity (see *Section 1903(i)(2)* of the Act and *Code of Federal Regulations 42 CFR 1001.1901(b)*). This payment ban applies to any items or services reimbursable under a Medicaid program that are furnished by an excluded individual or entity. The prohibition applies to payments for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services knew or should have known of the exclusion, even when the payment itself is made to another provider, practitioner, or supplier that is not excluded.

The HHS-OIG maintains the List of Excluded Individuals and Entities (LEIE), a database that provides information about parties excluded from participation in Medicare, Medicaid, and all other federal healthcare programs. The LEIE database is accessible to the general public from the *Exclusions Program* page at oig.hhs.gov, for online searching or to be downloaded. The online searchable database identifies currently excluded individuals or entities by name. When a match is identified, it is possible for the searcher to verify the accuracy of the match using a Social Security number (SSN) or Employer Identification Number (EIN). The downloadable version of the database may be compared against an existing database maintained by a provider. However, unlike the online format, the downloadable database does not contain SSNs or EINs.

All current IHCP providers and providers applying to participate in the IHCP are required to take the actions outlined in this section to determine whether their employees and contractors are excluded

individuals or entities. Providers are required to agree to comply with these obligations as a condition of enrollment:

- Screen all employees and contractors to determine whether any of them have been excluded. Providers can access the LEIE database on the HHS-OIG website at oig.hhs.gov and search by the names of any individual or entity.
- Search the HHS-OIG website monthly to capture exclusions and reinstatements that have occurred since the last search.
- Report to the State any exclusion information discovered by contacting the Provider and Member Concern Line toll free at 1-800-457-4515.

Because it is prohibited by federal law, no payments can be made for any amount expended for items or services (other than an emergency item or service not provided in a hospital emergency room) by an individual or entity while being excluded from participation (unless the claim for payment meets an exception listed in *42 CFR section 1001.1901(c)*). Any such payments actually claimed for federal financial participation (FFP) constitute an overpayment, and are therefore subject to recoupment. The amount of the Medicaid overpayment for such items or services is the actual amount of Medicaid dollars that were expended for those items or services. When Medicaid funds have been expended to pay an excluded individual's salary, expenses, or fringe benefits, the amount of the overpayment is the amount of those expended Medicaid funds. Civil monetary penalties may be imposed against Medicaid providers and managed care entities (MCEs) that employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid recipients.

For examples of types of items or services that, when provided by excluded parties, are not reimbursable and would constitute an overpayment subject to recoupment, see the *Provider and Member Utilization Review* module.

Provider Record Updates

To ensure timely communication of all information, providers must notify the FSSA DA and the IHCP when enrollment record information changes. Provider information is stored in several FSSA systems, including *Core*MMIS and the case management system, Care Management for Social Services (CaMSS). CoreMMIS is maintained by DXC Technology (the FSSA's fiscal agent). CaMSS is maintained by the FSSA DA for all DA waiver providers.

> *Note: On October 1, 2020, the name of the IHCP fiscal agent changed from DXC Technology to Gainwell Technologies.*

The fiscal agent is responsible for maintaining *Core*MMIS; therefore, the fiscal agent must have accurate information on file for all providers, including the current pay-to, mail-to, service location, and home office (legal) address. It is the provider's responsibility to ensure that the information on file with the fiscal agent is correct. As described in the *Provider Enrollment* module, providers are required to submit updated information to the IHCP within 10 business days of any applicable change. Provider profile maintenance forms are available at the *Update Your Provider Profile* page at in.gov/medicaid/providers, or updates can be made via the Provider Healthcare Portal, accessible from the home page of in.gov/medicaid/providers.

> *Note: For waiver providers, many types of updates must first be submitted to the DA and require a new Waiver Service Certification Letter before they can be submitted to the IHCP. See the DA Waiver Provider Information Updates section for details.*

CaMSS is the system that stores member eligibility information along with the member's service plans, NOAs, level-of-care (LOC) information, and case notes entered by the A&D care managers or TBI case manager for individual members. CaMSS also has a provider database that is maintained by DA staff and is intended to provide up-to-date information about the certification status of waiver providers. Provider selection profiles (pick lists) are generated from CaMSS; therefore, it is very important that the information listed in CaMSS is the most current and up-to-date information available. Provider information changes must be made by contacting the IHCP waiver/provider analyst at DAproviderapp@fssa.in.gov.

If the provider is licensed through the Indiana State Department of Health (ISDH), the provider must also notify the ISDH of any changes to the provider's name, address, or telephone number.

Provider Responsibilities Specific to the Waiver Program

The following sections describe responsibilities applicable to all waiver providers. For more provider-specific information, see the DA's *Provider Information* page at fssa.in.gov.

Pursuant to the signed provider agreement, all direct care providers must submit a criminal background check as required by *455 IAC 2*. The criminal background check must not show any evidence of acts, offenses, or crimes affecting the applicant's character or fitness to care for waiver participants in their homes or other locations.

The DA also requires that a current limited criminal history be obtained from the Indiana State Police central repository or through a third-party agency, for each employee or agent involved in the direct management, administration, or provision of services in order to qualify to provide direct care to members receiving services at the time of provider certification.

The IHCP implemented a CMS mandate to require federal criminal background checks for *owners* of entities assigned to the high risk category who have enrolled since August 1, 2015. For DA waiver providers, this mandate includes providers of the following:

- Attendant care services
- Specialized medical equipment and supplies

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

Licensed professionals are checked for findings through the Indiana Professional Licensing Agency (IPLA). Direct care staff is also checked against the nurse aide registry at the IPLA to verify that each unlicensed employee or agent involved in the direct provision of services has no finding entered into the registry in order to qualify to provide direct care to members receiving services.

The IPLA is responsible for maintaining the nurse aide registry. Pursuant to *455 IAC 2, General Requirements*, the provider must obtain and submit a current document from the nurse aide registry of the IPLA, verifying that each unlicensed employee involved in the direct provision of services has no finding entered into the registry before providing direct care to members receiving services. The DA Provider Relations waiver specialist verifies receipt of documentation as part of provider enrollment.

Nurse aide registry documents are maintained in agency files and are available upon request.

Waiver providers must understand the service definitions and parameters for each service authorized on a participant's NOA. All waiver providers are subject to audit and potential recoupment if the services provided are not in agreement with the services authorized as indicated on the approved NOA. If the needs of a member change, the provider must contact the care manager to discuss revising the service plan.

Providers are required to furnish at least 30 calendar days' written notice before terminating waiver services to a member. This notice must be made to the member, the legal representative (if applicable), the member's care manager, and the DA.

DA Waiver Provider Information Updates

Updates to the following information must be submitted within 10 calendar days of the change to the waiver/provider analyst at DAproviderapp@fssa.in.gov or (317) 232-4650:

- Name changes
- Tax identification changes
- Additional service locations (additional service location addresses)
  - Requires new DA Waiver Service Certification
- Changes to counties served
- Specialty changes (all specialties must be certified by the FSSA DA)
  - Requires new DA Waiver Service Certification
- Changes in ownership (CHOWs)
  - Requires new DA Waiver Provider Application
  - Requires new DA Waiver Service Certification

After update certification requirements for the provider have been met, the DA sends a new *Waiver Service Certification Letter* to the provider detailing the approved services and instructing the provider to begin the update process with the IHCP. The IHCP Provider Enrollment staff works closely with the DA to complete and maintain provider enrollment information.

Providers can update their information with the IHCP using the Portal or by mail using the appropriate enrollment packet or profile maintenance form, available from the *Update Your Provider Profile* page at in.gov/medicaid/providers. The new *Waiver Service Certification Letter* must be included with the update.

Section 3: Claim Billing and Reimbursement

The Family and Social Services Agency (FSSA) is the single State Medicaid Agency (SMA) for Indiana. The Division of Aging (DA), a division under the FSSA, has been given the authority to administer the Aged and Disabled (A&D) and Traumatic Brain Injury (TBI) waivers. The Office of Medicaid Policy and Planning (OMPP), also a division under the FSSA, has been given the administrative authority for the A&D and TBI waivers by the FSSA. The DA performs the daily operational tasks of the waivers.

Verifying Eligibility for HCBS Waiver Services

All potential Home and Community-Based Services (HCBS) waiver members must enroll in the Indiana Health Coverage Programs (IHCP). At this time, waiver participants may not be enrolled in managed care. To be eligible for reimbursement for waiver services, the waiver member must be enrolled in Traditional Medicaid (a fee-for-service program with full State Plan benefits) and have a waiver benefit plan assignment in the IHCP Core Medicaid Management Information System (*Core*MMIS).

The Area Agencies on Aging (AAAs) are the entry points for the A&D and TBI waivers. Initial eligibility and level of care (LOC) is determined by the entry point agencies. Before the waiver benefit plan is assigned in *Core*MMIS, the member must have fee-for-service Traditional Medicaid, the waiver benefit plan and the initial service plan must be approved, and a start date established. The waiver benefit plan with the start date is then entered into *Core*MMIS by the DA.

If an individual is enrolled in Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise, or any other Medicaid managed care program, the care manager must contact the local FSSA Division of Family Resources (DFR) caseworker to coordinate the managed care program stop date and waiver services start date. If applicable, the care manager and managed care benefit advocate must inform the individual and individual's parent or guardian of his or her options to ensure that he or she makes an informed choice.

All service providers must verify IHCP eligibility for each member before initiating services. If a member does not have an active waiver benefit plan and/or is not currently enrolled in IHCP Traditional Medicaid (fee-for-service) on the date on which services were provided, any claim submitted may not be paid. See the *Member Eligibility and Benefit Coverage* module for information about verifying eligibility.

> *Note: The fiscal agent cannot add or correct a waiver benefit plan assignment in CoreMMIS nor terminate a managed care enrollment.*

It is important to remember that, for members with a waiver *liability*, the IHCP does not reimburse for Traditional Medicaid **or** HCBS waiver services until their waiver liability is met for the month. The eligibility verification process indicates the member's monthly obligation and the amount remaining for the month (based on paid claims). Providers may not bill the member for their liability amount until after the claim has been submitted to the IHCP and adjudicated.

Confirming Authorization for Specific Waiver Services

AAAs, through their qualified care managers, are responsible for preparing a written care plan for each individual participant. The service plan must describe the following:

- Medical and other services to be furnished, regardless of funding source (such as medical transportation under prior authorization [PA], skilled respite under waiver, in-home hospice through the Medicaid State Plan PA process)

- Frequency of each service the member is receiving
- Type of provider (home health provider under Medicaid prior authorization, waiver provider, or family member) that will furnish each service.

All services must be furnished pursuant to a written care plan. The care plan is subject to the approval of the DA and/or the OMPP.

> *Note: Each of the 16 AAAs is responsible for disseminating information regarding the waiver to potential enrollees, assisting individuals in the waiver enrollment application process, conducting LOC evaluation activities, recruiting providers to perform waiver services, and conducting training and technical assistance concerning waiver requirements.*

The waiver care manager is responsible for completing the service plan, unless the participant has been in a nursing facility for at least ninety (90) days. In that instance, if a participant has already received a long term level of care designation for a nursing facility stay, then that determination will serve as the initial evaluation.

DA service plan approval results in an approved Notice of Action (NOA). The NOA provides the following details for each waiver-funded service that is approved for the member:

- Number of units to be provided
- Name of the authorized waiver provider
- Approved billing code with the appropriate modifiers

The care manager transmits this information to the waiver database, CaMSS. CaMSS communicates this data to *Core*MMIS, where it is stored in the PA database. Claims deny if no authorization exists in the database or if a code other than the approved code is billed. Providers are not to render or bill services without an approved NOA. It is the provider's responsibility to contact the care manager if there is any discrepancy in the services authorized or rendered on the approved NOA.

Billing Instructions

HCBS waiver services are billed as **professional** claims, using the IHCP Provider Healthcare Portal (Portal), 837P electronic transaction, or *CMS-1500* paper claim form:

- The Portal is an interactive web application that allows providers to submit claims and attachments, check eligibility, and check status of claims. The Portal is fast, free, and does not require special software. Providers must register on the Portal before they can use it to submit claims, verify member eligibility, and maintain enrollment data. See the *Provider Healthcare Portal* module for instructions on how to register.
- Professional claims can also be submitted via the 837P electronic transaction. To use this transaction, the provider must become an IHCP trading partner. See the *Electronic Data Interchange* module for more information.
- Paper copies of the *CMS-1500, Version 02/12* form are available from the U.S. Government Bookstore or other online retailers. Providers wishing to bill using the paper copies, must use an original *CMS-1500* form; black-and-white copies of the form are not accepted.

Instructions for completing the claim are in the *Home and Community-Based Services Billing Guidelines* and *Claim Submission and Processing* modules at in.gov/medicaid/providers.

> *Note: The fiscal agent and the FSSA recommend submitting claims electronically. For assistance, contact the electronic data interchange (EDI) technical assistance line at 1-800-457-4584 (option 3 and then option 3).*

Providers bill services based on an approved NOA for the individual member, using an appropriate procedure code and the pricing method associated with the procedure code, such as per unit, per day, or per month. Additional pricing information is available on the Professional Fee Schedule, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers. General guidelines include:

- Do not bill for services before they are provided.
- If a unit of service equals 15 minutes, a minimum of 8 minutes must be provided to bill for one unit.
- Activities requiring less than 8 minutes may be accrued to the end of that date of service.
- At the end of the day, partial units may be rounded as follows: units totaling 8 or more minutes may be rounded up and billed as one unit.
- Partial units totaling less than 8 minutes may not be billed.
- Monthly units are billed at the end of the month.
- Daily units may be billed daily, weekly, or monthly.

Assisted Living Billing Instructions

Assisted living facility (ALF) providers are now able to bill monthly or daily for services up to 29 days. Monthly billing can still be done even when a resident is out of the facility, as long as their time out of the facility does not exceed 30 consecutive days.

Example 1: The ALF provider normally bills monthly. During the month, the facility's resident, Mary, discharged to the hospital on February 13, 2020, with plans to return to the ALF. She was at the hospital for 4 days and then discharged to a skilled nursing facility (SNF). Mary remained in the SNF for 14 days. While in the SNF, Mary's family decided to move her to another ALF when she discharged from the SNF. On the date of discharge from the SNF (March 2, 2020), Mary's family informed her ALF provider that she would not be returning and that they wanted her to go to a different ALF.

In this scenario, the original ALF provider would need to bill daily only for the days that Mary was in the facility. If the ALF provider had already submitted monthly billing for Mary, the provider would need to void the original claim and rebill the claim for only the dates of services (DOS) that Mary was in its facility. The new ALF provider would also need to bill the first month using the daily method.

Example 2: The ALF provider normally bills monthly. During the month, the facility's resident, Mary, discharged to the hospital on February 13, 2020, with plans to return to the ALF. She was in the hospital for 4 days and then discharged to a SNF for 7 days. She returned to the ALF on February 24, 2020. The ALF can still bill the monthly rate for the entire month because Mary was not out of the ALF for 30 consecutive days. The ALF provider would need to choose a single DOS from February 1, 2020, through February 12, 2020, ***or*** from February 24, 2020, through February 29, 2020. The provider can bill for one date in the date range, for 1 unit (for example, From Date of Service [FDOS] February 2, 2020 – To Date of Service [TDOS] February 2, 2020), and bill for T2031 U7 with either U1, U2, or U3 modifiers and UA for 1 unit.

> *Note: The modifiers determine the reimbursement rate, and the level of care (LOC) for the member. Providers receive a notice of action (NOA) via mail and email before the member is admitted to the facility (and whenever there are changes to the NOA). The NOA lists the procedure code and basic modifiers, as well as the total dollar amount that the provider may bill. The NOA does not list modifier UA for monthly billing. However, the provider **may** choose monthly billing instead of daily.*

Example 3: The ALF provider normally bills monthly. During the month, the facility's resident, Mary, discharged to the hospital on February 3, 2020. Mary remained in the hospital for 10 days and then discharged to a SNF for 21 days. She returned to the ALF on March 5, 2020. In this scenario, Mary was out of the facility for more than 30 consecutive days. The ALF would need to bill daily only for the days that Mary was in the facility during February and March. If the monthly billing had already been completed for February, then the ALF would need to void the original claim and rebill for only February 1, 2020, through February 2, 2020.

> *Note: The NOA will **not** list the **UA** modifier. The NOA will list the daily rate as done previously. However, the maximum dollar amount will equal the monthly rate amounts for each LOC. If the ALF chooses to continue to bill for the daily rate, **29** is the maximum number of days that can be billed in any given month.*

Claim Tips and Reminders

When billing the IHCP waiver claims, the provider must consider the following:

- The IHCP does not reimburse HCBS claims for time spent by office staff billing claims.
- Providers may bill only for services authorized on an approved NOA that were delivered to the member.
- A claim should include dates of service within the same month. Do not submit a claim with dates of service that span more than 1 month on the same claim.
- The units of service as billed to the IHCP must be substantiated by documentation in accordance with the appropriate *Indiana Administrative Code* (IAC) regulations and the waiver documentation standards issued by the FSSA and be supported by the member's individual person-centered plan of care.
- Services billed to the IHCP must meet the service definitions and parameters, as published in the aforementioned rules and standards.
- Updated information is disseminated through IHCP provider bulletins or banner pages, available on the *News, Bulletins, and Banner Pages* page at in.gov/medicaid/providers, and DA bulletins (sent via email and posted on the DA agency websites). Each provider is responsible for obtaining the information and implementing new or revised policies and procedures, as outlined in these notices.

Third-Party Liability Exemption

The IHCP will not bill private insurance carriers through the third-party liability (TPL) or reclamation processes for claims containing any HCBS benefit modifier codes. This billing practice includes modifiers specific to claims for the following benefit plans:

- Aged and Disabled HCBS Waiver (A&D Waiver)
- Traumatic Brain Injury HCBS Waiver (TBI Waiver)

Electronic Visit Verification System Required for Personal Care Services

The 21st Century Cures Act requires Medicaid providers of personal care services to use an electronic visit verification (EVV) system to document services rendered. Use of an EVV system to document personal care services must be implemented by January 1, 2021. Affected providers may use an EVV system of their choice (either the State's EVV system [Sandata] or an alternate EVV system that can integrate with the

Sandata system); however, providers are responsible for ensuring that the system selected complies with federal requirements, including documentation of the following information:

- Type of service performed
- Individual receiving the service
- Date of the service
- Location of service delivery
- Individual providing the service
- Time the service begins and ends

Effective January 1, 2021, providers will be required to use EVV to document all personal care services (procedure code and modifier combinations) indicated in *Service Codes That Require Electronic Visit Verification*, accessible from the *Code Sets* page at in.gov/medicaid/providers. For more information, see the *Electronic Visit Verification* page at in.gov/medicaid/providers.

Claim Voids and Replacements

If a paid or denied claim must be adjusted (replaced), the initial claim is voided and a new claim takes the place of the old claim. If the claim was paid before the adjustment was made, any money paid is recouped by setting up an accounts receivable (A/R) for the amount of the recoupment, which is identified on the Remittance Advice (RA).

Waiver claim adjustments may be performed electronically or by mail. See the *Claim Adjustments* module for instructions. Adjustments requested by mail must be submitted on the *IHCP Professional, Dental, or Medicare Part B Crossover Claim Adjustment Request* form, available on the *Forms* page at in.gov/medicaid/providers.

Division of Aging HCBS Waiver Rates

Table 1 identifies procedure codes and modifiers, the waivers for which the service is available, and the payment methodology associated with the procedure code.

Table 1 – Division of Aging HCBS waiver rates and coverage, effective for dates of service on or after February 1, 2020

Service	Code	Mod 1	Mod 2	Mod 3	A&D	TBI	Notes
Residential-Based Habilitation	97535	U7			N/A	$6.99	0.25 Hour
Nutritional Supplements	B4150	U7			$1,200.00	$1,200.00	Per Year
Behavioral Management/Behavior Program and Counseling – Level 1	H0004	U7	U1		N/A	$18.20	0.25 Hour
Behavioral Management/Behavior Program and Counseling – Level 2	H0004	U7	U2		N/A	$18.20	0.25 Hour
Supported Employment	H2023	U7			N/A	$9.17	0.25 Hour

Service	Code	Mod 1	Mod 2	Mod 3	A&D	TBI	Notes
Adult Day Services – Level 1 (Category 1)	S5100	U7	U1	UC	$2.82	$2.82	0.25 Hour
Adult Day Services – Level 2 (Category 1)	S5100	U7	U2	UC	$3.40	$3.40	0.25 Hour
Adult Day Services – Level 3 (Category 1)	S5100	U7	U3	UC	$3.91	$3.91	0.25 Hour
Adult Day Services – Level 1 (Category 2)	S5100	U7	U1		$2.64	$2.64	0.25 Hour
Adult Day Services – Level 2 (Category 2)	S5100	U7	U2		$3.18	$3.18	0.25 Hour
Adult Day Services – Level 3 (Category 2)	S5100	U7	U3		$3.66	$3.66	0.25 Hour
Attendant Care (Agency)	S5125	U7	UA		$5.82	$5.82	0.25 Hour
Attendant Care (Non-Agency)	S5125	U7			$4.05	$4.05	0.25 Hour
Attendant Care (Participant-Directed)	S5125	U7	U1		$3.61	N/A	0.25 Hour
Attendant Care (Participant-Directed Overtime)	S5125	U7	U1	TU	$1.81	N/A	0.25 Hour
Home and Community Assistance (Agency)	S5130	U7	UA		$4.99	$4.99	0.25 Hour
Home and Community Assistance (Non-Agency)	S5130	U7			$4.59	$4.59	0.25 Hour
Structured Family Caregiving (Level 1)	S5140	U7	U1		$60.50	N/A	Per Day
Structured Family Caregiving (Level 2)	S5140	U7	U2		$71.04	N/A	Per Day
Structured Family Caregiving (Level 3)	S5140	U7	U3		$81.58	N/A	Per Day
Adult Family Care (Level 1)	S5141	U7	U1		$60.23	$60.23	Per Day
Adult Family Care (Level 2)	S5141	U7	U2		$69.50	$69.50	Per Day
Adult Family Care (Level 3)	S5141	U7	U3		$82.14	$82.14	Per Day
Respite (Unskilled)	S5150	U7	UA	U9	$5.59	$5.59	0.25 Hour
Personal Emergency Response System – Install	S5160	U7			$54.41	$54.41	One Time
Personal Emergency Response System – Maintenance	S5161	U7			$54.41	$54.41	Monthly
Home Modifications – Install	S5165	U7	NU		$20,000.00	$20,000.00	Lifetime Cap

Service	Code	Mod 1	Mod 2	Mod 3	A&D	TBI	Notes
Home Modifications – Maintenance	S5165	U7	U8		$1,000.00	$1,000.00	Per Year
Home-Delivered Meals	S5170	U7			$6.00	$6.00	Per Meal
Respite (LPN)	T1005	U7	UA	TE	$10.57	$10.57	0.25 Hour
Respite (RN)	T1005	U7	UA	TD	$14.33	$14.33	0.25 Hour
Home Modifications – Assessment	T1028	U7			$500.00	N/A	Per Project
Nonmedical Transportation Nonassisted (Base Trip)	T2003	U7	U1	UB	$8.02	$8.02	Base Trip
Nonmedical Transportation Nonassisted (Mileage)	T2003	U7	U1		$1.06	$1.06	Mileage
Nonmedical Transportation Assisted (Base Trip)	T2003	U7	U2	UB	$12.03	$12.03	Base Trip
Nonmedical Transportation Assisted (Mileage)	T2003	U7	U2		$1.54	$1.54	Mileage
Structured Day Program – Group Setting	T2021	U7	HQ		N/A	$1.67	0.25 Hour
Structured Day Program – Individual	T2021	U7			N/A	$8.38	0.25 Hour
Care Management	T2022	U7			$134.33	$134.33	Monthly
Integrated Healthcare Coordination	T2022	U7	U1		$10.30	N/A	0.25 Hour (16 Hours/ Month)
Pest Control	T2025	U7	U1		$4,000.00	$4,000.00	Per Year
Specialized Medical Equipment – New DME	T2029	U7	NU		$50,000.00	$50,000.00	Cap; no limit; subject to review
Specialized Medical Equipment – Replacement or Repair	T2029	U7	U8		$1,000.00	$1,000.00	Per Year
Assisted Living – Level 1 Monthly	T2031	U7	U1	UA	$2,153.84	$2153.84	Monthly
Assisted Living – Level 2 Monthly	T2031	U7	U2	UA	$2,391.44	$2391.44	Monthly
Assisted Living – Level 3 Monthly	T2031	U7	U3	UA	$2,768.04	$2,768.04	Monthly
Assisted Living – Level 1 Daily	T2031	U7	U1		$72.52	$72.52	1 Day
Assisted Living – Level 2 Daily	T2031	U7	U2		$80.52	$80.52	1 Day
Assisted Living – Level 3 Daily	T2031	U7	U3		$93.20	$93.20	1 Day
Community Transition	T2038	U7			$1,500.00	$1,500.00	Lifetime Cap

Service	Code	Mod 1	Mod 2	Mod 3	A&D	TBI	Notes
Vehicle Modifications	T2039	U7			$15,000.00	$15,000.00	$15,000.00 every 10 Years
Vehicle Modifications – Maintenance	T2039	U7	U8		$1,000.00	$1,000.00	Per Year

Section 4: Quality Assurance/Quality Improvement

The Division of Aging (DA) is responsible for the assessment and performance of contracted and/or local/regional non-State entities in conducting waiver operational functions. The DA also collaborates with the Office of Medicaid Policy and Planning (OMPP) regarding issues concerning contracted and/or local and regional non-State entities.

The DA monitors the Area Agencies on Aging (AAAs) and non-AAA care management entities through the electronic care management system, monthly communication with AAAs to verify compliance with performance, and on-site follow-up through quality assurance surveys using the Person-Centered Monitoring Tool (PCMT).

As detailed in *Indiana Administrative Code 455 IAC 2*, noncompliance with the standards may result in corrective action plans (CAPs) or other sanctions, up to and including termination as a waiver provider.

The purpose of the DA Quality Assurance (QA) and Quality Improvement (QI) Unit is to protect the safety and well-being of individuals by monitoring and ensuring the integrity and cost-effectiveness of programs administered by the DA. The role of the DA QA/QI Unit is to:

- Monitor all waiver enrolled providers that are delivering waiver services to enrolled members.
- Assure that services to all members are delivered in accordance with the member's person-centered service plan, the specifications identified in the approved waiver, and *455 IAC 2*.
- Collect and analyze information and data in order to implement sound remediation of problems at the individual, organization, and systemic levels.
- Participate with stakeholders in the development of policies and procedures that all providers, including care managers, must follow to assure compliance with *Indiana Administrative Code* (IAC) and Centers for Medicare & Medicaid Services (CMS) assurances, and to protect members' health and welfare.

The DA QA/QI program encompasses the following components:

- Incident reporting
- Complaint resolution
- Mortality review
- Coordination with Adult Protective Services (APS), the local AAAs and care managers
- Quality reviews – provider compliance reviews, person-centered compliance reviews, National Core Indicators survey for the aged and disabled population (NCI-AD)
- Coordination with Medicaid Surveillance and Utilization Review (SUR) and the Indiana State Department of Health (ISDH)
- Implementation of the Quality Improvement Strategy (QIS) process

Incident Reporting

Indiana's *455 IAC 2* requires all providers of DA HCBS waiver services, including care managers, to submit incident reports to the DA when specific events occur. The nature of these events is defined as an unusual occurrence affecting the health and safety of an HCBS participant.

Events that must be reported include but are not limited to:

- Alleged, suspected, reported, or observed abuse/battery, neglect, or exploitation of a participant

- The unexpected death of a participant
- Significant injuries to the participant requiring emergent medical intervention
- Any threat or attempt of suicide made by the participant
- Any unusual hospitalization due to a significant change in health and/or mental status that may require a change in service provision
- Participant elopement or missing person
- Inadequate formal or informal support for a participant, including inadequate supervision, which endangers the participant
- Medication error occurring in a 24/7 or day setting
- A residence that compromises the health and safety of a participant
- Suspected or observed criminal activity committed by any of the following:
  - Provider's staff when it affects or has the potential to affect the participant's care
  - A family member of a participant receiving services when it affects or has the potential to affect the participant's care or services
  - The participant receiving services
- Police arrest of the member or any person responsible for the care of that participant
- A major disturbance or threat to public safety created by the participant
- Any use of restraints

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

> *Note: Recent changes to the incident reporting tool allow for incident submission with less required information. This enhancement makes the system more accessible to participants, family members, and direct caregivers. For more information on the waiver incident reporting tool, see the Incident Reporting page at in.gov/fssa/da.*

Additionally, *455 IAC 2* requires reporting of known or suspected abuse, neglect, or exploitation (A-N-E) of an adult to Adult Protective Services (APS). A 24-hour hotline connected to the statewide APS system is available for this reporting, or reports can be made to the local APS or county prosecutor's office, APS State Hotline: 1-800-992-6978. A toll-free 24-hour number is available through Indiana Department of Child Services (DCS) for reporting child abuse, neglect, or exploitation, CPS State Hotline: 1-800-800-5556.

Providers are required to suspend from duty any staff suspected, alleged, or involved in incidents of A-N-E of a participant, pending the provider's investigation of the incident. If needed, the care manager coordinates replacement services for the participant. If the care manager is the alleged perpetrator, the participant will be given a new pick list from which a new care manager will be selected.

Providers of home and community-based services (HCBS) are required to submit an incident report for any reportable unusual occurrence within 48 hours of the time of the incident or becoming aware of the incident. However, if an initial report involves a participant death, or an allegation or suspicion of A-N-E, it is required to be submitted within 24 hours of "first knowledge" of the incident.

Incidents are received by the DA via a secure web-based reporting system that links to the electronic incident database. Incident reporting (IR) contract staff process the incidents within 1 work day of receiving the reports. Processing each report includes coding the incident by type, apparent cause, resources utilized, and when applicable, perpetrator, sub-type(s), and outcome. Reviewers also determine what level

of follow-up, if any, is required, and send notifications of required actions to the care manager, DA, and provider.

Required actions may include:

- Notification of APS or DCS if the incident involves A-N-E and notification is not documented in the report
- Additional follow-up by the care manager when the incident has not been resolved
- Follow-up by the DA when it appears the participant is at risk of further A-N-E or other substantial threat of harm (sentinel status). This follow-up is expected to be made by DA personnel within 48 hours of notification.
- Submission of a new report when the first report was inadequate or incomplete

The incident reviewer also sends notifications to the care manager when follow-up is not required and informs the DA of all A-N-E reports. Additional notifications may be sent to reporting entities and the DA when incident reporting requirements for timeliness are not met, or when the report should have been submitted by another party.

All incidents that are not resolved require care manager follow-up and reporting every 7 days until the incident reviewer determines that the incident is resolved. Follow-up reports are also submitted via the web-based incident reporting system.

Complaint Resolution

The DA addresses complaints submitted by or on behalf of any member receiving services through a waiver administered by the DA. Complaints may be initiated by any individual through the Incident and Follow-Up Reporting (IFUR) tool. Complaint investigations may result in findings requiring remediation. A provider's failure to complete remediation may result in sanctions up to and including termination as a waiver provider.

Mortality Review

As part of its Quality Assurance/Quality Improvement (QA/QI) process, participant deaths are reviewed by the DA QA/QI unit, along with any previously filed incident reports involving the participant. Additional information, including provider's records of service delivery, may be collected for further review of any unexpected deaths. If additional review is indicated, it is referred for review by the Mortality Review Committee (MRC).

The MRC will review all deaths that involve the participant when:

- Death is due to alleged, suspected, or known abuse or neglect
- Death is from trauma or accident
- Death is alleged or known suicide or homicide
- Death occurs unexpectedly following transition from a nursing facility
- Death occurs when participant has gone missing from normal care setting

The MRC 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 providers or a care manager, a referral to another entity, or a systemic recommendation
- Close a case with no recommendations

All participants' deaths are required to be reported to the relevant APS unit or to DCS, as applicable. APS units, DCS investigators, and/or law enforcement conduct independent investigations of deaths and A-N-E reports at their discretion and following their departmental protocols.

Provider Compliance Reviews

The DA conducts provider compliance reviews (PCRs) for all nonlicensed waiver service providers, as well as licensed providers that also offer services that fall outside the scope of the license. The PCR includes a review of provider policies and adherence to State and federal requirements, as well as the provider's own policies.

The Division of Aging Provider Relations Team administers compliance reviews that include an extensive review of provider and care manager documentation, service delivery records, policies and procedures, and compliance with other waiver and State requirements.

For licensed providers, this review is conducted by the Indiana State Department of Health (ISDH). Non-licensed providers are reviewed by the Division of Aging Provider Relations Team. Both ISDH and the Division of Aging have formal review and corrective action procedures submitted by the provider with approval or denial by the Division of Aging. If denied, the provider is required to resubmit the corrective action plan within a 2-week time frame. After it is approved, the Division of Aging verifies successful implementation of the corrective action plan. Any provider not successfully completing the corrective action process is decertified as a provider.

A provider's failure to cooperate with the review procedure or to complete the corrective action process results in a referral to the Provider Relations Director as a formal complaint, which may result in sanctions up to and including termination as a waiver provider.

Any provider decertified as a result of noncompliance with the provider agreement or failing to complete corrective actions is notified of the decision, and of the provider's right to appeal. Documentation of all corrective actions taken with providers is maintained in the Division of Aging's provider database. Prior to taking action to suspend or terminate a provider, alternative service options will be provided to any affected participants through their care manager.

Review of Waiver Process Outcomes

The Provider Relations Team aggregates and analyzes data from all waiver processes to identify incidents of noncompliance with waiver requirements and opportunities to achieve more positive outcomes. Findings are reviewed for viable remediation options at the individual and systemic levels. A provider's failure to complete required may result in sanctions up to and including termination as a waiver provider.

The Provider Relations Team recommends systemic improvements and assesses the performance of the QA/QI components.

Section 5: Program Integrity and Financial Oversight

The state of Indiana employs a hybrid program integrity (PI) approach to overseeing waiver programs, incorporating oversight and coordination by the Surveillance and Utilization Review (SUR) Unit, as well as engaging the full array of technology and analytic tools available through the Fraud and Abuse Detection System (FADS) contractor arrangements.

Waiver Audits

The Family and Social Services Administration (FSSA) has expanded its PI activities using a multifaceted approach to SUR activity that includes provider self-audits, desk audits, and on-site audits. SUR is required to complete an initial assessment of each provider type annually. Then, based on the assessment information and referrals, audits are completed as needed. The FADS team analyzes claims data, allowing them to identify providers and claims that indicate aberrant billing patterns and other risk factors.

The PI audit process uses data mining, research, identification of outliers, problematic billing patterns, aberrant providers, and issues that are referred by other divisions and State agencies. The SUR Unit also meets with all waiver divisions on a quarterly basis, at a minimum, and receives referrals on an ongoing basis to maintain open lines of communication and understanding in specific areas of concern, such as policy clarification.

The SUR waiver specialist is a subject-matter expert (SME) responsible for directly coordinating with the waiver divisions. This specialist also analyzes data to identify potential areas of risk and identify providers that appear to be outliers warranting review. The SME may also perform desk or on-site audits and be directly involved in reviewing waiver providers and programs.

The SUR Unit offers education regarding key program initiatives and audit issues at waiver provider meetings to promote ongoing compliance with federal and State guidelines, including all IHCP and waiver requirements is available in the *Provider and Member Utilization Review* provider reference module.

FSSA Audit Oversight

Throughout the entire PI process, the FSSA maintains oversight. Although the FADS contractor may be incorporated in the audit process, no audit is performed without the authorization of the FSSA. The FSSA's oversight of the contractor's aggregate data is used to identify common problems to be audited, determine benchmarks, and offer data to peer providers for educational purposes, when appropriate.

The Audit Division of the FSSA reviews waiver audit team schedules and findings to reduce redundancy and assure use of consistent methodology.

Medicaid Fraud Control Audit Overview

The Indiana Medicaid Fraud Control Unit (MFCU) is an investigative branch of the Attorney General's Office. MFCU conducts investigations in the following areas:

- Medicaid provider fraud
- Misuse of Medicaid members' funds
- Patient abuse or neglect in Medicaid facilities

When the MFCU identifies a provider that has violated regulations in one of these areas, the provider's case is presented to the State or federal prosecutors for appropriate action. Providers can access information about the MFCU at in.gov/attorneygeneral.

Section 6: Care Management

Medicaid Aged and Disabled (A&D) and Traumatic Brain Injury (TBI) Waiver care managers coordinate and integrate all services required in a participant's person-centered service plan, link participants to needed services, and ensure that participants continue to receive and benefit from services. Waiver care managers enable participants to receive a full range of services needed due to a medical condition in a planned, coordinated, efficient, effective manner.

Care management is a comprehensive service comprising specific tasks and activities designed to coordinate and integrate all other services required in the participant's service plan.

Care management encompasses the following components:

- Initial level-of-care (LOC) assessment
- Development of service plans including coordination of formal and informal supports
- Implementation of the service plan
- Assessment and care planning for discharge from institutionalization
- Biannual and ongoing reassessments of LOC
- Quarterly assessment of individual's needs, per 90-day review tool
- Periodic updates of service plans
- Monitoring the quality of home care and community services
- Determining and monitoring the cost effectiveness of providing home and community-based services (HCBS)
- Information and assistance services
- Enhancement or termination of services based on need
- Administrative guidance
- Participation in Medicaid Fair Hearing process

Care management services for persons on the nursing facility (NF) Medicaid waivers are provided by certified care managers, as approved by the Division of Aging (DA). The 16 local Area Agencies on Aging (AAAs) serve as the single point of entry for the NF Medicaid waivers. A care manager from the AAA is assigned to an applicant. After an applicant has been determined to meet the eligibility criteria and approved to receive NF Medicaid waiver services, he or she may choose to retain his or her current AAA care manager or choose a non-AAA or independent care manager, for ongoing care management services.

The following are minimum qualifications for care managers:

- All care management services provided must comply with the care management standards.
- The minimum educational and experience criteria for providing this service under the A&D and TBI waivers are:
  - A Qualified Intellectual Disabilities Professional (QIDP) who meets the QIDP requirements at *42 CFR 483.430*
  - Has achieved one of the following:
    - A registered nurse with 1 year experience in human services
    - A bachelor's degree in social work, psychology, counseling, gerontology, nursing, or health and human services
    - An associate's degree in nursing

  - A bachelor's degree in any field with a minimum of 2 years' full-time direct-service experience with the elderly or disabled (including assessment, care plan development, and monitoring)
  - A master's degree in a related field, which may substitute for the required experience
  - Cleared by background checks to ensure the individual applicant does not have a criminal background *(Note: Background check must have been completed within 1 year of request for care management certification.)*

- Before providing waiver care management services, all care managers must complete the DA Care Management Orientation (CMO) online training modules (accessible from the *Care Manager Resources* page at in.gov/fssa/da). Until a care manager has successfully completed the orientation, he or she may not work independently.
- All care managers must annually obtain at least 20 hours of training regarding care management services. Ten hours of this training must be training approved by the DA under the NF waiver program.

If the DA identifies a systemic problem with a care manager's services, the care manager must obtain training on the topics recommended by the DA.

Care management may not be conducted by any organization, entity, or individual that also delivers other in-home and community-based services under the DA waiver programs, or any organization, entity, or individual with common ownership or control in any other organization, entity, or individual that also delivers other in-home and community-based services under the NF waiver program. The exception is an AAA that has been granted permission by the Family and Social Services Administration (FSSA) to provide direct services to members. The DA uses the following definitions in determining common ownership, control, or relation:

- *Common Ownership* exists when an individual, individuals, or any legal entity possesses ownership or equity of at least 5% in the provider entity, as well as the institution or organization serving the provider.
- *Control* exists where an individual or organization has the power or the ability, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not the control is actually exercised.
- *Related* means associated or affiliated with, or having the ability to control, or be controlled by.

Reimbursement of care management services, as defined in this module, may not be made unless and until the client becomes eligible for waiver service. Care management service provided to individuals who are not eligible for DA waiver services will not be reimbursed as a waiver service.

Care Management Monitoring Standards

The *Ongoing Medicaid Home and Community-Based Services Waiver Care Management Standards* is the document that delineates the standards each nursing facility care manager must meet to fulfill the FSSA DA guiding principles:

- Responsive, efficient, effective, quality, and timely service delivery
- Effective communication
- Respect, dignity, integrity, and rights for all individuals
- Person-centered planning, informed choice, and personal empowerment
- Community-based services

- Fiscal stewardship
- Quality customer services

Care are to comply with all applicable DA standards. The following subsection is excerpted from the *Care Management Medicaid Waiver Provider Agreement*.

Ongoing Medicaid HCBS Waiver Care Management Standards

HCBS waiver care managers need to maintain the following standards:

- Care managers will maintain the highest professional and ethical standards in the conduct of their business.
- Care managers will comply with all DA-issued documents, as well as all federal, State, and local law, and all FSSA policy, rules, regulations and guidelines, including the *Health Insurance Portability and Accountability Act* (HIPAA).
- New care managers will complete CMO as approved by the DA prior to being eligible for Medicaid reimbursement. This orientation is now provided online and can be accessed from the *Care Manager Resources* page at in.gov/fssa/da. Completion of the modules is verified through completion of the final certification test. DA grades the test and issues certification for any score of 80% or higher.
- Care are required to complete annual training as follows:
  - The following components of the online orientation must be reviewed annually by all active care managers:
    - LOC modules – general, narrative, skilled needs, and activities of daily living
    - Incident reporting module
    - Service definition module
  - An additional eighteen (18) hours of training must be completed annually by all active care managers.
    - This training does not have to be preapproved by the DA.
    - This training does have to be relevant to core care management functions.
    - The Training Justification Form must be completed.
    - Training documentation is subject to review in compliance surveys and at DA request.
    - Relevant topics can include the following:
      - Care coordination
      - Documentation
      - Medical terminology
      - Other public or privately funded long-term services and support programs or benefits
      - Specific diagnosis or treatment topics affecting a broad spectrum of the client base, including but not limited to:
        - Fall prevention
        - Adaptive equipment
        - COPD
        - Congestive heart failure
        - Diabetes
        - Traumatic brain injury
        - Kidney disease
        - Alzheimer's disease
        - Seizures
        - Stroke
        - Heart disease

    - Mental health issues
    - Behavioral issues

- The following will ***not*** be accepted as part of the required training:
  - Care management orientation
  - Required annual retraining
  - Vendor fairs
  - Staff meetings (unless there is an outside speaker or expert speaking on a relevant topic, or someone who attended a State training as a trainer is sharing that information)
  - Presentations related to employment issues; for example, performance appraisal process and retirement
  - Communications that are part of supervisory oversight; for example, reinforcement of or retraining on job requirements, review of State guidelines, informational or training, sessions specific to a case, and so on
- Required training hours are prorated in a care first year and are in addition to new care manager orientation.
- Individuals will choose their service provider, including their care manager, and have the right to change any provider, including their care manager.
- Care managers will provide individuals a list of potential providers, furnished by the state of Indiana, including care managers and the services offered by each provider.
- Care managers will provide, at a minimum but not limited to, a state information guide to individuals on how to choose a provider and will assist the individual to evaluate potential service providers.
- A maximum response time between implementation of the initial service plan and the first monitoring contact will be no more than 30 calendar days.
- Care managers will have face-to-face contact with each individual a minimum of every 90 days to assess the quality and effectiveness of the service plan. At least two of these face-to-face contacts per year will be in the home setting.
- Care managers will document, in the chronological narrative, each contact with the individual and each contact with providers within 7 days of activity.
- Care managers documentation must show activity relevant to the service plan to be reimbursed.
- Care managers will facilitate and monitor the formal and informal supports that are developed to maintain the individual's health and welfare in the community.
- Care managers will provide each individual or guardian with clear and easy instructions for contacting the care manager or care manager agency. The care manager will also provide additional information and procedures for individuals who may need assistance or have an emergency that occurs before or after business hours. This information will be located in the home in a location that is visible from the telephone.
- Care managers will complete face-to-face annual assessments and update the service plan as needed, in collaboration with the individual, in a timely and appropriate manner to avoid gaps in service authorization, including assuring that the individual or guardian receives instructions on how to request an appeal through the Medicaid Fair Hearing process.
- Care managers will communicate the individual's needs, strengths, and preferences to the support team.
- Care managers will ensure that person-centered planning is occurring on an ongoing basis.
- Care managers will monitor the ongoing services to ensure that they reflect the service plan, including the individual's medication regime.
- Care managers will base the service plan upon the individual's needs, strengths, and preferences.
- Care managers will ensure that the individual and all providers have a current, comprehensive service plan that meets the needs of the individual.

- Care managers will review and explain to the individual or guardian the services that will be provided, and the individual or their designated representative will sign the service plan to show understanding of, and agreement with, the plan.
- Care managers will ensure that the individual or guardian, providers, and involved agencies have a copy of relevant documentation, including instructions on how to request an appeal.
- Care managers will obtain all required signatures on the service plan before submitting it to the State. The service plan will not be implemented prior to receiving State approval.
- Care managers will document the quality; timeliness; and appropriateness of care, services, and products delivered by providers.
- Care managers will initiate timely follow-up of identified problems, whether self-identified or referred by others. Critical or crisis issues, including incident reports, will be acted upon immediately, as specified by the DA. All follow-up and resolution will be documented in the individual record.
- Care managers will comply with all automation standards and requirements as prescribed by the DA for documentation and processing of care management activities.
- Care managers will maintain privacy and confidentiality of all individual records. No information will be released or shared with others without the individual or guardian's written consent.
- Care managers will provide to the State upon request, ready access to all care manager documentation, either electronic or hard copy.
- Care manager documentation will demonstrate that the safety and welfare of the individual are being monitored on a regular basis.

Section 7: Service Definitions and Requirements

This section lists service definitions and related information for the services currently approved for the two Indiana Division of Aging (DA) Home and Community-Based Services (HCBS) waiver programs: Aged and Disabled (A&D) Waiver and Traumatic Brain Injury (TBI) Waiver. Each service listed includes the following information as appropriate:

- Service definition
- Allowable activities
- Service standards
- Documentation standards
- Limitations if applicable
- Activities not allowed
- Provider qualifications
  - A provider qualifications table identifies the waiver, the license or certification requirements, and any additional standards that apply.

Table 1 shows procedure (billing) codes and modifiers, as well as unit rates.

All settings must be compliant with the Centers for Medicare & Medicaid Services (CMS) Final Rule on HCBS settings requirements as outlined in Indiana's Statewide Transition Plan. Sites certified prior to March 17, 2014, are part of the Statewide Transition Plan (STP) and must become compliant by March 17, 2022.

Adult Day Services

The following subsections provide information and requirements for adult day services (ADS).

Service Definition

ADS are community-based group programs designed to meet the needs of individuals who need structured, social integration through comprehensive and nonresidential programs. The service plan will identify the need through the person-centered assessment (PCA) process and evident through the assessment tool. The purpose for ADS is to provide health, social, recreational, supervision, support services, and personal care. Meals, specifically, and as appropriate, breakfast, lunch, and nutritious snacks are required. Participants attend ADS on a planned basis. The three levels of ADS are Basic, Enhanced, and Intensive.

Allowable Activities

Basic ADS (Level 1) services include the following activities:

- Monitoring of all activities of daily living (ADLs) defined as dressing, bathing, grooming, eating, walking, and toileting with hands-on assistance provided as needed
- Comprehensive, therapeutic activities for those with cognitive impairment in a safe environment

- Initial health assessment conducted by a registered nurse (RN) consultant prior to beginning services at the adult day, and intermittent monitoring of health status
- Monitoring of medication or medication administration

Enhanced ADS (Level 2) services include all activities of Level 1, as well as the following additional activities:

- Hands-on assistance with two or more ADLs or hands-on assistance with bathing or other personal care
- Initial health assessment conducted by RN consultant prior to beginning services as well as regular monitoring or intervention with health status
- Medication assistance
- Psychosocial needs assessed and addressed, including counseling as needed for individuals and caregivers
- Therapeutic structure and intervention for participants with mild to moderate cognitive impairments in a safe environment

Intensive ADS (Level 3) services includes all activities of Level 1 and Level 2, and the following additional activities:

- Hands-on assistance or monitoring with all ADLs and personal care
- One or more direct health intervention(s) required
- Rehabilitation and restorative services, including physical therapy, speech therapy, and occupational therapy coordinated or available
- Therapeutic intervention to address dynamic psychosocial needs such as depression or family issues affecting care
- Therapeutic interventions for those with moderate to severe cognitive impairments

Recommended Facility Standards

To promote best practices in facility standards for adult day physical spaces, the DA will provide additional reimbursement for providers that meet the following requirements (Adult Day Services Category 1):

- Each adult day health care program, when it is co-located with another facility, must have its own separate designated space during operational hours.
- The indoor space for an adult day center must be at least 100 square feet per participant including office space for staff, and must be 60 square feet per participant excluding office space for staff.
- Each program will need to design and partition its space to meet its own needs, but the following functional areas must be available:
  - A dividable multipurpose room or area for group activities, including dining, with adequate table setting space.
  - A kitchen area for refrigerated food storage, the preparation of meals and/or training participants in activities of daily living.
  - An examination and/or medication room.
  - A quiet room (with at least one bed), which functions to isolate participants who become ill or disruptive, or who require rest, privacy, or observation. It should be separate from activity areas, near a restroom, and supervised.
  - Bathing facilities adequate to facilitate bathing of participants with functional impairments.

  - Toilet facilities and bathrooms easily accessible to people with mobility problems, including participants in wheelchairs. There must be at least one toilet for every ten participants. The toilets must be equipped for use by persons with limited mobility, easily accessible from all programs areas, i.e. preferably within 40 feet from that area, designed to allow assistance from one or two staff, and barrier free.
  - Adequate storage space. There should be space to store arts and crafts materials, personal clothing and belongings, wheelchairs, chairs, individual handiwork, and general supplies. Locked cabinets must be provided for files, records, supplies, and medications.
  - An individual room for counseling and interviewing participants and family members.
  - A reception area.
  - An outside space that is used for outdoor activities that is safe, accessible to indoor areas, and accessible to those with a disability. This space may include recreational space and a garden area. It should be easily supervised by staff.
- Furnishings must be available for all participants. This must include functional furniture appropriate to the participants' needs.

Service Standards

ADS must follow a written service plan addressing specific needs determined by the client's assessment. The ADS provider is responsible for sharing the client's service plan with the client's care manager to ensure continuity of care.

Basic ADS (Level 1) service standards include the following:

- Appropriate structure for those with mild cognitive impairment in a safe environment
- Minimum staff ratio: one staff for each eight individuals
- Registered nurse (RN) consultant available

Enhanced ADS (Level 2) services includes all activities of Level 1, and the following additional activities:

- Therapeutic structure and intervention for participants with mild to moderate cognitive impairments in a safe environment
- Minimum staff ratio: one staff for each six individuals
- RN consultant available
- Minimum of one full-time licensed practical nurse (LPN) staff person with monthly RN supervision

Intensive ADS (Level 3) services includes all activities of Level 1 and Level 2, and the following additional activities:

- Therapeutic interventions for those with moderate to severe cognitive impairments
- Minimum staff ratio: one staff for each four individuals
- RN consultant available
- Minimum of one full-time LPN staff person with monthly RN supervision
- Minimum of one qualified full-time staff person to address participants' psychosocial needs

Documentation Standards

Care managers must maintain the following documentation:

- Justification for the service is documented.
  - The documented need for the service is to include, but not be limited, to the following:
    - Describe the structure needed for the participant (medical, social, recreational)
    - Types of ADL care the participant may require and level of assistance needed
- Level of service as determined in the PCA, which is given to provider.
- Completed *Adult Day Service Level of Service Evaluation* form. The care manager must give the completed *Adult Day Service Level of Service Evaluation* form to the provider.

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

- ADS are allowed for a maximum of 10 hours per day.

Activities Not Allowed

ADS will not be provided to participants receiving the assisted living waiver service.

> *Note: Therapies provided through this service will not duplicate therapies provided under any other service.*

Provider Qualifications

Provider qualifications for ADS are presented in the following table.

Table 2 – Provider Qualifications for Adult Day Service

Waiver	Provider	Licensure/ Certification	Other Standards
A&D, TBI	FSSA DA-approved ADS provider	Not required	Must comply with the Adult Day Services Provision and Certification Standards DA approved *455 IAC 2* Provider qualifications: Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Provider qualifications: General requirements for direct care staff *455 IAC 2* Procedures for protecting individuals *455 IAC 2* Unusual occurrence; reporting *455 IAC 2* Transfer of individual's record upon change of provider *455 IAC 2* Notice of termination of services *455 IAC 2* Provider organizational chart *455 IAC 2* Collaboration and quality control *455 IAC 2* Data collection and reporting standards *455 IAC 2* Quality assurance and quality improvement system *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC 2* Maintenance of personnel records *455 IAC 2* Adoption of personnel policies *455 IAC 2* Operations manual *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Individual's personal file; site of service delivery

Adult Family Care

The following subsections provide information and requirements for adult family care (AFC).

Service Definition

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

AFC is designed to provide options for alternative long-term care to individuals who meet nursing facility level of care and whose needs can be met in a home-like environment.

The goal of the service is to provide necessary care while emphasizing the participant's independence. This goal is reached through a cooperative relationship between the participant (or the participant's legal guardian), the participant's HCBS Medicaid waiver care manager, and the AFC provider. The participant's

needs must be addressed in a manner that supports and enables the individual to maximize abilities to function at the highest possible level of independence.

Another goal of this service is to preserve the dignity, self-respect, and privacy of the participant by ensuring high-quality care in a non-institutional setting. Care is to be furnished in a way that fosters the independence of each participant to facilitate aging in place in a home environment that will provide the participant with a range of care options as his or her needs change.

Participants selecting AFC service may also receive care management service, adult day service, specialized medical equipment and supplies, and healthcare coordination through the waiver.

> *Note: Participants living in AFC settings are entitled to retain at least their personal needs allowances (PNAs) as established by the state of Indiana. The PNA is currently $52.00 per month per IC 12-15-7-2.*
>
> *A provider, after ensuring that the participants retain their PNAs, may bill participants up to the current maximum federal Supplemental Security Income (SSI). Providers may not charge Medicaid waiver participants a room-and-board rate that exceeds the maximum SSI rate.*

Allowable Activities

The following are included in the daily per diem for AFC:

- Attendant care related to ADLs
- Home and Community Assistance care related to instrumental activities of daily living (IADLs)
- Medication oversight (to the extent permitted under State law)

Service Standards

These service standards must be followed for AFC:

- AFC services must follow a written service plan addressing specific needs determined by the participant's PCA.
- Services must address the participant's level of service needs.
- Provider must live in the AFC home, unless another provider-contracted primary caregiver, who meets all provider qualifications, lives in the AFC home.
- Backup services must be provided by a qualified participant familiar with the participant's needs for those times when the primary caregiver is absent from the home or otherwise cannot provide the necessary level of care (LOC).
- AFC provides an environment that has the qualities of a home, including the following:
  - Privacy
  - Safe place that is free of environmental hazards such as pests
  - Habitable environment
  - Comfortable surroundings
  - Opportunity to modify one's living area to suit one's participant preferences
- Rules managing or organizing the home activities in the AFC home must be provided to the participant prior to the start of AFC services and may not be so restrictive as to interfere with a participant's rights under State and federal law; these rules are developed by the provider, the provider-contracted primary caregiver, or both and approved by the Medicaid waiver program.

- Participant-focused activity plans are developed by the provider with the participant or the participant's representative.
- Providers or provider's employees who furnish medication oversight, as addressed under *Allowable Activities*, must receive necessary instruction from a doctor, nurse, or pharmacist on the administration of controlled substances prescribed to the participant.

Documentation Standards

Level of service is determined in the PCA. The care manager must follow these documentation standards:

- Document the medical need for AFC and types of ADL and IADL care the participant may require.
- Document the expected AFC activity to meet the individual's needs, which is accurately shown in the intermediate LOC E-screen.
- If the participant requires skilled care, justify how the skilled-care need will be met and by whom with the required documentation, describing:
  - Reason to use attendant care services
  - Who will be providing this service
  - Activities that are expected to be performed and frequency
- Give the completed PCA to the provider.

The provider must follow these documentation standards:

- Daily documentation to support services rendered by the AFC to address needs identified in the PCA:
  - Participant's status, including health, mental health, medication, diet, sleep patterns, social activity
  - Updates, including health, mental health, medication, diet, sleep patterns, social activity
  - Participation in participant-focused activities
  - Medication management records, if applicable
- Monthly updated service plans provided to the participant's care manager from the AFC caregiver
  - Notification to the participant's care manager, within 48 hours, of any changes in participants care plan
- Maintenance of participant's personal records to include:
  - Social Security number
  - Medical insurance number
  - Birth date
  - Emergency contact(s)
  - All medical information available including all known current prescription and nonprescription drug medication
  - Most recent prior residence
  - Hospital preference
  - Primary care physician
  - Mortuary (if known)
  - Religious affiliation and place of worship, if applicable
- Participant's personal records must contain copies of all the following documents, if applicable (the AFC caregiver will also provide these documents to the participant's care manager on an ongoing basis if there are changes):
  - Advance directive
  - Living will

- Power of attorney
- Health care representative
- Do not resuscitate (DNR) order
- Letters of guardianship

Note: If applicable, copies of personal record must be:

- *Placed in a prominent place in the participant's file*
- *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Activities Not Allowed

The following activities are not allowed or reimbursed under AFC:

- Services provided in the home of a caregiver who is related by blood or related legally to the participant
- Services provided as an individual provider by the following:
  - Parent of a minor child participant
  - Spouse of a participant
  - Attorney-in-fact (or power of attorney [POA]) of a participant
  - Health care representative (HCR) of a participant
  - Legal guardian of a participant
- Payments for room and board or the costs of facility maintenance, upkeep, or improvement
- Personal care services provided to medically unstable or medically complex participants as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician, or other health professional

Separate payment will not be made for the following services furnished to a participant selecting AFC services, as these activities are integral to and inherent in the provision of AFC services:

- Attendant Care
- Community Transition
- Home Modifications
- Home-Delivered Meals
- Home and Community Assistance
- Pest Control
- Respite
- Structured Family Caregiving

Provider Qualifications

Provider qualifications for AFC services are presented in the following table.

Table 3 – Provider Qualifications for Adult Family Care

Waiver	Provider	Licensure/ Certification	Other Standards
A&D, TBI	FSSA DA-approved Adult Family Care individual	Not required	Provider and home must meet the requirements of the *Indiana Adult Family Care Service Provision and Certification Standards*. AFC service providers are required to maintain Commercial General Liability insurance with the Indiana Division of Aging identified as a Certificate Holder. DA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications; General requirements *455 IAC 2* General requirements for direct care staff *455 IAC 2* Procedures for protecting individuals *455 IAC 2* Unusual occurrence; reporting *455 IAC 2* Transfer of individual's record upon change of provider *455 IAC 2* Notice of termination of services *455 IAC 2* Provider organizational chart *455 IAC 2* Collaboration and quality control *455 IAC 2* Data collection and reporting standards *455 IAC 2* Quality assurance and quality improvement system *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC 2* Transportation of an individual *455 IAC 2* Documentation of qualifications *455 IAC 2* Maintenance of personnel records *455 IAC 2* Adoption of personnel policies *455 IAC 2* Operations manual *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Individual's personal file; site of service delivery
A&D, TBI	FSSA DA-approved Adult Family Care agency	Not required	Provider and home must meet the requirements of the *Indiana Adult Family Care Service Provision and Certification Standards*. DA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* General requirements for direct care staff *455 IAC 2* Procedures for protecting individuals *455 IAC 2* Unusual occurrence; reporting *455 IAC 2* Transfer of individual's record upon change of provider *455 IAC 2* Notice of termination of services *455 IAC 2* Provider organizational chart *455 IAC 2* Collaboration and quality control *455 IAC 2* Data collection and reporting standards *455 IAC 2* Quality assurance and quality improvement system *455 IAC 2* Financial information

Waiver	Provider	Licensure/ Certification	Other Standards
			455 IAC 2 Liability insurance *455 IAC 2* Transportation of an individual *455 IAC 2* Documentation of qualifications *455 IAC 2* Maintenance of personnel records *455 IAC 2* Adoption of personnel policies *455 IAC 2* Operations manual *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Individual's personal file; site of service delivery

Assisted Living

The following subsections provide information and requirements for assisted living (AL) services.

Service Definition

The AL service is defined as personal care and services, home and community assistance, chore, attendant care and companion services, medication oversight (to the extent permitted under State law), and therapeutic social and recreational programming provided in a congregate residential setting in conjunction with the provision of participant-paid room and board. The participant retains the right to assume risk.

Participants selecting the AL service may also receive the following services through the waiver:

- Care management
- Specialized medical equipment and supplies

> *Note: Under 455 IAC 3-1-12, participants living in assisted living facilities are entitled to retain at least their PNAs, as established by the state of Indiana. The PNA is currently $52.00 per month per IC 12-15-7-2.*
>
> *A provider, after ensuring that the participants retain their PNAs, may bill participants up to the current maximum federal SSI. Providers may not charge Medicaid eligible individuals a room and board rate that exceeds the maximum SSI amount for a studio apartment. A participant who wishes to select a larger room, may pay extra for any unit exceeding the size of a studio based on the monthly amount determined by the facility.*

Allowable Activities

The following activities are included in the daily per diem for AL service:

- Attendant care related to ADLs
- Home and Community Assistance care related to IADLs
- Medication oversight (to the extent permitted under State law)
- Nonemergency nonmedical transportation
- Therapeutic social and recreational programming

Service Standards

Assisted living service must follow a written service plan addressing specific needs determined by the participant's PCA.

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

Documentation Standards

The care manager must follow these documentation standards:

- Document the need for, types of, and frequency of ADL and/or IADL care the participant may require, which is identified in the PCA.
- If the participant requires skilled care, justify how the skilled-care need will be met and by whom. The documentation must describe the following:
  - Reason to use AL service
  - Who will be providing this service
  - Activities that are expected to be performed and frequency of the activities
- Give the completed PCA to the provider.

The provider must follow these documentation standards:

- Complete and accurate documentation to support daily services rendered by the AL service to address needs identified in the Person Centered Care Plan:
  - Participant's status, including health, mental health, medication, diet, sleep patterns, social activity
  - Updates, including health, mental health, medication, diet, sleep patterns, social activity
  - Participation in participant-focused activities
  - Medication management records, if applicable
  - Quarterly updated service plans provided to the participant's care manager from the AL service
  - Notification to the participant's care manager, within 48 hours, of any changes in participant's care plan
- Maintenance of participant's personal records to include:
  - Social security number
  - Medical insurance number
  - Birth date
  - Emergency contact(s)
  - Available medical information, including known current prescription and nonprescription drug medication
  - Hospital preference
  - Primary care physician
  - Mortuary (if known)
- Participant's personal records must include copies of the following documents, if available (the AL caregiver will also provide these documents to the participant's care manager on an ongoing basis if there are changes):
  - Advance directive
  - Living will
  - Power of attorney

  - Health care representative
  - Do not resuscitate (DNR) order
  - Letters of guardianship
  - Fully executed lease agreement with the AL service

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

- Services outlined in the service plan
- Documentation to support service rendered

Activities Not Allowed

The following activities are not allowed under the AL service:

- Per diem does not include room and board
- Personal care services provided to medically unstable or medically complex participants as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician, or other health professional
- Separate payment will not be made for the following services furnished to a participant selecting AL service, as these activities are integral to and inherent in the provision of the AL service:
  - Adult day services
  - Adult family care
  - Attendant care
  - Home modifications
  - Home-delivered meals
  - Home and community assistance
  - Personal emergency response system
  - Pest control
  - Respite
  - Structured family caregiving
  - Transportation

Provider Qualifications

Provider qualifications for AL service are presented in the following table.

Table 4 – Provider Qualifications for Assisted Living

Waiver	Provider	Licensure/ Certification	Other Standards
A&D, TBI	Licensed Assisted Living Agencies	*IC 16-28-2*	DA approved *410 IAC 16.2-5*

Attendant Care

The following subsections provide information and requirements for attendant care services.

Service Definition

Attendant care services are provided to participants with nursing facility level-of-care needs. Attendant care services provide direct, hands-on care to participants for the functional needs with ADLs. The participant is the employer for Participant-Directed Attendant Care, or appoints a representative to be the employer on their behalf. For the TBI waiver, attendant care services are provided to participants with either nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID) level-of-care needs.

Allowable Activities

Attendant care includes all nonskilled ADL care as identified in the PCA, which includes but is not limited to the following:

- Provides assistance with personal care, which includes:
  - Bathing, partial bathing
  - Oral hygiene
  - Hair care including clipping of hair
  - Shaving
  - Hand and foot care
  - Intact skin care
  - Application of cosmetics
  - Dressing
- Provides assistance with mobility, which includes:
  - Proper body mechanics
  - Transfers
  - Ambulation
  - Use of assistive devices
- Provides assistance with elimination, which includes:
  - Assistance with bedpan, bedside commode, toilet
  - Incontinent or involuntary care
  - Emptying urine collection and colostomy bags
- Provides assistance with nutrition, which includes:
  - Meal planning
  - Meal preparation
  - Clean-up
- Provides assistance with safety, which includes:
  - Use of the principles of health and safety in relation to self and individual
  - Identification and elimination of safety hazards
  - Practicing health protection and cleanliness by appropriate techniques of hand washing
  - Waste disposal and household tasks
  - Reminding the participant to self-administer medications
  - Providing assistance with correspondence and bill paying

  - Transportation of individuals to nonmedical community activities (*Note: Out-of-state transportation is limited to 50 miles of State geographic limits. Escorting of participants does not include mileage or other costs that are not associated with the provision of personal care.*)

Service Standards

Attendant care services may be provided from the following:

- Agency – An agency enrolled in the program is responsible to hire and render services
- Nonagency/solo provider – The solo provider classification refers to an individual (as opposed to an agency) operating under their SSN and operating without employees.
- Participant-directed – The participant is the employer and acts as the agency directing his or her own care.

If direct care or monitoring of care is not provided to the client and the documentation of services rendered for the units billed reflects home and community assistance duties, an entry must be made to indicate why the direct care was not provided for that day. If direct care or supervision of care is not provided for more than 30 days and the documentation of services rendered for the units billed reflects home and community assistance duties, the care manager must be contacted to amend the service plan to do one of the following:

- Add home and community assistance services and eliminate attendant care.
- Reduce attendant care hours and replace with the appropriate number of hours of home and community assistance services.

Documentation Standards

The care manager must follow these documentation standards:

- Document the medical need for attendant care and types of ADL care the participant may require.
- Document the type of attendant care (attendant care or participant-directed) determined to meet the needs of the individual or caregiver through the PCA.
- Document the attendant care activity that will meet the participant's needs and assure it is accurately documented in the LOC E-screen.
- If the participant is skilled LOC (SK-LOC), document how the skilled-care need is being met and by whom. If attendant care is being requested for an individual with skilled care, documentation must describe the following:
  - Who will be providing attendant care
  - Frequency of care
  - Activities being performed
- If the attendant care is participant-directed, documentation must describe the following:
  - Who the employer is
  - Who the employee/direct worker is and their relationship to the participant (include POA, guardian status as well)

Attendant care providers must follow these documentation standards:

- In addition to electronic visit verification (EVV), providers will record services provided, including:
  - Complete date and time of service (in and out)
  - Specific services/tasks provided

  - Signature of participant verifying the service was provided by agency
  - Signature of employee providing the service (minimally the last name and first initial) (*Note: If the person providing the service is required to be a professional, the title must also be included.*)

- Each staff member providing direct care or supervision of care to the participant must make at least one entry on each day of service.
- Documentation of service delivery is to be signed by the participant or designated participant representative.
- Notification to the participant's care manager within 48 hours of any changes in the participant's person-centered service plan.

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Activities Not Allowed

The following activities are not allowed and will not be reimbursed under attendant care services:

- Services provided to people with unstable medical needs as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician, or other health professional
- Services provided for a participant regarding specialized feeding (such as difficulty swallowing, refuses to eat, or does not eat enough), unless permitted under law and not duplication of State Plan services
- Hoyer lift and weight bearing transfer assistance (*Note: These services should be considered for State Plan Home Health Services or respite home health aide under the supervision of a registered nurse.*)
- Services provided to a participant requiring management of the following (which must be considered for respite nursing services unless permitted under law and not a duplication of State Plan services):
  - Uncontrolled seizures
  - Infusion therapy
  - Venipuncture
  - Injection
  - Wound care for decubitus or incision
  - Ostomy care
  - Tube feedings
- Services provided as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician, or other health professional
- Setting up and administering medications
- Assisting with catheter and ostomy care
- Services provided to household members other than to the participant
- Services provided when the owner of the agency is one of the following:
  - Parent of a minor child participant
  - Spouse of a participant
  - Attorney-in-fact (or POA) of a participant

  - HCR of a participant
  - Legal guardian of a participant
- Services provided to participants receiving any of the following waiver services:
  - Adult family care
  - Structured family caregiving
  - Assisted living

Provider Qualifications

Provider qualifications for ATTC services are presented in the following table.

Table 5 – Provider Qualifications for Attendant Care

Waiver	Provider	Licensure/ Certification	Other Standards
A&D, TBI	Licensed Home Health Agency	*IC 16-27-1 IC 16-27-4*	DA approved
A&D, TBI	Licensed Personal Services Agency	*IC 16-27-4*	DA approved
A&D, TBI	FSSA DA-approved Attendant Care Individual	*IC 16-27-4*	DA approved *455 IAC 2* Provider qualifications; General requirements *455 IAC 2* General requirements for direct care staff *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements *455 IAC 2* Personnel records The division may reject any applicant with a conviction of a crime against persons or property, a conviction for fraud or abuse in any federal, state, or local government program, (*42 USC §1320a-7*) or a conviction for illegal drug possession. The division may reject an applicant convicted of the use, manufacture, or distribution of illegal drugs (*42 USC §1320a7*). The division may reject an applicant who lacks the character and fitness to render services to the dependent population or whose criminal background check shows that the applicant may pose a danger to the dependent population. The division may limit an applicant with a criminal background to caring for a family member only if the family member has been informed of the criminal background. Compliance with *IC 16-27-4*, if applicable.

Behavior Management/Behavior Program and Counseling

The following subsections provide information and requirements for behavior management/behavior program and counseling provided under the TBI waiver.

Service Definition

Behavior management includes training, supervision, or assistance in appropriate expression of emotions and desires, assertiveness, acquisition of socially appropriate behaviors, and the reduction of inappropriate behaviors for members who receive TBI services.

Behavior plans must be developed, monitored, and amended by a master's level psychologist or a master's in special education, supervised by an individual with a doctor of philosophy (PhD) in behavioral science. Persons providing behavior management/behavior program and counseling services who are employed by a qualified agency must be a master's level behaviorist, a Certified Brain Injury Specialist (CBIS), a Qualified Mental Retardation Professional (QMRP), a Qualified Intellectual Disability Professional (QIDP), or a Certified Social Worker who is supervised by a master's level behaviorist. An individual practitioner providing this service must be a master's level behaviorist.

Allowable Activities

The following activities are allowed under behavior management/behavior program and counseling services:

- Observation of the individual and environment for purposes of developing a plan and determining a baseline
- Developing a behavioral support plan and subsequent revisions
- Training in assertiveness
- Training in stress reduction techniques
- Training in the acquisition of socially accepted behaviors
- Training staff, family members, roommates, and other appropriate individuals in implementing the behavior support plan
- Consultation with members
- Consultation with a health service provider in psychology (HSPP)

Service Standards

The following service standards must be met:

- Behavior management/behavior program and counseling services must follow a written service plan addressing specific needs determined by the individual's assessment.
- The behavior specialist will observe the individual in his or her own environment and develop a specific plan to address identified issues.
- The efficacy of the plan must be reviewed no less than quarterly and adjusted as necessary.
- The behavior specialist will provide a written report to pertinent parties at least quarterly. "Pertinent parties" include the individual, guardian, waiver care manager, all service providers, and other involved entities.

Documentation Standards

The following documentation standards must be met for behavior management/behavior program and counseling services:

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

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Activities Not Allowed

The following activities are not allowed or reimbursed under behavior management/behavior program and counseling services:

- Aversive techniques
- Any techniques not approved by the individual's person-centered planning team and the DA
- Services when provided as an individual provider by any of the following:
  - Parent of a minor child participant
  - Spouse of a participant
  - Attorney-in-fact (or POA) of a participant
  - HCR of a participant
  - Legal guardian of a participant

Provider Qualifications

Provider qualifications for behavior management/behavior program and counseling services are presented in the following table.

Table 6 – Provider Qualifications for Behavior Management/ Behavior Program and Counseling

Waiver	Provider	Licensure/ Certification	Other Standards
TBI	FSSA DA-approved Behavior Management/ Behavior Program and Counseling Individual	Not required	DA approved *455 IAC 2* Provider qualifications; General requirements *455 IAC 2* General requirements for direct care staff *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements *455 IAC 2* Personnel records An individual practitioner providing this service must be a master's level behaviorist.
TBI	FSSA DA-approved Behavior Management/ Behavioral Program and Counseling Agency	Not required	DA approved *455 IAC 2* Provider qualifications; General requirements *455 IAC 2* General requirements for direct care staff *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements *455 IAC 2* Personnel records

Care Management

The following subsections provide information and requirements for care management.

Service Definition

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

Allowable Activities

The following activities are allowed under the Care Management service:

- Person-centered assessment and planning:
  - Includes but is not limited to discovering the participant's strengths, needs, goals, and preferences.
  - Appropriate facilitation of the assessment process to engage the participant and their circle of support. The assessment and planning phase can include but is not limited to, brokering community resources, action and/or service planning, and eligibility for funded services.
- Development and implementation of a person-centered support plan, including action and/or service plans:
  - Action planning is a process to determine community resources to meet the participant's functional and social needs.
  - Service planning is a process to determine funded services and eligibility to appropriately meet the participant's needs.

- Monitoring and evaluating all action and/or service plans:
  - Care managers are responsible to monitor progress for all services displayed on the action and/or service plans.
  - The care manager will provide and coordinate high quality services to the participant, while promoting seamless, integrated, coordinated care.
  - The care manager will monitor person-centered support plans in a face-to-face contact every 90 days from the initial service plan activation. When the initial care plan is activated, the care manager will either call or visit the participant within 30 days and no more than 40 days from initial service plan activation to ensure implementation of services.
  - The care manager is responsible to complete annual person-centered assessments, including eligibility and service planning.
  - The care manager will be responsible to evaluate the effectiveness of all services. Evaluation is demonstrated through but not limited to the following:
    - Monitoring the progress from identifying need to meeting goals and/or preferences identified by the participant
    - Direct collaboration and coordination with providers to ensure services are within the participant's preferences
    - Adjusting action and service plans appropriately to identify changing needs that meet the participant's needs
- Termination of plans
  - The care manager will follow the DA HCBS Waiver termination procedures when a participant is no longer eligible to receive services under the waiver program. This includes providing a 30-day notice to any participant the care manager is terminating.
- Transition follow-up
  - The care manager must ensure that participants fully understand their ability to make choices concerning all services they receive, including care management services.
  - In the event the participant chooses another care management agency, the current care management agency fully assists the participant in his or her transition to the new agency or individual care manager of choice. The goal is to ensure a seamless transition for the participant.

Service Standards

These service standards must be followed for Care Management:

- Care management services must be reflected in the service plan of the participant.
  - Care managers enhance the participant's functional and social well-being.
  - Care managers broker community resources that align with the participant's unique needs.
- Care managers will engage the participant and his or her circle of support in all aspects of the care management process and tailor the person-centered support plan to the participant's needs, preferences, goals, and strengths.
- The care manager is expected to coordinate and collaborate with other care managers, other organizations, community partners, and DA staff to ensure quality care management is being delivered and options are being discovered and presented to the participant to optimize his or her overall functioning capability.
- A care manager's maximum Medicaid waiver caseload is not to exceed 65 participants at any time.
- Care managers are responsible for the following:
  - Identifying when a participant is residing in a provider-owned or -controlled setting
  - Monitoring HCBS characteristics
  - Monitoring person-centered modifications to HCBS characteristics and documenting them in the PCA as such

Documentation Standards

The care manager must follow these documentation standards:

- Development and implementation of a person-centered support plan, including action and/or service plans (as described in the *Allowable Activities* section)
- Completes annual person-centered assessments, including eligibility and service planning
- Completes all assessment tools, including but not limited to timely incident reports

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Activities Not Allowed

The following activities are not allowed under the Care Management service:

- Care management may not be conducted by any organization, entity, or participant that also delivers other in-home and community-based services, or by any organization, entity, or participant related by common ownership or control to any other organization, entity, or participant who also delivers other in-home and community-based services, unless the organization is an Area Agency on Aging (AAA) that has been granted permission by the FSSA DA to provide direct services to participants. Prior to billing, a care manager must have completed the care management curriculum to become a Medicaid certified care manager.

> *Note: Common ownership exists when a participant, or any legal entity possess ownership or equity of at least 5% in the provider as well as the institution or organization serving the provider. Control exists where a participant or organization has the power or the ability, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not actually exercised. Related means associated or affiliated with, or having the ability to control, or be controlled by.*

- Independent care managers and independent care management agencies may not provide initial applications for Medicaid waiver services.
- Reimbursement of care management under Medicaid waivers may not be made unless and until the participant becomes eligible for Medicaid waiver services. Care management provided to participants who are not eligible for Medicaid waiver services will not be reimbursed as a Medicaid waiver service.
- Care management services will not be reimbursed when the owner of the agency is one of the following:
  - Parent of a minor child participant
  - Spouse of a participant
  - Attorney-in fact (or POA) of a participant
  - HCR of a participant
  - Legal guardian of a participant

Provider Qualifications

Provider qualifications for care management services are presented in the following table. Prior to billing, a care manager must have completed the care management curriculum to become a Medicaid certified care manager.

Table 7 – Provider Qualifications for Care Management

Waiver	Provider	Licensure/ Certification	Other Standards
A&D, TBI	FSSA DA-approved Care Management Individual	Not required	DA, or its designee, approved *455 IAC 2* Documentation of qualifications *455 IAC 2* Care management Liability insurance Training in the nursing facility LOC process by the DA or designee Education and work experience: • A Qualified Intellectual Disability Professional (QIDP) who meets the requirements at *42 CFR 483.430* • A registered nurse with 1 year of experience in human services • A bachelor's degree in social work, psychology, sociology, counseling, gerontology, or nursing; health and human services • A bachelor's degree in any field with a minimum of 2 years of full-time, direct-service experience with the elderly or disabled (this experience includes assessment, care plan development, and monitoring) • A master's degree in a related field may substitute for the required experience
A&D	FSSA/DA-approved Care Management Agency	Not required	DA, or its designee, approved *455 IAC 2* Provider qualifications; General requirements *455 IAC 2* General requirements for direct care staff *455 IAC 2* Procedures for protecting individuals *455 IAC 2* Unusual occurrence; reporting *455 IAC 2* Transfer of individual's record upon change of provider *455 IAC 2* Notice of termination of services *455 IAC 2* Provider organizational chart *455 IAC 2* Collaboration and quality control *455 IAC 2* Data collection and reporting standards *455 IAC 2* Quality assurance and quality improvement system *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC 2* Documentation of qualifications *455 IAC 2* Maintenance of personnel records *455 IAC 2* Adoption of personnel policies *455 IAC 2* Operations manual *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Individual's personal file; site of service delivery

Waiver	Provider	Licensure/ Certification	Other Standards
			455 IAC 2 Maintenance of records of services provided *455 IAC 2* Care management Training in the nursing facility level of care process by the DA or designee – education and work experience: • An individual continuously employed as a care manager by an Area Agency on Aging (AAA) since January 1, 1990 • A Qualified Intellectual Disability Professional who meets the requirements at *42 CFR 483.430* • A registered nurse with 1 year of experience in human services • A bachelor's degree in social work, psychology, sociology, counseling, gerontology, nursing or health and human services • A bachelor's degree in any field with a minimum of 2 years full-time, direct service experience with the elderly or disabled (this experience includes assessment, care plan development, and monitoring) • A master's degree in a related field may substitute for the required experience
TBI	FSSA DA-approved Care Management Agency	Not Required	DA, or its designee, approved *455 IAC 2* Provider qualifications; General requirements *455 IAC 2* General requirements for direct care staff *455 IAC 2* Procedures for protecting individuals *455 IAC 2* Unusual occurrence; reporting *455 IAC 2* Transfer of individual's record upon change of provider *455 IAC* 2 Notice of termination of services *455 IAC 2* Provider organizational chart *455 IAC 2* Collaboration and quality control *455 IAC 2* Data collection and reporting standards *455 IAC 2* Quality assurance and quality improvement system *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC 2* Documentation of qualifications *455 IAC 2* Maintenance of personnel records *455 IAC 2* Adoption of personnel policies *455 IAC 2* Operations manual *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Individual's personal file; site of service delivery *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Individual's personal file; site of service delivery *455 IAC* 2 Care management Education and work experience • A Qualified Intellectual Disability Professional who meets the requirements at *42 CFR 483.430* • A registered nurse with 1 year of experience in human services

Waiver	Provider	Licensure/ Certification	Other Standards
			• A bachelor's degree in social work, psychology, sociology, counseling, gerontology, or nursing • A bachelor's degree in any field with a minimum of 2 years of full-time, direct service experience with the elderly or disabled (this experience includes assessment, care plan development, and monitoring) • A master's degree in a related field may substitute for the required experience

Community Transition

The following subsections provide information and requirements for community transition services.

Service Definition

Community transition services include but are not limited to reasonable setup expenses for participants who make the transition from an institution to their own home, where the person is directly responsible for his or her own living expenses in the community. Community transition services will not be reimbursable on any subsequent move.

> *Note: "Own home" is defined for this service as any dwelling – including a house, an apartment, a condominium, a trailer, or other lodging – that is owned, leased, or rented by the participant or the participant's guardian or family, or a home that is owned or operated by the agency providing supports.*

Items purchased through community transition are the property of the participant individual receiving the service, and the participant individual takes the property with him or her when moving to another residence, even if the residence from which he or she is moving is owned by a provider agency. Nursing facilities are not reimbursed for community transition because those services are part of the *per diem*. For participants receiving this service under the waiver, approved community transition expenditures are reimbursed through the local Area Agency on Aging (AAA) or DA-approved provider that maintains all applicable receipts and verifies the delivery of services. Providers can directly communicate with the State Medicaid Agency at the provider's election.

Allowable Activities

The following activities are allowed under community transition services:

- Security deposits and application fees that are required to obtain a lease on an apartment or home
- Essential (not luxury) furnishings and moving expenses required to occupy and use a community domicile, including but not limited to a bed, table and chairs, window coverings, one land-line telephone, eating utensils, housekeeping supplies, food preparation items, microwave, hygiene products, and bed and bath linens
- Setup 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

> *Note: If the participant lacks the required government-issued identification items to secure housing or utilities (including but not limited to birth certificate, Social Security card, state ID, and state driver's license), costs related to obtaining these items are also covered under CTS.*

Service Standards

Community transition services must follow a written service plan addressing specific needs determined by the PCA.

Documentation Standards

The care manager must follow these documentation standards:

- Document the need for CTS and reasonable furnishings or set-up expenses being requested by the participant (determined through the PCA) in the service plan.
- Outline the services in the service plan.
- Maintain receipts for all expenditures, showing the amount and what item or deposit was covered.
- If a care manager requests the full $1,500 lifetime cap (described in the *Limitations* section) and not all funds are used, the care manager must complete a service plan update to reduce the amount to ensure Medicaid is not over-reimbursing for these services.

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

The following restrictions are made for community transition services:

- Reimbursement for community transition is limited to a lifetime cap for setup expenses of up to $1,500.
- When the participant is discharged from the facility, the community transition service must be identified, ordered, delivered, and reimbursed within 3 months.

Activities Not Allowed

The following activities are not allowed through community transition services:

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

Provider Qualifications

Provider qualifications for community transition services are presented in the following table.

Table 8 – Provider Qualifications for Community Transition

Waiver	Provider	Licensure/ Certification	Other Standards
A&D, TBI	FSSA DA-approved Community Transition Service Agency	Not required	DA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Transfer of individual's record upon change of provider *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC 2* Transportation of an individual *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Maintenance of personnel records *455 IAC 2* Adoption of personnel policies *455 IAC 2* Operations manual *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Individual's personal file; site of service delivery

Home and Community Assistance

The following subsections provide information and requirements for home and community assistance services.

Service Definition

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

Allowable Activities

The following activities are allowed under the home and community assistance services:

- IADL care that may include but are not limited to the following:
  - Dusting and straightening furniture
  - Cleaning floors and rugs by wet or dry mop and vacuum sweeping
  - Cleaning the kitchen, including washing dishes, pots, and pans; cleaning the outside of appliances and counters and cupboards; cleaning ovens; and defrosting and cleaning refrigerators
  - Maintaining a clean bathroom, including cleaning the tub, shower, sink, toilet bowl, and medicine cabinet; emptying and cleaning commode chair or urinal
  - Laundering clothes in the home or laundromat, including washing, drying, folding, putting away, ironing, and basic mending and repair

  - Changing linen and making beds
  - Washing insides of windows
  - Removing trash from the home
- Assistance with meal planning and preparation, including special diets under the supervision of a registered dietitian or health professional
- Completing essential errands and/or unassisted transportation for nonmedical, community activities
- Assistance with correspondence and bill paying
- Minor pet care *(Note: This activity may be allowed at the discretion of the agency.)*
- Assistance with outdoor tasks including raking leaves, snow removal, lawn mowing, and weeding

Service Standards

These service standards must be followed:

- Home and community assistance services must follow a written service plan addressing specific needs determined by the client's assessment.
- The care manager will document through the PCA the need for HMK, the frequency of need, the required type of HMK activities.

Documentation Standards

The care manager will document the following through the PCA:

- Need for home and community assistance
- Frequency of need
- Required type of home and community assistance activities

Home and community assistance providers are responsible for the following documentation standards:

- Data record of services provided must include the following:
  - Complete date and time of service (in and out)
  - Specific services/tasks provided
  - Notification to the participant's care manager, within 48 hours, upon any changes in the participant's person-centered service plan
  - Time spent traveling and completing the errand as well as the specific tasks and necessity of the task being completed (for errands such as using a laundromat due to there not being a washer or dryer in the participant's home)

    Note: If home and community assistance services take place outside the participant's home (such as errands being required due to no washer/dryer in home, or travel for other allowable tasks), travel expenses beyond the time spent on the errand are the responsibility of the agency providing home and community assistance services.

  - Signature of employee providing the service (minimally the last name and first initial) (*Note: If the person providing the service is required to be a professional, that title must also be included.*)
- Each staff member providing direct care or supervision of care to the participant must make at least one entry on each day of service. All entries should describe an issue or circumstance concerning the participant.

- Documentation of service delivery is to be signed by the participant or designated participant representative.

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Activities Not Allowed

The following services are not allowed under home and community assistance services:

- Assistance with ADL hands-on care (*Note: Specifically home and community assistance services do not include any ADL assistance, such as eating, bathing, dressing, personal hygiene, or medication setup and administration.*)
- Transportation, or assisted transportation, of participants to community activities or errands
- Home and community assistance services provided to household members other than to the participant
- Home and community assistance services when the owner of the organization is one of the following:
  - Parent of a minor child participant
  - Spouse of a participant
  - Attorney-in-fact (or POA) of a participant
  - HCR of a participant
  - Legal guardian of the participant
  - Any member of the participant's household
- Services provided to participants receiving any of the following waiver services:
  - Adult family care
  - Structured family caregiving
  - Assisted living

Provider Qualifications

Provider qualifications for home and community assistance services are presented in the following table.

Table 9 – Provider Qualifications for Home and Community Assistance Services

Waiver	Provider	Licensure/ Certification	Other Standards
A&D, TBI	Licensed Personal Services Agency	*IC 16-27-4*	DA approved

Waiver	Provider	Licensure/ Certification	Other Standards
A&D, TBI	FSSA/DA- approved Homemaker Individual	Not required	DA approved *455 IAC 2* Provider qualifications: becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: general requirements *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements *455 IAC 2* Personnel records Compliance with *IC 16-27-4*, if applicable
A&D, TBI	Licensed Home Health Agency	*IC 16-27-1* *IC 16-27-4*	DA approved

Home-Delivered Meals

The following subsections provide information and requirements for home-delivered meals.

Service Definition

A home-delivered meal is a nutritionally balanced meal. This service is essential in preventing institutionalization, because the absence of proper nutrition in individuals with frail and disabling conditions presents a severe risk to health. No more than two meals per day will be reimbursed under the waiver.

Allowable Activities

The home-delivered meals service may include but is not limited to:

- Provision of meals
- Diet and nutrition counseling provided by a registered dietician
- Nutritional education
- Diet modification according to a physician's order, as required, meeting the individual's medical and nutritional needs

Service Standards

These service standards must be followed:

- Home-delivered meals services must follow a written service plan addressing specific needs determined by the participant's PCA.
- Home-delivered meals services will be provided to persons who are unable to prepare their own meals and for whom there are no other persons available to do so or where the provision of a home-delivered meal is the most cost-effective method of delivering a nutritionally adequate meal and it is not otherwise available through other funding sources.

- All meals provided under the home-delivered meals service must meet State, local, and federal laws and regulations regarding the safe handling of food. The provider must also hold adequate and current Servsafe certification.
- All meals provided under the home-delivered meals service must contain at least one-third of the current daily recommended dietary allowance (RDA) as established by the Food and Nutrition Board of the National Academy of Sciences, National Research Council, including but not limited to the following foods:.
  - A variety of vegetables (dark green, red, and orange), legumes (beans and peas), and starchy and other vegetables
  - Fruits, especially whole fruit
  - Grains, at least half of which are whole grain
  - Fat-free or low-fat dairy, including milk, yogurt, cheese, and/or fortified soy beverages
  - A variety of protein foods, including seafood, lean meats and poultry, eggs, legumes (beans and peas), soy products, and nuts and seeds
  - Oils, including those from plants: canola, corn, olive, peanut, safflower, soybean, and sunflower. Oils also are naturally present in nuts, seeds, seafood, olives, and avocados
- Meals shall contain less than 10% daily calories from added sugars unless prior DA or registered dietitian approval is received.
- Meals shall contain less than 10% of daily calories from saturated fats unless prior DA or registered dietitian approval is received.
- Meals shall contain less than 2,300 mg of sodium per day unless prior DA or registered dietitian approval is received.

Documentation Standards

These documentation standards must be followed:

- The care manager is responsible for documenting the need for HDM and the amount being requested.
- The provider is responsible for the following:
  - Documenting the date of delivery, how many meals are included, and the name of the care professional or care manager that involved the participant
  - Documenting any food allergies, food preferences, or gluten sensitivity for waiver participants
  - Ensuring date of expiration is included on all meals
  - Providing either written or oral instruction for:
    - Appropriate storage of meal
    - Preparing meal

Note: If applicable, copies of personal record must be:

- *Placed in a prominent place in the participant's file*
- *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Activities Not Allowed

The following activities are not allowed or reimbursed under home-delivered meals:

- More than two meals per day
- Services provided to participants receiving either of the following waiver services:
  - Adult family care
  - Assisted living

Provider Qualifications

Provider qualifications for home-delivered meals services are presented in the following table.

Table 10 – Provider Qualifications for Home-Delivered Meals

Waiver	Provider	Licensure/ Certification	Other Standards
A&D, TBI	FSSA DA-approved Home Delivered Meals Agency	Not required	DA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Liability insurance *455 IAC 2* Maintenance of records of services provided Must comply with all state and local health laws and ordinances concerning preparation, handling, and serving of food.

Home Modification Assessment

The following subsections provide information and requirements for home modification assessment services under the A&D Waiver.

Service Definition

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

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

The assessor will be responsible for writing the specifications, review of feasibility, and the post-project inspection:

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

Allowable Activities

The home modification assessment service includes the following activities:

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

Service Standards

These service standards must be followed for the home modification assessment:

- The need for home modification must be indicated in the participant's plan of care.
- The modification must address the participant's level-of-service needs.
- Proposed specifications for the modification must conform to the requirements and limitations of the current approved service definition for Home Modifications.
- The assessment should be conducted by an approved, qualified individual who is independent of the entity providing the home modifications.
- The appropriate authority must be contacted regarding potential code violations.

Documentation Standards

These documentation standards must be followed:

- The need for home modification must be indicated in the participant's plan of care.
- The modification must address the participant's level-of-service needs.
- Any discrepancy noted by the provider, care manager, and/or participant shall be detailed in the final inspection, and addressed by the assessor.

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

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

Activities Not Allowed

The following activities are not allowed:

- Home modification assessment services will not be reimbursed when owner of the organization is any of the following:
  - Parent of a minor child participant
  - Spouse of a participant
  - Attorney-in fact (or POA) of a participant
  - HCR of a participant
  - Legal guardian of a participant
- Payment will not be made for home modifications under this service.
- Payment will not be made for a home modification assessment for the maintenance, repair, or service of an existing home modification that was funded by an HCBS waiver.

Provider Qualifications

Provider qualifications for home modification assessment services are presented in the following table.

Table 11 – Provider Qualifications for Environmental Modification Assessor

Waiver	Provider	Licensure/ Certification	Other Standards
A&D	FSSA DA-approved Environmental Modification Assessment Individual	One of the following: • License: *IC 2520.2* Home Inspector • Certified Aging-In-Place Specialist (CAPS Certification – National Association of Home Builders) • Executive Certificate in Home Modifications (University of Southern California) Verification required every 3 years	DA Approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC* 2 Professional qualifications and requirements; documentation of qualifications *455 IAC* 2 Warranty required Compliance with applicable building codes and permits

Home Modifications

The following subsections provide information and requirements for the home modifications service.

Service Definition

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

Home Ownership

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

Choice of Provider

The participant chooses the certified providers to submit bids for the home modifications. If the participant chooses to continue with the home modification after receiving the bids, then the lowest bid that meets the minimum requirements shall be chosen, such as, timeframe to start service. There is a minimum requirement to gather two bids for any expected amount over $5,000.

Allowable Activities

Modifications allowed under the home modifications service may include but are not limited to the following:

- Adaptive door openers and locks
- Bathroom modification – including but not limited to:
  - Removal of existing bathtub, toilet, and/or sink
  - Installation of roll-in shower, grab bars, toilet, and sink
  - Installation of replacement incidental items (such as flooring, storage space, and cabinets) that are necessary due to the bath modification
- Home control units − Adaptive switches and buttons to operate medical equipment, communication devices, heat and air conditioning, and lights for an individual living alone or who is alone without a caregiver for a substantial portion of the day.
- Kitchen modification, including but not limited to:
  - Removal of existing cabinets and sink
  - Installation of sink and cabinet
  - Installation of replacement incidental items (such as flooring, storage space, and cabinets) if necessary due to kitchen modification
- Home safety devices such as:
  - Door alarms
  - Anti-scald devices
  - Hand-held shower head
  - Grab bars for the bathroom
- Ramp – including but not limited to: portable (considered for rental property only) and permanent
- Single room air or portable conditioner(s)/single room air purifier(s):
- Vertical lift and/or stair lift
- Widening of doorways, including:
  - Exterior
  - Interior bedroom, bathroom, kitchen door, or any internal doorway as needed to allow for access. Pocket doors may be requested.
- Windows − Replacement of glass with Plexi-glass or other shatterproof material when there is a documented medical or behavioral reason
- Matching interior – Upon completion of the modification, the room being modified will be matched to the degree possible with the same paint, wall texture, wall coverings, doors, trim, flooring, and so on to the previous color/style/design.

Items requested that are not listed in this section must be reviewed and a decision rendered by the State DA director or State agency designee.

Service Standards

All home modifications must be approved by the waiver program prior to services being rendered.

The care manager must follow these service standards:

- Document the need for home modification assessment.

- Share expected modification requests identified by the participant determined through the PCA to the assessor.
- Collect two bids if the cost is over $5,000.00.

  If only one bid is obtained, the care manager must document the date of contact, the provider name, and why a bid was not obtained from another provider.
- Notify the DA of any discrepancies or complaints about the work while it is being completed. Notice must be provided to the DA within 48 hours upon learning of the issues.
- Ensure that before and after drawings are submitted for bathroom, kitchen, and ramps.
- Ensure that bid contains warranty information.
- If a home assessor is available in the county where the participant lives, then
- All participants must receive a home modification assessment if a provider is available in that county, with a certified waiver provider selected by the participant prior to any subsequent home modifications as well as a home modification inspection upon completion of the work.

The provider must meet these standards:

- The need for home modification must be indicated in the participant's service plan.
- Proposed specifications for modification must conform to the requirements and limitations of the current approved service definition for home modification services.
- Providers are required to provide a written warranty for a new product or service in the form of a binding document stating that, for a period of not less than 1 year, the service provider shall replace or repair any product or installation.
- If the State agency determines the provider is at fault for poor and/or incorrect work during the home modification, then the provider is responsible for correcting work at the cost of the provider.
- Bid must contain warranty information.
- Before and after drawings are required for bathroom, kitchen, and ramps.
- Bid must be itemized with cost for each major component of the modification.
- Prohibited from placing residential liens.
- Home modification requests must be provided in accordance with applicable State and/or local building codes. Home modifications must be compliant with applicable building codes.
- A land survey may be required when exterior modifications approach the property line.
- Providers of services must maintain receipts for all incurred expenses related to the modification; must be in compliance with FSSA and DA-specific guidelines and/or policies.
- Notification to the participant's care manager and DA of any discrepancies or complaints about the work while it is being completed. Notice must be provided to the DA within 48 hours upon learning of the issues.

Documentation Standards

The care manager must provide documentation/explanation of the service within the Request for Approval to Authorize Services (RFA) including the following:

- Property owner of the residence where the requested modification is proposed
- Property owner's relationship to the participant
- What, if any, relationship the property owner has to the waiver program

- Written agreement of landlord or home owner for modification, including agreement about items purchased during the modification, such as a bathtub, upon participant moving from the property or eviction.

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

The following limits apply for the home modifications service:

- A lifetime cap of $20,000 is available for home modifications – installation (procedure code and modifier S5165 U7 NU); however, the cap on any single project is $15,000. The cap represents a cost for basic modification of a participant's home for accessibility and safety and accommodates the participant's needs for housing modifications.
- The cost of a home modification includes all materials, equipment, labor, and permits to complete the project. No parts of a home modification may be billed separately as part of any other service category (such as specialized medical equipment).
- In addition to the $20,000 lifetime cap, $1,000 is allowable annually for the repair, replacement, or an adjustment to an existing home modification that was funded by an HCBS waiver.
- Home modification – maintenance is limited to $1,000 annually for the repair and service of environmental modifications that have been provided through an HCBS waiver. The following apply for these home modification maintenance services:
  - Requests for service must detail parts cost and labor cost.
  - If the need for maintenance exceeds $1,000, the care manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor funded through a nonwaiver funding source.
- Items requested that are not listed in the *Allowable Activities* section must be reviewed and decision rendered by the State DA director or State agency designee.
- Requests for modifications at two or more locations may only be approved at the discretion of the DA director or designee.
- Requests for modifications may be denied if the State DA director or State agency designee determines the documentation does not support residential stability and/or the service requested.

The services under home modifications are limited to additional services not otherwise covered under the Medicaid State Plan, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), but consistent with waiver objectives of avoiding institutionalization.

Activities Not Allowed

Activities not allowed under home modifications include but are not limited to the following:

- adaptations or improvements that are not of direct medical or remedial benefit to the participant, such as:
  - Central heating and air conditioning
  - Routine home maintenance

  - Roof repair
  - Structural repair that is not incidental to the original modification
  - Driveways, decks, patios, sidewalks, and household furnishings
  - Swimming pools, spas, or hot tubs
  - Outside storage spaces
  - Home security systems
- Modifications that create living space or facilities where they did not previously exist (for example, installation of a bathroom in a garage/basement, and so on)
- Modifications that will add non-incidental square footage to the home
- Home modification services for participants living in foster homes, group homes, assisted living facilities, or homes for special services (any licensed residential facility) (*Note: The responsibility for home modifications rests with the facility owner or operator*.)
- Home modification services for participants living in a provider-owned or controlled residence (*Note: The responsibility for home modifications rests with the facility owner or operator*.)
- Completion of, or modifications to, new construction or significant remodeling/reconstruction, unless there is documented evidence of a significant change in the participant's medical or remedial needs that now require the requested modification
- Home modification services when the owner of the organization is any of the following:
  - Parent of a minor child participant
  - Spouse of a participant
  - Attorney-in fact (or POA) of a participant
  - HCR of a participant
  - Legal guardian of a participant

Provider Qualifications

Provider qualifications for home modifications are presented in the following table.

Table 12 – Provider Qualifications for Home Modifications

Waiver	Provider	Licensure/ Certification	Other Standards
A&D, TBI	FSSA/DA-approved Environmental Modification Individual	Any applicable licensure must be in place	DA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Warranty required Compliance with applicable building codes and permits

Waiver	Provider	Licensure/ Certification	Other Standards
A&D, TBI	FSSA/DA-approved Environmental Modification Agency/ Contractor	Any applicable licensure *IC 25-20.2* Home inspector *IC 25-28.5* Plumber *IC 25-23.5* Evaluator Certification *IC 25-4* Architect	DA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Warranty required Compliance with applicable building codes and permits
A&D, TBI	Plumber	*IC 25-28.5*	DA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Warranty required Compliance with applicable building codes and permits
A&D, TBI	Architect	*IC 25-4*	DA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Warranty required Compliance with applicable building codes and permits

Integrated Healthcare Coordination

The following subsections provide information and requirements for integrated healthcare coordination for the A&D Waiver.

Service Definition

Integrated healthcare coordination is to promote improved health status and quality of life, delay/prevent deterioration of health status, manage chronic conditions in collaboration with physicians, and integrate medical and social services.

Healthcare coordination includes medical coordination provided by an RN, LPN, or licensed social worker (LSW) to manage the healthcare of the individual including physician consults, medication ordering, and development and nursing oversight of a healthcare support plan. Skilled nursing services are provided within the scope of the *Indiana State Nurse Practice Act*. The purpose of healthcare coordination is stabilization, delaying/preventing deterioration of health status, management of chronic conditions, and/or improved health status. Health care coordination is open to any waiver participant whose needs demonstrate the need for such level of service without duplicating other formal and informal supports.

Allowable Activities

IHCC may include the following activities:

- Development and oversight of a healthcare support plan that includes coordination of medical care and proactive care management of both chronic diseases and complex conditions such as falls, depression, and dementia (*Note: Skilled nursing services are provided within the scope of the Indiana State Nurse Practice Act*.)
- Physician collaboration
- Medication review
- Transitional care from hospital or nursing facility to home/assisted living
- Advance care planning

Service Standards

These service standards must be followed for integrated healthcare coordination:

- Weekly consultations or reviews
- Face-to-face visits with the participant; including a minimum of one face-to-face visit per month
- No duplication of services provided under integrated healthcare coordination with to services provided under the Medicaid State Plan or under any other waiver service
- Services must address needs in the plan of care.

The care manager is expected to coordinate and collaborate with other care managers, other organizations, community partners, healthcare professionals, and DA staff to ensure quality care management is being delivered and options are being discovered and presented to the individual to optimize their overall functioning capability.

Documentation Standards

These documentation standards must be followed for integrated healthcare coordination:

- Current Indiana RN license for each nurse;
- Current Indiana license for LPN
- Current Indiana license for social worker (LSW) with master's degree in social work with additional documentation of at least 2 years of experience providing health care coordination

- Evidence of a consultation, including complete date and signature (*Note: Consultation can be with the participant, informal caregivers, other staff, other professionals, as well as healthcare professionals.*)
  - Weekly consultations or reviews
  - Minimum of one face-to-face visit with the participant per month
- Services required to address needs identified in the plan of care or PCA
- Written report provided to pertinent parties at least quarterly by the IHCC provider (*Note: Pertinent parties include the participant, guardian, waiver care manager, all waiver service providers* including mental health providers, *State Plan services, and physicians.*)

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

Integrated healthcare coordination is not to exceed 16 hours per month, including travel time.

Integrated healthcare coordination services will not duplicate services provided under the Medicaid State Plan or any other waiver service.

IHCC services are:

- A minimum of one face-to-face visit per month
- Not to exceed 16 hours of healthcare coordination per month, including travel time

Activities Not Allowed

The following activities are not allowed under integrated healthcare coordination:

- Skilled nursing services that are available under the Medicaid State Plan
- Any other service otherwise provided by the waiver

Provider Qualifications

Provider qualifications for integrated healthcare coordination are presented in the following table.

Table 13 – Provider Qualifications for Integrated Healthcare Coordination

Waiver	Provider	Licensure/ Certification	Other Standards
A&D	Licensed Home Health Agency	*IC 16-27-1* Home Health Agency *IC 25-23-1* RN	DA approved

Nonmedical Transportation

The following subsections provide information and requirements for nonmedical transportation services.

Service Definition

Nonmedical transportation services are offered to enable participants served under the waiver to gain access to waiver and other nonmedical community services, activities, and resources, specified by the service plan.

Service Standards

These service standards must be followed for nonmedical transportation waiver services:

- Transportation services must follow a written service plan addressing specific needs determined by the participant's PCA.
- This service is offered in addition to medical transportation required under *42 CFR 431.53* and transportation services under the Medicaid State Plan, defined at *42 CFR 440.170(a)* (if applicable), and shall not replace them.
- Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be used.

Transportation services are reimbursed as three types of service:

- Nonassisted Transportation − The participant does not require mechanical assistance to transfer in and out of the vehicle.
- Assisted Transportation − The participant requires mechanical assistance to transfer into and out of the vehicle.
- Adult Day Service Transportation − The participant requires round-trip transportation to access adult day services.

Documentation Standards

These documentation standards must be followed for transportation waiver services:

- Identified need in the service plan
- Services outlined in the service plan
- Documentation, maintained by the provider or its agent, that the provider meets and maintains the requirements for providing services under *455 IAC 2*
- Specify applicable (if any) limits on the amount, frequency, or duration of this service.

Note: If applicable, copies of personal record must be:

- *Placed in a prominent place in the participant's file*
- *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

Services provided under nonmedical transportation services will not duplicate services provided under the Medicaid State Plan or any other waiver service.

Activities Not Allowed

The following activities are not allowed under the nonmedical transportation waiver service:

- Services available through the Medicaid State Plan (*Note: A Medicaid State Plan prior authorization denial is required before reimbursement is available through the Medicaid waiver for this service.*)
- Services provided to participants receiving any of the following waiver services:
  - Adult family care
  - Assisted living

Provider Qualifications

Provider qualifications for nonmedical transportation waiver services are presented in the following table.

Table 14 – Provider Qualifications for Nonmedical Transportation

Waiver	Provider	Licensure/ Certification	Other Standards
A&D, TBI	Licensed Home Health Agency	*IC 16-27-1*	DA approved Compliance with applicable vehicle/driver licensure for vehicle being utilized
A&D, TBI	FSSA DA-approved Transportation Agency	Not required	DA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: general requirements *455 IAC 2* General requirements for direct care staff *455 IAC 2* Procedures for protecting individuals *455 IAC 2* Unusual occurrence; reporting *455 IAC 2* Transfer of individual's record upon change of provider *455 IAC 2* Notice of termination of services *455 IAC 2* Provider organizational chart *455 IAC 2* Collaboration and quality control *455 IAC 2* Data collection and reporting standards *455 IAC 2* Quality assurance and quality improvement system *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC 2* Transportation of an individual *455 IAC 2* Documentation of qualifications *455 IAC 2* Maintenance of personnel records *455 IAC 2* Adoption of personnel policies *455 IAC 2* Operations manual

Waiver	Provider	Licensure/ Certification	Other Standards
			455 IAC 2 Maintenance of records of services provided *455 IAC 2* Individual's personal file; site of service delivery Compliance with applicable vehicle/driver licensure for vehicle being utilized

Nutritional Supplements

The following subsections provide information and requirements for the Nutritional Supplements service.

Service Definition

Nutritional (dietary) supplements include liquid supplements, such as Boost or Ensure, to maintain an individual's health, so they are able to remain in the community.

Supplements must be ordered by a physician, physician assistant, or nurse practitioner.

Approved nutritional supplement expenditures are reimbursed through the local AAA, which maintains all applicable receipts and verifies the delivery of services. Providers can directly communicate with the State Medicaid Agency at the provider's election.

Allowable Activities

The nutritional supplements service includes enteral formulae, category 1, such as Boost or Ensure.

Service Standards

Nutritional supplements services must follow a written service plan addressing specific needs determined by the individual's PCA.

Documentation Standards

The care manager must complete these documentation tasks:

- Document the need for nutritional supplements and amount being requested.
- Identify the amount requesting from the annual cap of $1,200 for nutritional supplemental services.

The provider must follow document the following:

- Date of delivery
- How many meals were provided
- Care professional or care manager that involved the participant

Note: If applicable, copies of personal record must be:

- *Placed in a prominent place in the participant's file*
- *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

An annual cap of $1,200 is available for nutritional supplements services.

Activities Not Allowed

The following activities are not allowed under nutritional supplements:

- Services available through the Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before reimbursement is available through the Medicaid waiver for this service)

Provider Qualifications

Provider qualifications for the Nutritional Supplements service are presented in the following table.

Table 15 – Provider Qualifications for Nutritional Supplements

Waiver	Provider	Licensure/ Certification	Other Standards
A&D, TBI	FSSA DA-approved Nutritional Supplements Agency	Not required	DA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Transfer of individual's record upon change of provider *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Liability insurance *455 IAC 2* Individual's personal file; site of service delivery

Participant-Directed Home Care Service

The following subsections provide information and requirements for Participant-Directed Home Care Service (PDHCS) under the A&D waiver.

Service Definition

The PDHCS is a health-related service under the A&D waiver that can be performed by either licensed or trained nonmedical personnel, and is provided for the primary purpose of meeting chronic medical needs and maintaining, as opposed to improving, a level of function to an extent that allows for a participant to avoid unnecessary institutionalization.

Initially, PDHCS will be limited to the 46202 and 46204 ZIP codes. This is a new service and if successful, then the expectation would be make it available in more areas of the state.

Limitations

PCHCS has the following limitations:

- PDHCS is offered to Aged and Disabled Waiver participants.

- PDHCS is offered to participants who receive State Plan Home Health Skilled Care.
- PDHCS is offered to individuals in a non-congregate setting.
- PDHCS is offered to individuals living alone without family or other informal supports willing and able to be trained to care for the participant and assume a portion of the participant's care.
- PDHCS is offered to individuals able to direct their own care.
- PDHCS is offered to individuals with a stable and chronic medical condition as diagnosed by a physician (MD/DO) or nurse practitioner, evidenced by a physician's or nurse practitioner's order.
- PDHCS is offered to individuals 21 years or older.
- PDHCS is offered to individuals residing in postal codes 46202 and 46202
- PDHCS does not include administration of level II, III, IV, and V medications.

Documentation Standards

The care manager must maintain these documentation standards:

- Provide a current assessment, including scope, frequency, duration and activities of PDHCS, which documents the participant's needs.
- Assess the needs of the participant through a person-centered planning process. The care manager is required to develop a person-centered plan to meet those needs and create a service request (expressed in service units and cost reimbursement services); the care manager must document the budget process and review with the participant.
- Responsible for documenting the medical need for a skilled service and types of skilled care the participant may require.
- Responsible for documenting the frequency, duration, and types of appropriate skilled activities.
- Responsible for documenting the skilled activity that will meet the participant's needs and assuring it is accurately documented in the skilled level of care E-screen.
- Responsible for monitoring the service delivery every month. The care manager shall coordinate service delivery (frequency, activities) with the employee/direct worker and also contact the fiscal intermediary agency to verify.
- Responsible for conducting monthly face-to-face visits with participants.
- Responsible for completing face-to-face assessments, including the Person Centered Monitoring tool every quarter and annually.
- Responsible for documenting the backup plan for the participant for when the direct worker is unavailable to deliver skilled care.
- Responsible for having participant sign a waiver liability form.
- Responsible for documenting who is the employer, who is the employee/direct worker, and their relationship to the participant.
- Responsible for completing the participant-directed checklist before the service may be added to the service plan and at the initial, quarter review, annual and re-entry assessments.

- Responsible for monitoring the enrollment process for the participant and their employee/direct worker.
- Responsible for collecting all training paperwork containing signatures for the file.

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Activities Not Allowed

The following activities are not allowed under PDHCS:

- Home Care Service shall not be reimbursed when provided by the attorney-in fact (POA) of a participant, the health care representative (HCR) of a participant, or the legal guardian of a participant.
- Participant must be able to direct their own care.

Provider Standards

The caregiver applicant must enter into the IHCP agreement to become a paid caregiver. The caregiver will be authorized to provide home care attendant services to participants if the individual:

- Either meets the personnel qualifications specified in *IC.16-27-1* or successfully completed the following, as applicable (verified by the fiscal intermediary):
  - If applicable, a competency evaluation program or training and competency evaluation program approved or conducted under section 10.2.2 of the American Association of Respiratory Care (AARC) Clinical Practice Guideline
  - A program that includes cardiopulmonary resuscitation (CPR), basic first aid, and any applicable durable medical equipment (DME) training
- Identifies and documents participant need in the provider service plan:
  - Services must be outlined in the provider service plan.
  - Data record of services must be provided and maintained, including:
    - Complete date and time of service (in and out)
    - Specific services or tasks provided
    - Signature of paid caregiver providing the service (minimally the last name and first initial)
  - Each paid caregiver providing direct care or supervision of care to the participant must make at least one entry on each day of service. All entries must describe an issue or circumstance offered to the individual.
  - Daily documentation of service delivery is to be signed by the participant. If the participant cannot sign, then the paid caregiver must self-attest and sign in lieu of the participant. The paid caregiver is required to coordinate information about the participant's care, including backup plan, with any and all other providers and care manager rendering services to the participant. Provider coordination shall occur among providers/paid caregivers during shift changes for the participant and at any other time where the participant experiences a healthcare change.

Personal Emergency Response System

The following subsections provide information and requirements for the Personal emergency response system (PERS) service.

Service Definition

The PERS is an electronic device that enables certain participants at high risk of institutionalization to secure help in an emergency. The participant may also wear a portable help button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center after a button is activated. The response center is staffed 24 hours a day, 7 days a week by trained professionals.

Allowable Activities

The following activities are allowed under the PERS service:

- Device installation
- Ongoing monthly maintenance of the device
- Electronic service that is usually a portal help button; however, it can also be an electronic device that includes, but is not limited to GPS or video monitoring service (*Note: Remote monitoring will not be placed in participant bedrooms or bathrooms.*)

Service Standards

The PERS service must follow a written service plan addressing specific needs determined by the individual's assessment.

The care manager is required to contact the waiver participant if contacted by the PERS provider that waiver participant experienced a fall.

Documentation Standards

The care manager is responsible for the documenting the following:

- The need for PERS
- The need for PERS maintenance
- Whether the person is residing alone or alone for significant parts of the day without a caregiver present

The provider is responsible for documenting the following:

- Date of installation
- Expense for installation
- Monthly rental fee
- Ongoing monthly maintenance of device
- Monthly written notification to care managers of any participant who experienced a fall within a 1-month time frame

The monitor positions would be determined during the person-centered service planning process.

Persons responsible for monitoring would be determined during the person-centered service planning process.

The mainframe location would be determined by the provider.

The State confirms there is a backup plan in the event of equipment failure.

The care manager is the central vehicle for the State to provide information to the participant, his or her family, and the entire circle of support. This is part of the person-centered planning process, which would include the provider.

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Activities Not Allowed

The following activities are not allowed under the PERS service:

- Replacement cost of lost or damaged equipment
- Services provided to participants receiving the assisted living or adult family care waiver services

Provider Qualifications

Provider qualifications for the PERS service are presented in the following table.

Table 16 – Provider Qualifications for Personal Emergency Response System

Waiver	Provider	Licensure/ Certification	Other Standards
A&D, TBI	FSSA DA-approved Personal Emergency Response System Agency	Not required	DA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Warranty required Compliance with applicable building codes and permits

Pest Control

The following subsections provide information and requirements for pest control services.

Service Definition

Pest control services are designed to prevent, suppress, or eradicate anything that competes with humans for food and water, injures humans, spreads disease to humans, or annoys humans, and is causing or is

expected to cause more harm than is reasonable to accept. Pests include but are not limited to insects such as roaches, mosquitoes, bed bugs, and fleas; insect-like organisms, such as mites and ticks; and vertebrates, such as rats and mice.

Services to control pests are services that prevent, suppress, or eradicate pest infestation.

Reimbursement for approved pest control expenditures is through the local AAA, which maintains all applicable receipts and verifies the delivery of services. Providers can directly communicate with to the State Medicaid agency at the provider's election.

Allowable Activities

Pest control services are added to the service plan when the care manager determines – either through direct observation or by participant report – that a pest is present and is causing or is expected to cause more harm than is reasonable to accept.

Services to control pests are services that prevent, suppress, or eradicate pest infestation.

Service Standards

Pest control services must follow a written service plan addressing specific needs determined by the individual's PCA.

Documentation Standards

The care manager is responsible for documenting the following through the PCA:

- Need for pest control
- Types of pests to eradicate

Note: If applicable, copies of personal record must be:

- *Placed in a prominent place in the participant's file*
- *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

An annual cap of $4,000 is available for pest control services.

Activities Not Allowed

The following activities are not allowed under the pest control service:

- Services used solely as a preventative measure (*Note: There must be documentation of a need for this service either through the care manager's direct observation or participant report that a pest is causing or is expected to cause more harm than is reasonable to accept.*)
- Services provided to participants receiving either of the following waiver services:
  - Adult family care
  - Assisted living

- Preventive measures or ongoing need for service
- Eradication or prevention of mold or mold-like substances

Provider Qualifications

Provider qualifications for pest control services are presented in the following table.

Table 17 – Provider Qualifications for Pest Control

Waiver	Provider	Licensure/ Certification	Other Standards
A&D, TBI	FSSA DA-approved Pest Control Agency	*IC 15-3-3.6*	DA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Warranty required Pesticide applicators must be certified or licensed through the Purdue University Extension Service and the Office of the Indiana State Chemist.

Residential-Based Habilitation

The following subsections provide information and requirements for residential-based habilitation under the TBI waiver.

Service Definition

Residential-based habilitation service provides training to regain skills that were lost secondary to the traumatic brain injury (TBI).

Allowable Activities

Residential-based habilitation services include goal-oriented training and demonstration with the following:

- Skills related to activities of daily living:
  - Personal grooming
  - Bed making and household chores
  - Planning meals and the preparation of food
- Skills related to living in the community:
  - Using the telephone
  - Learning to prepare lists and maintaining calendars of essential activities and dates, and other organizational activities to improve memory
  - Handling money and paying bills

  - Shopping and errands
  - Accessing public transportation

Service Standards

The following service standards must be met:

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

Documentation Standards

Documentation standards for residential-based habilitation include the following:

- Identified need in the service plan
- Services outlined in the service plan
- A data record of services provided, including:
  - Complete date and time of service (in and out)
  - Specific services/tasks provided
- Monthly documentation of progress toward identified goals
- Signature of employee providing the service (minimally the last name and first initial) (*Note: If the person providing the service is required to be a professional, the title of the individual must also be included.*)
- At least one entry on each day of service from each staff member providing direct care or supervision of care to the individual (*Note: All entries should describe an issue or circumstance concerning the individual.*)
- Documentation of service delivery signed by the participant or designated participant representative.

Note: If applicable, copies of personal record must be:

- *Placed in a prominent place in the participant's file*
- *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

Services provided through residential-based habilitation service will not duplicate services provided under the Medicaid State Plan or any other waiver service.

Activities Not Allowed

Activities that are not reimbursed under residential-based habilitation include the following:

- Payments for room and board
- Payments made directly or indirectly when services are provided as an individual provider by any of the following:
  - Parent of a minor child participant

  - Spouse of a participant
  - Attorney-in-fact (or POA) of a participant
  - HCR of a participant
  - Legal guardian of a participant
- Routine care and supervision
- Residential-based habilitation services to participants receiving adult family care waiver service

Provider Qualifications

Provider qualifications for residential-based habilitation are presented in the following table.

Table 18 – Provider Qualifications for Residential-Based Habilitation

Waiver	Provider	Licensure/ Certification	Other Standards
TBI	FSSA DA-approved Residential Based Habilitation Agency	Not required	DA approved *455 IAC 2* Provider qualifications; general requirements *455 IAC 2* General requirements for direct care staff *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements *455 IAC 2* Personnel records Habilitation services must be performed by persons who are supervised by: a Certified Brain Injury Specialist (CBIS); a Qualified Mental Retardation Professional (QMRP); Qualified Intellectual Disability Professional (QIDP); or a physical, occupational, or speech therapist licensed by the state of Indiana who has successfully completed training or has experience in conducting habilitation programs.

Respite Services

The following subsections provide information and requirements for respite services.

Service Definition

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

Allowable Activities

The following activities are allowed under respite services:

- Home health aide services
- Skilled nursing services

Service may be provided in home and community-based settings.

Service Standards

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

The level of professional care provided under respite services depends on the needs of the participant and caregiver determined in the PCA. The service standards under respite care are as follows:

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

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

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

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

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

Documentation Standards

The care manager is responsible for the following documentation standards:

- Identify the primary caregiver being relieved; identify that the primary caregiver is not being paid by the agency to respite themselves during this time.
- Document needs and activities that require respite.

The provider is responsible for the following documentation standards:

- Complete a data record of staff to participant service, documenting the complete date and time in and time out, and the number of units of service delivered that day.
- Ensure that each staff member providing direct care or supervision of care to the participant makes at least one entry on each day of service describing an issue or circumstance concerning the participant.
- Include date and time, and at least the last name and first initial of the staff person making the entry in documentation. (*Note: If the person providing the service is required to be a professional, include that title – for example, if a nurse is required to perform the service, the RN title would be included with the name.*)
- Document any significant issues involving the participant that require intervention by a healthcare professional; also document the care manager that involved the participant.
- Include the following elements: the reason for the respite and the type of respite rendered.
- Provide notification to the participant's care manager and other unskilled provider, within 48 hours, upon changes to the participant's person-centered service plan.

> *Note: If applicable, copies of personal record must be:*
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Activities Not Allowed

The following activities are not allowed under respite services:

- Replacing services that should be provided under the Medicaid State Plan
- Provided when the owner of the organization is one the following:
  - Parent of a minor child participant
  - Spouse of a participant
  - Attorney-in-fact (or POA) of a participant
  - HCR of a participant
  - Legal guardian of a participant
- Duplication of any other service being provided under the participant's service plan
- Services provided to participants receiving any of the following waiver services:
  - Adult family care
  - Assisted living

Provider Qualifications

Provider qualifications for respite services are presented in the following table.

Table 19 – Provider Qualifications for Respite

Waiver	Provider	Licensure/ Certification	Other Standards
A&D, TBI	Licensed Home Health Agency	*IC 16-27-1*	DA approved

Specialized Medical Equipment and Supplies

The following subsections provide information and requirements for specialized medical equipment and supplies.

Service Definition

The specialized medical equipment and supplies service includes medically prescribed items required by the participant's service plan, which assist the participant in maintaining his or her health, welfare and safety, and enable the participant to function with greater independence in the home. The specialized medical equipment and supplies service provides therapeutic benefits to a participant in need, because of certain medical conditions and/or illnesses. Specialized medical equipment and supplies primarily and customarily are used to serve a medical purpose and are not useful to a person in the absence of illness or injury. All specialized medical equipment and supplies must be approved by the waiver program prior to the service being rendered.

- Participants requesting authorization for this service through an HCBS waiver must first exhaust eligibility of the desired equipment or supplies through the Indiana Medicaid State Plan, which may

require prior authorization (PA). The Division of Aging will deny any provider claim that did not follow the correct Medicaid billing practices:

- There should be no duplication of services between HCBS waiver and Medicaid State Plan.
- The refusal of a Medicaid vendor to accept the Medicaid reimbursement through the Medicaid State Plan is not a justification for waiver purchase.
- Preference for a specific brand name is not a medically necessary justification for waiver purchase. The Medicaid State Plan often covers like equipment but may not cover the specific brand requested. When this occurs, the participant is limited to the service/brand covered by the Medicaid State Plan.
- Reimbursement is limited to the Medicaid State Plan fee schedule, if the requested item is covered under Medicaid State Plan.
- All requests for items to be purchased through a Medicaid waiver must be accompanied by documentation of Medicaid State Plan PA request and decision, if requested item is covered under State Plan.

- Requests will be denied if the DA director or designee determines the documentation does not support the service requested.

Allowable Activities

The services under Specialized Medical Equipment and Supplies are limited to additional services not otherwise covered under the Medicaid State Plan (including EPSDT), but consistent with waiver objective of avoiding institutionalization.

Justification and documentation are required to demonstrate that the request is necessary to meet the participant's identified needs.

The following are allowable activities under specialized medical equipment and supplies:

- Lift chairs – The HCBS program will cover the chair. Medicaid State Plan should be pursued first for prior approval of the lift mechanism.
- Medication dispensers
- Toileting and/or incontinence supplies that do not duplicate Medicaid State Plan Services
- Slip-resistant socks
- Self-help devices – including over-the-bed tables, reachers, adaptive plates, bowls, cups, drinking glasses, and eating utensils
- Strollers – when needed because participant's primary mobility device does not fit into the participant's vehicle/mode of transportation, or when the participant does not require the full time use of a mobility device, but a stroller is needed to meet the mobility needs of the participant outside of the home setting.
- Voice active smart devices
- Interpreter service – provided in circumstances where the interpreter assists the individual in communication during specified scheduled meetings for service planning (such as waiver case conferences or team meetings) and is not available to facilitate communication for other service provision.

Note: Items requested that are not listed in this section will be submitted in the service plan and reviewed by the State DA director.

Service Standards

The following service standards must be met for the specialized medical equipment and supplies service:

- All items must be of direct medical or remedial benefit to the participant.
- All items must meet applicable standards of manufacture, design, and service specifications.

Documentation Standards

The care manager is responsible for the following documentation standards:

- Document the need for medical specialized equipment.
- Describe how the equipment is expected to improve the participant's quality of ADL.
- Collect two bids if over $1,000; if only one bid is obtained, the care manager must document the date of contact, the provider name, and why the bid was not obtained from another provider.
- Ensure that bid contains warranty information and picture of the equipment.
- Submit State Plan denial information for the equipment and/or supplies.

The provider must follow these document standards:

- Document date of installation.
- Document expense for installation.
- Document the identified direct benefit or need within the following:
  - Person-centered service plan
  - Physician prescription and/or clinical evaluation as deemed appropriate
- Obtain Medicaid State Plan prior authorization (PA) request and the decision rendered, if applicable.
- Obtain signed and approved Request for Approval to Authorize Services (RFA).
- Obtain signed and approved person-centered service plan.
- Maintain receipts for all incurred expenses related to this service.
- Must be in compliance with FSSA and DA-specific guidelines and/or policies.

Note: If applicable, copies of personal record must be:

- *Placed in a prominent place in the participant's file*
- *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

Maintenance is limited to $1,000 annually for the repair and service of items that have been provided through an HCBS waiver:

- Requests for service must detail parts and labor costs.
- If the need for maintenance exceeds $1,000, the care manager works with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, parts and labor costs funded through the waiver must be itemized clearly to differentiate parts and labor costs provided by the waiver service from parts and labor provided through a nonwaiver funding source.

Activities Not Allowed

The following activities are not allowed under specialized medical equipment and supplies:

- Unallowable items including, but not limited to the following:
  - Hospital beds or air fluidized suspension mattresses/beds
  - Therapy mats
  - Parallel bars
  - Scales
  - Paraffin machines or baths
  - Therapy balls
  - Books, games, or toys
  - Electronics such as CD players, radios, cassette players, tape recorders, television, VCRs/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, or hot water heater
  - Indoor and outdoor play equipment such as swing sets, swings, slides, bicycles adaptive tricycles, trampolines, play houses, or merry-go-rounds
  - Swimming pools, spas, hot tubs, or portable whirlpool pumps
  - Adjustable mattresses (such as, but not limited to, Tempur-Pedic), positioning devices, or pillows
  - Motorized scooters
  - Barrier creams, lotions, or personal cleaning cloths
  - Essential oils
  - Totally enclosed cribs and barred enclosures used for restraint purposes
  - Manual wheelchairs
  - Vehicle modifications
- Any equipment or items that can be authorized through the Medicaid State Plan
- Any equipment or items purchased or obtained by the participant, his or her family members, or other nonwaiver providers

Provider Qualifications

Provider qualifications for specialized medical equipment and supplies are presented in the following table.

Table 20 – Provider Qualifications for Specialized Medical Equipment and Supplies

Waiver	Provider	Licensure/ Certification	Other Standards
A&D, TBI	Licensed Home Health Agency	*IC 16-27-1*	DA approved *455 IAC 2* Warranty required

Waiver	Provider	Licensure/ Certification	Other Standards
A&D, TBI	FSSA DA-approved Specialized Medical Equipment and Supplies Agency	*IC 25-26-21 Certification IC 6-2.5-8-1*	DA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: general requirements *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Warranty required

Structured Day Program

The following subsections provide information and requirements for structured day program services covered under the TBI Waiver.

Service Definition

The structured day program provides assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that takes place in a nonresidential setting, separate from the home in which the individual resides. Services will normally be furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, unless provided as an adjunct to other day activities included in an individual's service plan.

Service Standards

The following service standards must be met for the structured day program:

- Must follow a written service plan addressing specific needs determined by the individual's assessment.
- Shall focus on enabling the individual to attain or maintain his or her functional level.
- May serve to reinforce skills or lessons taught in school, therapy, or other settings.

Documentation Standards

The following service standards must be met:

- Identified need in the service plan
- Services outlined in the service plan
- Data record of services provided, including:
  - Complete date and time of service (in and out)
  - Specific services/tasks provided
  - Signature of the employee providing the service (minimally the last name and first initial) (*Note: If the person providing the service is required to be a professional, the title of the individual must also be included.*)

- At least one entry on each day of service from each staff member providing direct care or supervision of care to the individual (*Note: All entries should describe an issue or circumstance concerning the individual.*)

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

Services provided through structured day programs should not duplicate any services provided under the Medicaid State Plan or other waiver service.

Provider Qualifications

Provider qualifications for structured day program are presented in the following table.

Table 21 – Provider Qualifications for Structured Day Program

Waiver	Provider	Licensure/ Certification	Other Standards
TBI	FSSA DA-approved Structured Day Program Agency	Not required	DA approved *455 IAC 2* Provider Qualifications; General requirements *455 IAC 2* General requirements for direct care staff *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements *455 IAC 2* Personnel Records Habilitation services must be performed by persons who are supervised by a CBIS; QMRP; QIDP; or a physical, occupational, or speech therapist licensed by the state of Indiana and have successfully completed training or have experience in conducting habilitation programs.

Structured Family Caregiving

The following subsections provide information and requirements for structured family caregiving under the A&D Waiver.

Service Definition

Structured family caregiving means a caregiving arrangement in which a participant lives with a principal caregiver who provides daily care and support to the participant based on the participant's daily care needs.

The principal caregiver may be a nonfamily member or a family member who lives with the participant in the private home of the participant or the principal caregiver.

Necessary support services are provided by the principal caregiver (family caregiver) as part of structured family caregiving service. Caregivers must be qualified to meet all federal and State regulatory guidelines, and be able to provide care and support to a participant based on the participant's assessed needs. Caregivers receive training based on the participant's assessed needs and are paid a per diem stipend for the care and support they provide to participants.

Structured family caregiving preserves the dignity, self-respect and privacy of the participant by ensuring high-quality care in a non-institutional setting. The goal of this service is to provide necessary care while fostering and emphasizing the participant's independence in a home environment that will provide the participant with a range of care options as the needs of the participant change. The goal is reached through a cooperative relationship between the participant (or the participant's legal guardian), the caregiver, HCBS Medicaid waiver care manager and the structured family caregiving provider. Participant needs will be addressed in a manner that supports and enables the individual to maximize abilities to function at the highest level of independence possible, while caregivers receive initial and ongoing support so they can provide high quality care. The service is designed to provide options for alternative long-term care to persons who meet nursing facility level of care and whose needs can be met in structured family caregiving.

Only agencies may be structured family caregiving providers, with the home settings being assessed and accessible, and caregivers being qualified as able to meet the participant's needs. The provider agency must conduct at a minimum of two quarterly home visits. Additional home visits and ongoing communication with the caregiver is based on the assessed needs of the participant and the caregiver. Home visits are conducted by a registered nurse and/or a caregiver coach as determined by a person-centered plan of care. The provider agency must capture daily notes that are completed by the family caregiver in an electronic format, and use the information collected to monitor participant health and caregiver support needs. The agency provider must make such notes available to waiver care managers and the State, upon request.

Allowable Activities

Structured family caregiving includes the following activities (Levels 1-3):

- Home and community assistance care services related to needed IADLs
- Attendant care services related to needed ADLs
- Medication oversight (to the extent permitted under State law)
- Escorting to necessary appointments, whenever possible, such as transporting individuals to doctor appointments and community activities that are therapeutic in nature or assists with maintaining natural supports
- Caregivers not living in the home of the participant if this arrangement began prior to February 1, 2020
- Unskilled respite for the family caregiver for a maximum of 15 days per calendar year (*Note: Funding for this respite is included in the per diem paid to the service provider; the actual respite service may not be billed in addition to the per diem.*)
- Other appropriate supports as described in the individual's service plan

Service Standards

These service standards must be followed for structured family caregiving:

- Agency providers must demonstrate 3 years of delivering services to elders and adults with disabilities and their caregivers in Indiana or as a Medicaid participating provider in another state or have a national accreditation.
- Structured family caregiving must be reflected in the participant's service plan and address specific needs determined by the participant's PCA.
- Agency providers develop, implement, and provide ongoing management and support of a person-centered service plan that addresses the participant's level of service needs.
- The supports provided within the home are managed and completed throughout the day based on the participant's daily needs.
- Structured family caregiving is provided in a private residence and affords all the rights, dignity, and qualities of living in a private residence including privacy, comfortable surroundings, and the opportunity to modify one's living area to suit one's individual preferences.
- Provider agencies must conduct, at a minimum, two quarterly home visits based on the participant's assessed needs and caregiver coaching needs, but the actual frequency of visits should be based on the participant's assessed needs and caregiver coaching needs.
- Caregivers receive a minimum of 8 hours in-person annual training that reflects the participant's and caregiver's assessed needs. Training may be delivered during quarterly home visits, or in another manner that is flexible and meaningful for the caregiver.
- Agency providers must work with participants and caregivers to establish backup plans for emergencies and other times when the principal caregiver is unable to provide care.
- Paid unskilled respite services must be provided by a qualified caregiver familiar with the participant's needs during those times when the primary caregiver is absent from the home or otherwise cannot provide the necessary level of care.
- Structured family caregiving emphasizes the participant's independence in a setting that protects and encourages the participant's dignity, choice, and decision-making while preserving self-respect.
- Employees of agency providers who provide medication oversight, as addressed in the *Allowable Activities* subsection, must receive necessary instruction from a doctor, nurse, or pharmacist regarding medications prescribed to the participant.

Documentation Standards

These documentation standards must be followed for structured family caregiving:

- Identified need in the service plan
- Services outlined in the service plan
- Completed PCA given to the provider by the care manager
- Documentation to support service rendered, including:
  - Electronic caregiver notes that record and track the participant's status, updates or significant changes in their health status or behaviors, and participation in community-based activities and other notable or reportable events
  - Medication management records, if applicable

- Regular review of caregiver notes by agency provider to:
  - Understand and respond to changes in the participant's health status and identify potential new issues in an effort to better communicate changes with the participant's doctors or healthcare providers and avoid unnecessary hospitalizations or emergency room use
  - Document, investigate, and refer reportable events to the waiver care manager
- Documentation of home visits conducted by the registered nurse and caregiver coach
- Documentation of education, skills training, and coaching conducted with the caregiver
- Documentation demonstrating collaboration and communication with other service providers and healthcare professionals (as appropriate), waiver care managers and other caregivers or individuals important to the participant regarding changes in the participant's health status and reportable events
- Documentation of all qualified caregivers (including paid respite caregivers)

Note: If applicable, copies of personal record must be:

- *Placed in a prominent place in the participant's file*
- *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Activities Not Allowed

The following activities are not allowed under structured family caregiving:

- Structured family caregiving service provided as a participant provider by any of the following:
  - Parent of a minor child participant
  - Spouse of a participant
  - Attorney-in-fact (or POA) of a participant
  - HCR of a participant
  - Legal guardian of a participant
- Personal care services provided to medically unstable or medically complex participants as a substitute for care provided by a registered nurse, licensed practical nurse, licensed nurse, or other health professional

Separate payment will not be made for any of the following waiver services:

- Adult family care
- Assisted living
- Attendant care
- Home and Community Assistance
- Transportation

Provider Qualifications

Provider qualifications for structured family caregiving are presented in the following table.

Table 22 – Provider Qualifications for Structured Family Caregiving

Waiver	Provider	Licensure/ Certification	Other Standards
A&D	FSSA DA-approved Structured Family Caregiving Agency	Not required	Provider and home must meet the requirements of the *Indiana AFC Service Provision and Certification Standards*. DA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: general requirements *455 IAC* 2 General requirements for direct care staff *455 IAC 2* Procedures for protecting individuals *455 IAC 2* Unusual occurrence; reporting *455 IAC 2* Transfer of individual's record upon change of provider *455 IAC 2* Notice of termination of services *455 IAC 2* Provider organizational chart *455 IAC 2* Collaboration and quality control *455 IAC 2* Data collection and reporting standards *455 IAC 2* Quality assurance and quality improvement system *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC 2* Transportation of an individual *455 IAC 2* Documentation of qualifications *455 IAC 2* Maintenance of personnel records *455 IAC 2* Adoption of personnel policies *455 IAC 2* Operations manual *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Individual's personal file; site of service delivery

Supported Employment

The following subsections provide information and requirements for supported employment services under the TBI Waiver.

Service Definition

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

Service Standards

The following service standards must be met:

- Supported employment services must follow a written service plan addressing specific needs determined by the individual's assessment.
- When supported employment services are provided at a worksite where persons without disabilities are employed, payment will be made only for the adaptation, supervision, and training required by individuals receiving waiver services as a result of their disabilities and will not include payment for supervisory activities rendered as a normal part of the business setting.
- Supported employment services furnished under the waiver must be services that are not available under a program funded by either the *Rehabilitation Act of 1973* or *Public Law PL 94-142*.

Documentation Standards

The following documentation standards must be met for supported employment services:

- Identified need in the service plan
- Services outlined in the service plan
- Data record of services provided, including:
  - Complete date and time of service (in and out)
  - Specific services /tasks provided
  - Signature of employee providing the service (minimally the last name and first initial) (*Note: If the person providing the service is required to be a professional, the title of the individual must also be included.*)
- At least one entry on each day of service made by each staff member providing direct care or supervision of care to the individual (*Note: All entries should describe an issue or circumstance concerning the individual.*)
- Documentation must be maintained in the file of each individual receiving this service, showing that the service is not otherwise available under a program funded under the *Rehabilitation Act of 1973* or *PL 94-142*.

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

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

Activities Not Allowed

The following activities are not allowed under the supported employment service:

- Services funded under the *Rehabilitation Act of 1973* or *PL 94-142*

- Reimbursement for supervisory activities rendered as a normal part of standard business procedures in a business setting where persons without disabilities are also employed
- Reimbursement for incentive payments, subsidies, or unrelated vocational training expenses for the following:
  - Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program
  - Payments that are passed through to users of supported employment programs
  - Payments for vocational training that are not directly related to an individual's employment program

Provider Qualifications

Provider qualifications for the supported employment service are presented in the following table.

Table 23 – Provider Qualifications for Supported Employment

Waiver	Provider	Licensure/ Certification	Other Standards
TBI	FSSA DA-approved Supported Employment Agency	Certification from the Commission on Accreditation of Rehabilitation Facilities (CARF)	DA approved *455 IAC 2* Provider qualifications; general requirements *455 IAC 2* General requirements for direct care staff *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements *455 IAC 2* Personnel records
TBI	FSSA DA-approved Community Mental Health Center	Not required	DA approved *455 IAC 2* Provider qualifications; general requirements *455 IAC 2* General requirements for direct care staff *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements *455 IAC 2* Personnel records *IC 12-7-2-38(1)* Community Mental Health Center

Vehicle Modifications

The following subsections provide information and requirements for vehicle modifications and vehicle modifications maintenance.

Service Definition

Vehicle modifications are the addition of adaptive equipment or structural changes to a motor vehicle that will empower a participant to have safe transportation in a motor vehicle.

Allowable Activities

Justification and documentation are required to demonstrate that the modification is necessary to meet the participant's identified need(s).

The following are allowable under the vehicle modifications service:

- 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

Maintenance is limited to $1,000.00 annually for repair and service of items that have been funded through a HCBS waiver:

- Requests for service must differentiate between parts and labor costs.
- If the need for maintenance exceeds $1,000 the care manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a nonwaiver funding source.

> *Note: Items requested that are not listed in this section, must be reviewed and decision rendered by the State division director or State agency designee.*

Service Standards

These service standards must be followed:

- The vehicle to be modified must meet all the following:
  - The participant or primary caregiver 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 participant's sole or primary means of transportation.
  - The vehicle is not registered to or titled by an FSSA-approved provider.
  - Only one vehicle per a participant's household may be modified.
- Many automobile manufacturers offer a rebate of up to $1,000 for participants purchasing a new vehicle requiring modifications for accessibility. To obtain the rebate, the participant is required to submit to the manufacturer documented expenditures of modifications. If the rebate is available, it must be applied to the cost of the modifications.
- Requests for modifications may be denied if the DA director or designee determines the documentation does not support the service requested.
- All vehicle modifications must be approved by the waiver program prior to services being rendered.

Documentation Standards

The care manager is responsible for the following documentation standards:

- Document the medical need for vehicle modifications determined to meet the needs of the participant through the PCA.
- Describe the specific modification being requested to the vehicle.
- Collect two bids if over $1,000; if only one bid is obtained, the care manager must document the date of contact, the provider name, and why the bid was not obtained from another provider.
- Submit warranty information from the provider to the DA.
- Ensure that a picture of vehicle modification is included with the bid.

The provider is responsible for the following documentation standards:

- Maintain receipts for all incurred expenses related to the modification.
- Itemize all bids.
- Be in compliance with FSSA and DA-specific guidelines and/or policies.

Note: If applicable, copies of personal record must be:

- *Placed in a prominent place in the participant's file*
- *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

A lifetime cap of $15,000 is available for one vehicle per every 10-year period for a participant's household. In addition to the applicable lifetime cap, $1,000 will be allowable annually for repair, replacement, or an adjustment to an existing modification that was funded by an HCBS waiver.

Activities Not Allowed

Examples or descriptions of modifications or items not covered under this service 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

Provider Qualifications

Provider qualifications for vehicle modifications are presented in the following table.

Table 24 – Provider Qualifications for Vehicle Modifications

Waiver	Provider	Licensure/ Certification	Other Standards
A&D, TBI	FSSA DA-approved Vehicle Modification Agency	Not required	DA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: general requirements *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Warranty required

Helpful Websites

Consult the following websites for more information:

- in.gov/fssa – Find information by type of person in need: children, seniors, families, those with intellectual disabilities (ID), and so forth. All programs and services available are listed on this site.
- in.gov/fssa/2329.htm – Find information and resources about the Division of Aging (DA) programs and services.
- in.gov/fssa/da/3476.htm – Find information about how to become a provider of DA services.
- ddrsprovider.fssa.in.gov/IFUR – Submit initial incident reports and care manager follow-up reports for waiver and Money Follows the Person (MFP) services via the Incident and Follow-Up Reporting Tool.
- in.gov/medicaid/providers – Find Indiana Health Coverage Programs (IHCP) provider bulletins and banner pages and the IHCP provider reference modules. Telephone contact information for providers is also available on this website.

Helpful Contact Numbers

Contact the DA at 1-888-673-0002. See Figure 1 for information on local Area Agency on Aging (AAA) offices.

Figure 1 – Location and Contact Information for Local AAA Offices

16 Area Agencies

AREA 1
Northwest Indiana Community Action Corporation
5240 Fountain Drive
Crown Point, IN 46307
(219) 794-1829 or 1-800.826.7871
TTY: 1-888-814-7597
Fax: (219) 794-1860
nwi-ca.org

AREA 2
REAL Services, Inc.
1151 S. Michigan Street
South Bend, IN 46601-3427
574.284.2644 or 800.552.7928
Fax: (574) 284-2642
realservicesinc.org
info@realservices.org

AREA 3
Aging & In-Home Services of Northeast Indiana, Inc.
8101 W. Jefferson Blvd.
Fort Wayne, IN 46804
(260) 745-1200 or 1-800-552-3662
Fax: (260) 422-4916
agingihs.org

AREA 4
Area IV Agency on Aging & Community Action Programs, Inc.
660 N. 36th Street
Lafayette, IN 47903-4727
(765) 447-7683 or 1-800-382-7556
TDD: (765) 447-3307
Fax: (765) 447-.6862
areaivagency.org

AREA 5
Area Five Agency on Aging & Community Services, Inc.
1801 Smith Street, Suite 300
Logansport, IN 46947-1577
(574) 722-4451 or 1-800-654-9421
Fax: (574) 722-3447
areafive.com

AREA 6
LifeStream Services, Inc.
1701 Pilgrim Boulevard
Yorktown, IN 47396-0308
(765) 759.1121 or 1-800-589-1121
TDD: 1-800-801-6606
Fax: (765) 759-0060
lifestreaminc.org

AREA 7
Area 7 Agency on Aging and Disabled
West Central Indiana
Economic Development District, Inc.
1718 Wabash Avenue
Terre Haute, IN 47807
(812) 238-1561 or 1-800-489-1561
TDD: 1-800-489-1561
Fax: (812) 238-1564
westcentralin.com

AREA 8
CICOA Aging & In-Home Solutions
8440 Woodfield Crossing Blvd., Ste. 175
Indianapolis, IN 46240
(317) 254-5465 or 1-800-432-2422
TDD: (317) 254.5497
Fax: (317) 254-5494
cicoa.org

AREA 9
LifeStream Services, Inc.
423 Commerce Road
Richmond, IN 47374
(765) 966-1795 or 1-800-458-9345
Fax: (765) 962-1190
lifestreaminc.org

AREA 10
Area 10 Agency on Aging
631 W. Edgewood Drive
Ellettsville, IN 47429
(812) 876-3383 or 1-800-844-1010
Fax: (812) 876-9922
area10agency.org

AREA 11
Thrive Alliance
1531 13th Street, Suite G900
Columbus, IN 47201
(812) 372-6918 or 1-866-644-6407
Fax: (812) 372-7864
thrive-alliance.org

AREA 12
LifeTime Resources, Inc.
13091 Benedict Drive
Dillsboro, IN 47018
(812) 432-6200 or 1-800-742-5001
Fax: (812) 432-3822
lifetime-resources.org

AREA 13
Generations
Vincennes University Statewide Services
1019 N. 4th Street
Vincennes, IN 47591
(812) 888-5880 or 1-800-742-9002
Fax: (812) 888-4566
generationsnetwork.org

AREA 14
LifeSpan Resources, Inc.
33 State Street, Third Floor
New Albany, IN 47151-0995
(812) 948-8330 or 1-888-948-8330
TTY: (812) 542-6895
Fax: (812) 948-0147
lsr14.org

AREA 15
Hoosier Uplands / Area 15 Agency on Aging and Disability Services
521 W. Main Street
Mitchell, IN 47446
(812) 849-4457 or 1-800-333-2451
TDD: 1-800-743-3333
Fax: (812) 849-4467
hoosieruplands.org

AREA 16
SWIRCA & More
16 W. Virginia Street
Evansville, IN 47737-3938
(812) 464-7800 or 1-800-253-2188
Fax: (812) 464-7843
swirca.org

To contact your local Area Agency toll-free, call **1-800-986-3505.**

Communications

The IHCP publishes the following communications to providers on the *News, Bulletins, and Banner Pages* page at in.gov/medicaid/providers:

- *IHCP Bulletins*
- *IHCP Banner Pages* (published weekly)

Providers may also subscribe to the Email Notification Service, accessible from the home page at in.gov/medicaid/providers. This service sends emails to subscribers when new communications are posted on the IHCP website.