

Public Comments for Indiana State Transition Plan

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Version I – December 2014

Division of Aging

Summary: The Division of Aging solicited comments on the State Transition Plan as it applies to the Aged and Disabled and Traumatic Brain Injury Medicaid waivers. Comments were encouraged through five public forums conducted at Assisted Living facilities across the state, as well as at Provider and Case Management Training sessions reaching approximately 430 attendees. E-mail notifications were made to waiver providers and to case managers, asking them to reach out to their waiver participants and other interested parties.

The Division of Aging received comments from waiver participants, family members, providers, consumer advocate organizations and industry associations. There was wide support for the HCBS rule in general and for the transition plan. Numerous comments included suggestions for improvements to the plan, but most were questions seeking interpretation of the rule itself. While some comments have been combined, most are unique and the DA is including individual responses below. The DA revised the transition plan to include consumers and advocates earlier in the transition process, see pages 13-14 (of Version One).

SUBJECT: Assessments of Settings and Compliance

Comment: The DA received one comment endorsing the use of the current Provider Compliance Review Tool and the Person-Centered Compliance Review tool as a means of assessing settings and rule implementation.

Comment: One commenter is concerned about the strong reliance on the Provider Compliance Review and Person-Centered Compliance Review process to ensure ongoing compliance with the HCBS rules. This commenter would also like to see more substantive detail as to how these tools will be updated and strengthened to comply with the new rules.

Comment: One commenter is concerned with the strong reliance on provider self-surveys and case manager reviews to identify noncompliance. “The structure or substance of the survey and review should be described in greater detail. With regard to the case manager reviews, the concern is that there is a potential for bias or influence. Ideally, the process would incorporate onsite compliance reviews (prior to a CAP), as well as member/resident interviews that are conducted in such a way as to prevent the appearance of bias and that are meaningful to the person. Another concern with the heavy reliance on provider self-assessments to determine noncompliance is that the use of onsite reviews and service recipient reviews come so late in the process that its impact may be diminished.”

Response: It needs to be noted that initial assessments will be used only for assessment and enforcement will not begin until after 2017 once specific standards are in place. The DA intends to first use a self-assessment to allow for analysis of the current inventory, and use case manager assessments in conjunction with Person-Centered Compliance Reviews, Provider Compliance Reviews and possibly DA site visits to verify initial results. The DA recognizes that current assessment tools will need to be modified to conduct these assessments. The case manager review is anticipated to be a modification of the current 90 Review Tool that is very comprehensive in nature and is usually conducted on-site. It has been the DA’s experience that case manager reviews have not been biased toward providers. On-site reviews are currently conducted at all provider-operated service settings, which are not licensed by the State Department of Health, and it is expected that these will continue with modifications to account for new HCBS standards. Individual PCCRs are

currently conducted for a statistically significant random sample of waiver participants and it is anticipated that an increased number of these reviews will need to be targeted toward participants receiving services in “heightened scrutiny” settings. The DA recognizes that the PCCR tool will either need to be modified or replaced to assess for HCBS standards.

Comment: Regarding Assisted Living regulations: Who holds these facilities accountable for compliance? How often are they inspected? Are all compliance visits unannounced? Actually giving freedom to compliance officers to walk through all parts of the facility, talk with clients and their families is key to better care for these persons. Is there a “whistle-blower” protection for employees of the company? Are there financial forensic specialists available to audit records of these facilities?

Response: Assisted Living facilities are licensed through the Indiana State Health Department. Compliance visits and complaint visits are conducted “unannounced” and include the freedom to inspect all parts of the facility and talk with residents and family members. The DA also monitors AL services provided to residents served under Medicaid waiver and has, under the Waiver Provider Agreement, full access to the facilities. FSSA has the ability to conduct financial audits on all Medicaid waiver providers under their provider agreement. Generally, Medicaid and Department of Labor laws protect “whistleblowers.”

Comment: With regard to the Adult Day Services and Structured Day Program services, one commenter would like to see substantive comments regarding how these programs will be assessed for compliance. It is our experience that these programs, in particular, are most problematic with regard to HCBS rule requirements. The plan seems to presume that because the services are supposed to be community-based that they meet the HCBS standards, which assessment may determine to not be true.

Response: The DA does not presume these settings to be compliant, but rather these service settings will receive a heightened level of scrutiny. The DA has chosen to focus initially on residential providers but will be starting to assess ADS and SDP settings as our next step. It needs to be noted that the initial assessment will be used only for assessment and enforcement will not begin until after 2017 once specific standards are in place. The DA intends to first use a self-assessment to allow for analysis of the current inventory, and use case manager assessments in conjunction with Person-Centered Compliance Reviews, Provider Compliance Reviews, and possibly DA site visits to verify initial results. The DA recognizes that current assessment tools will need to be modified to conduct these assessments.

Comment: What about Structured Family Caregiving?

Response: The DA presumes SFC settings are compliant with new HCBS standards as this service is usually implemented in the consumer’s home or in the home of a caregiver in a non-congregate setting. However, SFC services are not in any way exempt and the DA anticipates that individuals receiving SFC services will be monitored to assure their settings do not have or develop characteristics of an institutional setting.

Comment: The final rule identifies other settings that are presumed to have institutional qualities, and do not meet the threshold for Medicaid HCBS. These settings include those in a publicly or privately-owned facility that provides inpatient treatment: Many of our Medicaid Waiver assisted living members are attached to or are part of campuses with nursing homes. We understand that continuing care retirement communities are specifically exempted from this provision and many of our members are CCRCs and not impacted but the remainder of our Medicaid Waiver assisted living members are part of campuses where this continuum is available but don’t meet Indiana’s specific CCRC definition. This continuum is very

important to seniors who know as their care needs changes that these important nursing facility services are available from the same organization for either short term or long term placements. The assisted living components are separate from the nursing home component and meet all of the requirements for HCBS settings noted earlier. We hope that these facilities that will be under heightened scrutiny will be allowed to provide these important Waiver services. For most of the residents, the only alternative may be a nursing home and greater expense to the state and in a much more institutional environment.

Response: It is the DA’s understanding that CMS’ use of the term “publicly-owned” refers to government-owned facilities only, and not to facilities owned through publically traded corporations or those which offer services to the general public. While it is the DA’s understanding that the majority of CCRCs will meet the HCBS standards, the DA is not aware of a “specific exemption” for CCRCs and each of these facilities will need to be assessed for compliance as there is the potential for these having the characteristics of an institutional setting. The DA does not feel that an Assisted Living facility adjacent or attached to a nursing facility is inherently non-compliant, but will receive higher scrutiny during the assessment and implementation phases. The state recognizes and endorses “aging in place” principles and will advocate for settings implementing these principles.

Comment: With regard to determining compliance with having a lease agreement, one commenter expressed that there is too much reliance on provider self-report and requiring submission of a standard lease agreement. There should also be a process to verify that the lease has been signed by the resident.

Response: The requirement to submit a standard lease agreement is only an initial step. It is anticipated that the presence of a properly constructed lease will be monitored through both case manager assessments and through the Person-Centered Compliance Review process. There will be challenges to monitoring this as lease requirements may vary from location to location around the state.

SUBJECT: Access to the Community/Settings That May Isolate

Comment: Several comments were received from residential providers regarding community access and whether transportation services would be required; or whether public transportation or family members could be utilized to meet the individual’s community integration needs.

Comment: Assisted Living residents are free to participate in community activities as they desire just as individuals who receive Medicaid Waiver services in their own home. Transportation is inevitably the issue for both of these types of Waiver clients. Coordination of transportation, transportation by family members, public transportation, and transportation provided by the facility should all be considered. We want to make sure that this does not require that the facility provide transportation at any time for any reason.

Response: The DA does not anticipate a requirement that residential providers offer transportation services for noncritical events, but also recognizes that on an individual basis, lack of transportation resources does create an isolating environment for the individual. The DA invites AL providers to be part of the discussion on how we avoid settings that isolate individuals.

Comment: The CMS guidance implies that secured dementia units or secured adult day care facilities may not be acceptable. This would pose significant issues for providers serving Medicaid Waiver participants in these settings. These assisted living settings are very homelike and provide the same amenities as other units but they are secured for the protection of cognitively impaired residents who might wander out of

the facility. The same thing applies for secured adult day care settings. This security is for the protection of the resident/client to keep them from wandering out of the facility into unsafe settings. The alternative would be placement in a nursing home where such units are specifically permitted at a much higher cost to the state and most likely a less home-like setting for the resident. It would be our hope that through the development of person centered care plans, waivers will be permitted for these secured units and adult day care facilities.

Comment: What are special memory units? What if everyone in the memory care unit had to leave? Where would they all go?

Response: The DA intends to demonstrate the value of secured memory care units within the waiver program, but will also partner with providers and advocates to develop standards that ensure secured settings offer frequent and meaningful access to the community and assure that other HCBS setting requirements are met. It is anticipated that standards will be built into the person-centered planning process to assure that decisions regarding memory care placements are truly individualized, necessary, closely monitored and routinely reviewed. Please note that the DA will not close any memory care units. Should a memory care unit, operating as or within an Assisted Living facility, not be able to achieve the required standards, it would no longer be able to serve waiver consumers in that manner.

Comment: Any setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS is presumed to have the qualities of an institution: This is a more general statement that seems to imply that assisted living facilities in general have the qualities of an institution since seniors served in these settings have chosen to live in a congregate setting that by definition isolates them from the broader community. Some AL providers have developed facilities primarily serving Waiver clients that would possibly cause greater concern regarding this presumption. It would be our desire that through the heightened scrutiny process and person centered planning that these settings will be permitted.

Response: All provider operated residential settings will be subject to heightened scrutiny. Precise standards have not yet been developed but the DA anticipates that these standards will focus on how the resident experiences the service in relation to the principles of self-direction, choice, and their level of satisfaction with opportunities to interact with the broader community.

Comment: There appears to be fairly broad assumptions about services being community-based. For example, has the state looked to see if any of the facilities are geographically clustered such that they become isolating or have institutional characteristics? This concern is especially true for Assisted Living facilities, which should garner heightened scrutiny due to many services being self-contained within the facility.

Response: Assisted Living facilities are subject to heightened scrutiny and the state recognizes that local geography and community characteristics may contribute to isolation. Standards regarding access to the community will need to be developed.

Comment: With regard to Adult Day Services, the plan should address in more detail how the adult day services will be modified to assure that participants have the opportunity to interact routinely with people without disabilities, since these settings are designed exclusively or primarily for people with disabilities.

Response: The DA is in the early stages of developing and implementing the transition plan. The specific compliance indicators have yet to be determined for any service. The process of developing

these standards and identifying appropriate indicators will involve significant input from stakeholders, and it would be premature to identify specific changes without including that input.

Comment: As noted on page 11 of the Transition Plan: “Current Waiver requirements forbid any use of individual restraint but do not extend to this definition to include the restriction of facilities which may have secured perimeters or delayed egress systems.” Many of the alarmed exits and delayed egress systems within the adult day center settings are in place for the safety of participants that are diagnosed with Alzheimer’s or dementia. To remove this safety precaution in the ADC setting could endanger participants due to an increase in participant wandering and elopement behaviors. A Consumer Risk Contract can be utilized to provide other participants the ability to “opt out” of such a restriction. Please note that Centers serving a population of participants with an Alzheimer’s or dementia diagnosis are following best practices recommended by the Alzheimer’s Association. Provisions such as secured doors and alarms, locked cabinets, portion and dietary controls, and other measures were designed to promote the care and safety of these participants. Without such precautions, many participants would be unable to attend adult day services, thus resulting in an increase in premature institutionalization.

Comment: With a majority of adult day centers serving the senior population and/or individuals with chronic diseases Adult Day Centers work to maintain physical or cognitive function, or to slow the rate of degeneration. While our participant population will have an interest in integrating into other community activities, by and large, they will not be seeking employment options. To provide diversity in activity programming, many adult day centers partner with outside organizations to bring education and entertainment opportunities inside.

Response: The DA recognizes the challenge of allowing freedom of mobility while ensuring individual needs for health and safety are addressed. Person-centered planning and negotiated risk principles will be key to addressing these challenges. But in the spirit of being “community-based,” the site itself should not have the characteristics of an institutional setting. As you or I may very well enjoy experiencing entertainment and educational opportunities “in-house,” this does not serve as a replacement for access to the greater community.

SUBJECT: Visitation in Residential Settings

Comment: While it is desirable to allow visitation at any time, the requirement must be balanced with security concerns in a congregate setting. Just like in many multi-unit apartment buildings, doors are locked to outsiders and visitors must go through some type of security procedure. This is particularly true during overnight hours since staff is less available. Reasonable security rules should be permitted. In addition, the facility must be able to limit the number of overnights visitors can stay or it is possible that family or friends could become permanent without payment or approval.

Comment: With unlimited visitation it opens it up for someone to show up at 1 a.m. and stay in a person’s room. How would we monitor?

Response: Residential providers will need to develop clear and realistic standards to distinguish between a visitor and an “unauthorized resident,” and make sure these standards are clearly communicated in the lease agreement. It will be determined during the assessment and implementation period whether to have a state standard in this regard. This requirement does not prevent facilities from locking exterior doors as long as there is a means for the visitor to be allowed entrance.

SUBJECT: Access to Food in a Residential Setting

Comment: Our members offer cooking facilities and refrigerators in the units, three meals a day, and snacks available at other times. We assume that this requirement is not meant to imply that you have to have 24 hour dining services since this is not realistic to have full kitchen staff available at all times.

Response: It is correct that the DA does not intend to require residential facilities to offer 24 hour dining services. We are also not sure that the current requirement to offer cooking facilities in the units automatically meets the standard of having 24/7 availability of food. Standards will be developed as part of the implementation process.

Comment: What if a person is morbidly obese and on a special diet plan?

Comment: A significant percentage of our Adult Day Service participant population has special dietary needs (diabetic diets, low sodium diet, soft foods diet, etc.), and ADS centers foster partnerships with the participant's family members and medical providers to assist in maintaining the health of participants. Providing open access to food and meals may negatively affect the health of those participants who are not able to properly maintain their diet

Response: Individual situations such as these will need to be addressed through person-centered planning, but as in community living, an individual has a right to make poor decisions regarding their health.

SUBJECT: Legally Enforceable Leases

Comment: Assisted living providers that are eligible to participate in the Medicaid Waiver program must be licensed residential care providers by the Indiana State Department of Health. The rules for licensed residential care provide a long list of residential rights that go well beyond those required by local landlord-tenant lease requirements. However, they clearly specify when a resident must be transferred to a nursing facility based on the care needs. Hopefully, these rules and the residency agreements required will suffice to comply with this requirement.

Response: The state is aware of possible conflicts with the Indiana State Health Department but needs to assess the conflicts more thoroughly to develop standards to address these situations. It must be remembered that movement to a nursing facility does not negate an individual's residency status any more than it would require them to surrender an apartment if they moved to an NF from the community. It is not unusual for an individual admitted to a NF to stay only short-term.

Comment: What if a person is very aggressive and there is a need to evict them?

Response: Providers will need to utilize the same community resources that any other residential provider in their community uses, including local law enforcement and the court system as necessary. In such a situation, it is expected that focused person-centered planning will occur, but this will not over-ride an individual's rights under local residency and eviction laws.

Comment: How long does a lease need to be?

Response: The DA does not anticipate imposing any standard for this. Leases will need to be constructed to comply with state and local requirements.

Comment: With regard to determining compliance with having a lease agreement, one commenter feels there is too much reliance on provider self-report and requiring submission of a standard lease agreement. There should also be a process to verify that the lease has been signed by the resident.

Response: The requirement to submit a standard lease agreement is only an initial step. It is anticipated that the presence of a properly constructed lease will be monitored through both case manager assessments and through the Person-Centered Compliance Review process. There will be challenges to monitoring this as lease requirements may vary from location to location around the state.

Comment: That lease thing - Does that mean if they want to, they can kick you out of here if they want to?

Response: No. It means you and the provider will be required to have an agreement or a lease that states the criteria under which you are protected in this environment but it also lists your responsibilities as a resident. So it protects you, but it also protects the facility. It requires all parties to abide by local residency and eviction laws.

SUBJECT: Stakeholder Participation and Outreach

Comment: One commenter was encouraged to see the reliance on key stakeholders starting in 2016. However, the stakeholders should include several representatives from service recipients, families, advocates, and self-advocates. Otherwise, it would appear that service recipients are not included in the process until the case management reviews in 2017. The state is encouraged to include service recipients, their families, and advocates early on, and frequently, in the process.

Response: The DA appreciates and agrees with the suggestion that waiver participants and their families are included earlier and more frequently in the transition planning process and will incorporate that into the transition plan.

Comment: One commenter requests that to the greatest extent possible, materials developed and proposed changes to policy and procedures, regulations, etc., should include key stakeholders, with an emphasis on service recipients, and their families and advocates, in all stages of development and planning. The materials should be freely accessible on the state's website and the process should be as transparent as possible.

Response: The state strives to be transparent but struggles with the challenge of moving forward while including all who desire to participate. To date, the involved state agencies have set up a [HCBS transition](https://www.in.gov/fssa/da/4917.htm) specific website at <https://www.in.gov/fssa/da/4917.htm>. We hope that this will serve as a "launch site" for division specific information and stakeholder participation. The state appreciates it when outside entities challenge us to be more transparent. When the DA uses the terms "advocate" and "stakeholders," it should be interpreted to include service recipients, self-advocates, families, advocacy and self-advocacy organizations, providers and their representing associations, concerned citizens and any member of the public who wishes to participate in the process.

SUBJECT: Participant Choice of Settings

Comment: One entity expressed concern that the transition plan does not discuss how the state will ensure, as is required by the regulation, that individuals will have a choice of setting, including a non-disability specific setting. Aside from brief mention of the lack of compliance in the DDRS system (see page 37), the plan does not address how the issue will be remedied. The lack of discussion of this issue in the other three transition plans is concerning.

Response: Settings funded by the A&D and TBI Medicaid waivers are rarely “disability specific” (we have identified one dementia-specific setting to-date), although many are segregated by age. CMS guidance on “choice of settings” acknowledges that this choice is subject to availability within the market. There is not a requirement within the HCBS rule that states expand the number or range of available settings.

Comment: There is an inadequacy of the system to support individuals in the community: many rural areas have no staff, do not have needed transportation, etc.

Comment: There is an inadequate provider network to provide real choice in living settings. Most individuals have to choose a provider who is accepting new clients and then move to a setting that has an opening. There is little meaningful consumer choice in those decisions.

Response: Provider “capacity” is an on-going concern. While the state continues to address this issue, consumer choice is subject to the availability of options with the market.

Comment: We believe that most of this guidance was designed to address the unique concerns and interests of younger persons with intellectual, developmental, and physical disabilities. Many of these individuals and their advocates are opposed to congregate residential settings under the Medicare Waiver program. However, many seniors are attracted to congregate settings for socialization, security, and a broader range of activities and experiences than are available in their individual residences. Mobility issues, frailty, and cognitive impairments make it easier and more appealing for these individuals to receive services, activities, recreation, and socialization in these congregate setting.

Response: The DA recognizes the demand for congregate settings with integrated services and opportunities for active participation through continuing care retirement communities. The DA also advocates for residential options that allow for “aging in place.” We do not feel that these Assisted Living or CCRC settings are inherently non-compliant, but we also agree that such settings must be individually assessed to assure that HCBS characteristics are maintained.

Comment: One entity is concerned with the timelines for completion of CAPs that stretch into 2018. Given the likelihood of some facilities requiring substantial correction, the timeframe seems tight to ensure compliance by March 17, 2019.

Response: The DA is confident that providers choosing to continue under the new HCBS standards will be able to implement needed changes by the March 17, 2019 deadline.

Comment: One commenter was encouraged to see the plan address non-provider-owned residential settings (e.g., pg.64) and stated that Indiana did a good job recognizing that as an issue and coming up with a plan in the Children’s Mental Health system. However, there are other non-provider owned residential settings in the other contexts and the state should determine how they plan to address those settings before finalizing the plan.

Response: At this stage of transition, the DA has chosen to focus on settings that are presumed non-compliant or that require heightened scrutiny. The DA does recognize that there are non-provider owned settings where waiver services are delivered. The DA does not have any regulatory authority over these setting and anticipates that these will be assessed at the participant level taking into account individual choice of settings. There is still room here for much discussion and we welcome further input on addressing these situations.

Comment: We are pleased to see that the draft Statewide Transition Plan notes that “It is not the intention of CMS or the state of Indiana to take away any residential options, or to remove access to services and supports.” However, we are concerned about how some of these requirements might be interpreted which could limit the availability of high quality home and community based options in assisted living facilities.

Response: The DA shares a concern that misinterpretation and misrepresentation of existing and future standards may discourage quality providers from pursuing or maintaining participation in the waiver program. The DA intends to work closely with all stakeholders, throughout the transition process, to assure that standards and interpretations are clear to all parties.

SUBJECT: Remediation Strategies

Comment: The Plan’s Proposed Remediation Process appears thorough and appropriate. We appreciate that the process includes significant input from providers as the details for how facilities comply with individual requirements are defined. This input will be critical since there are various aspects of the CMS guidance on the rule that will pose concerns for our Medicaid Waiver certified members.

Response: The DA intends to include waiver participants and advocates in development of standards as well as providers.

Comment: It is unclear what role service recipients will have in the CAP process and whether they will have input on CAP development.

Response: The DA has traditionally allowed providers to submit corrective action plans to the state for approval. These CAPs have been assessed and either accepted or returned for re-submission. Upon notice of implementation, the DA has then verified implementation. The DA would be open to receiving comments on how service recipients might participate in this process.

Comment: One commenter expressed that they are pleased to see that the state recognizes that some providers may need to be decertified if they cannot meet the new regulations.

Comment: I don’t think an 85% compliance rate is acceptable. Maximizing opportunities for A&D, TBI clients is a noble goal. Without adequate funding for services and incentives for excellence in care we won’t see progress and there will continue to be non-compliance issues.

Response: The Division of Aging does not recognize an 85% compliance rate for new HCBS standards. The DA intends to remediate all occurrences of non-compliance to 100%. This may necessitate termination of some providers.

General Comments

Comment: Will the state wait a full five years to implement the rule, or will there be steps along the way?

Response: There will be steps along the way. The transition plan lays out a general schedule. Many components of the new HCBS rule are already part of the current waiver rules so we will continue to ensure compliance with those components.

Comment: Several comments were received in support of home and community based services and detailing how non-waiver home health providers can be a part of the overall strategy to keep people in their homes through provision of skilled home health services, nursing services, physical therapy, occupational therapy, and by providing caregiver training

Response: The DA recognizes the importance of non-waiver home health, medical and therapy providers and appreciates their willingness to be part of the overall strategy to implement the HCBS rules.

Comment: A concern was expressed that the plan doesn't address how the state will implement and monitor any individual modifications to the additional requirements for provider-owned settings. This information should be addressed in the transition plan before it is submitted to CMS.

Response: The transition process is in its initial stages and the DA has not yet addressed needed enhancements to the Person-Centered Planning process or the process through which individual modifications will be implemented and monitored. The DA will seek public input and participation as we enter future stages.

Comment: Who determines if the client is in an appropriate setting?

Response: For residential service options under the A&D and TBI waivers (Adult Family Care, Assisted Living, and Structured Family Care) the DA utilizes a Service Level Assessment to determine the level of need on an individual basis. This assessment is conducted by the case manager with input from the individual and/or their representative and the service provider. This assessment does include a maximum score beyond which the individual's needs exceed the service that can be provided by the facility. Aside from this assessment, it is the participant, their chosen representative, or their guardian who decides the appropriate setting.

Comment: Persons on A&D and TBI waivers have unique considerations. Will there be a team, including the client, who will be making a decision about how and how much funding will be available for the services.

Response: The waiver participant will continue to choose who will be on their team and maintains the right to choose services based on their individual needs. The DA funds services based on individually assessed needs.

Comment: How often will participant assessments be made? Will there be opportunities for appeal and review of services by a nonpartisan representative?

Response: The DA currently utilizes several layers of assessment. All waiver participants have a service assessment every 90 days and a Level of Care Assessment every six months. Both of these assessments are conducted by their case manager. Some services require a Level of Service assessment. The state recognizes that enhancements to the person-centered planning process will require a review and changes to the current assessment protocols and will use the transition process to achieve those enhancements. The DA currently has an appeal process for all decisions the individual wishes to appeal. It is not anticipated that there will be changes to this process as it includes opportunities for internal (DA) and neutral (Administrative Law judge) review.

Comment: Along with physical and mental assessments will there be opportunities provided for financial education such as budgeting, planning and consumer education?

Response: These subjects, while important, are not within the scope of the transition plan or the HCBS final rule.

Comment: If a client is deemed unable to have total control over personal resources, either temporarily or permanently who will aid them?

Comment: Who determines if the client is capable of making all decisions re: their care, finances, education, etc.? Is there a set of guidelines already in place or are there new guidelines being implemented as part of the transition plan? Who will make these assessments (BDD, Health professionals, Medicare or Medicaid)?

Response: The individual has the right to appoint financial and personal representatives, granting power of attorney at their discretion. For individuals unable to make these appointments, another entity may obtain guardianship through legal channels. It is not anticipated that these will be addressed through the implementation of this transition plan.

Comment: Medicaid fraud seems to be on the rise and because there has been a reduction of reimbursements for Medicare & Medicaid clients some clients are being underserved. Who is writing the regulations or updating them?

Response: The DA agrees that Medicaid fraud is serious problem. The State has two organizations that investigate Medicaid Fraud; Program Integrity operates through FSSA Operations and the Medicaid Fraud Unit operates within the Attorney General's office. The DA's transition plan does not include any changes within these organizations.

Comment: The complexity of medical conditions, medical ethics, and medical treatment need to be reviewed more frequently. Also I remember just last year that a state legislator was questioned about his actions on a funding bill because he had interest in a health care business. Does this new plan have a federal (GAO) and state collaborative investigative unit?

Response: As the A&D and TBI waivers include very limited medical services, it is not anticipated that there will be standards regarding medical treatment or medical ethics, or include a federal/state collaborative investigative unit. Medical service providers are required to be licensed under the Indiana State Department of Health and to abide by their standards.

Comment: One commenter expressed a fear that the new HCBS rules will create a greater burden of paperwork.

Response: The DA does not anticipate an increased level of paperwork for providers over the long-term. Individual exceptions may occur if extensive corrective actions are required.

Division of Disability and Rehabilitative Services

Summary: On Oct. 31, 2014, Indiana posted public notice of the Family Supports Waiver Comprehensive Transition Plan, the Community Integration Waiver Comprehensive Transition Plan and the Indiana Statewide Transition Plans to the FSSA/DDRS website and to all individuals on the Division of Disability and Rehabilitative Services listserv. The DDRS listserv has a total of 5,078 registered individuals. Letters were also sent to every individual who is currently utilizing waiver services inviting them to participate in a webinar and phone conference to educate them of the HCBS rules and transition plans. In addition, throughout October and November, DDRS hosted a variety of events to generate public comments on the posted Transition Plans. Events included the DDRS Quarterly Provider Meeting attended by over 167 individuals, a meeting with the Arc Self Advocates Officers, three Webinars and phone conferences for families with over 400 participants, a presentation at Indiana Association of Rehabilitation Facilities, Inc. Quarterly Conference, a podcast by the Director of DDRS with the Arc of Indiana; the DDRS Advisory Council; Quarterly Case Management Meeting and multiple meetings and announcements by local provider and advocacy groups. During the public comment period, a variety of comments were received from individuals, family members, providers and advocacy groups. The public comment received ranged from detailed suggestions regarding the various phases of the Transition Plan to long-term remedial strategies. Indiana noted many individuals reported an overall satisfaction with the Comprehensive Transition Plans, as it ensures that individuals receiving HCBS are integrated in and have access to supports in the community. The DDRS revised the Transition plan to explain use of 85% as baseline for compliance, to clarify language and policy goals and explain the review and potential modification of documents and process as well as to include the addition of a Transition Taskforce based on public comment. See pages 26, 30 and 60 (Version One).

SUBJECT: Assessment of Settings

Comment: Indiana identified 85% and below as the threshold for low level compliance with National Core Indicators. One commenter asked what the national standard is for compliance and how Indiana compares to other states across the country if the threshold of 85% compliance is met.

Comment: The Indiana demographics section of the 2013 National Core Indicators Report indicates that most interviewees resided with family. In this setting, rules and activities are generally determined by a parent or family member, making individual choice a matter of family dynamics. This situation may unintentionally skew the results related to self-determination, as well as potentially make remediation and compliance challenging. The commenter recommends that this be taken into consideration in further assessment activities and in the final determination of setting compliance.

Comment: One commenter was pleased with the use of NCI data to assess compliance. They felt the state's use of the NCI survey (National Core Indicators) is helpful because it demonstrates that there needs to be significant change in a broad range of topics. However, there is concern with the use of the 90-day checklist as an indicator of compliance given that in several instances the results were contradictory with the NCI data.

Response: While the State used NCI data as a preliminary assessment tool, the State acknowledges concern with contradictory data obtained by the 90 day checklist. For this reason, a more in-depth approach will be carried out through the individual experience surveys to determine HCBS compliance. The individual experience surveys will also allow for all participants settings to be analyzed, not just residential. In March 2014, CMS also issued modifications to Quality Measures and Reporting on 1915(c) Home and Community Based Waivers. Specific to Improvements in

1915c Waiver Quality Requirements (June 15, 2014), CMS issued guidance to the States indicating that any level of performance measuring “less than 86%” compliance indicated a need for improvement and further analysis to determine the cause(s) of the performance problem. DDRS chose to use that same percentage (less than 86%, or 85%) as the threshold for low level compliance within our National Core Indicator and 90-Day Checklist data findings. [National Core Indicator findings, including those specific to Indiana, are available at http://www.nationalcoreindicators.org/states/](http://www.nationalcoreindicators.org/states/).

Comment: One commenter stated the transition plan read as though the assumption was everyone is out of compliance and requested language clarification, specifically how the site survey’s will be assessed.

Response: Compliance cannot be assumed nor does Indiana assume that it is not in compliance. The transition plan was developed to clearly delineate Indiana’s assessment and potential remediation activities.

SUBJECT: Preliminary Settings Inventory/Analysis

Comment: In the preliminary settings analysis, one commenter would like to see more substantive comments regarding how compliance will be determined in all instances where there is no NCI data and no 90 day checklist data.

Comment: Information reviewed and used for future data collection to manage accomplishment includes the 90 day checklist and pre/post transition documents, both of which are significantly in need of modification to more appropriately represent the current and future waiver recipients. It is concerning going forward if the intent is to continue to use these two documents as part of the transition process/plan. Perhaps part of the transition plan could speak to the necessary document changes in assuring they support what is being monitored and leading the team to successfully support the individual.

Comment: Standards, Rules, Regulations and/or Requirements should be broad in scope, being applicable to individuals of all ages. The average age of individuals served is decreasing as school age individuals are targeted, rather than deinstitutionalized individuals such as in previous decades.

Comment: Due to the fact that NCI data and 90 day checklists frequently contradicted each other, several areas of the initial assessment have been noted to require further study. This suggests the need to review the validity of the 90 day checklists and/or the NCI data collection process as it relates to determining compliance with CMS rules.

Comment: One commenter has concerns about the 90-day checklist process. Specifically, who responds to the questions; the case manager or the individual? It was recommended that a trained individual, outside of the case management team, to ensure that the data is truly person-centered, conduct Personal Outcome Measurement interviews. For the CMS Criteria that is not obtained through the 90 day checklist, it is recommended that the criteria be added to the checklist, and referenced in the individual’s person-centered plan.

Response: The State will incorporate specific components of the above suggestions into the transition plan by clarifying language and policy goals. The review and potential modification of documents and process to support the changes will be incorporated into the transition plans. Currently, both the case manager and the individual waiver participant (consumer)/family or guardian are to respond to questions on the 90 day checklist during the 90 day meetings of the Individualized Support Team, but the case manager is responsible for its completion and processing. At this time, it is the responsibility of the Individual Support Team to ensure the

accuracy of the 90 day checklist responses and there are no immediate plans to bring in outside entities.

Comment: One commenter suggested policy specifics be a part of a later comment period around rules and regulation changes.

Comment: 90 – Day Checklist:

1. I see that this is used to review many of the desired outcomes. With new policies being implemented and because this is one of the main pieces of information being used to measure current and future outcomes; will there be more accountability for all case managers to complete this documentation with the review of the IST team state wide?
2. A Focus of training on this documentation may need to be implemented through AdvoCare for all individual case managers, as historically, many newer CMs have either overlooked this or completed it without the input of the IST.

Response: The state will review the suggestions listed above in order to identify areas of inadequacy or weakness within the 90-day check list and develop necessary modifications to assure the state’s compliance with HCBS requirements. Case managers will continue to be trained and held accountable for following proper procedure in the completion of this task. While the specific suggestions will not be incorporated into the high level Transition Plan, the State will ensure stakeholders have an opportunity to review any policy/process changes listed above and, to the greatest extent possible, the State will incorporate the suggestions within the specific processes.

SUBJECT: Validation of Preliminary Setting Inventory

Comment: One commenter felt that using the Indiana Institute on Disability and Community to complete the next phase of assessment is a wise decision. IIDC’s expertise and reputation will reinforce the process as fair and credible. Further, by testing with a sub-group of individuals with disabilities, the assessment will have a high level of validity.

Comment: One commenter felt it was unclear if all waiver recipients will be surveyed or only Individuals receiving RHS services. They suggested DDRS should consider scaling down the implementation of a statewide survey for 17,000+ Individuals on the waiver. A large percentage of the Individuals receiving waiver services live in their family home, and these settings are considered to be site appropriate. If the goal of this survey is to identify specific sites that may need further review, it may be advantageous for DDRS to focus only upon Individuals receiving residential services or supported living services.

Comment: Once the survey tool is completed, the state should consider changing the implementation process. Right now, this plan outlines a provider-led process, with the provider responsible for ensuring the survey is completed for each Individual. The state will have difficulty getting full compliance with this process. Instead, the state should consider having case management facilitate the questions to the Individual and their support team as part of the 90 day process.

Comment: One commenter recommends that the Provider and Member Surveys are inclusive of individuals Receiving HCBS services, as well as those on the wait list.

Response: Final details on how, to whom, and by whom the site surveys should be administered for optimal results is still in the final planning stages and will be incorporated in future updates of the transition plan. The State will review the suggestions listed above in order to finalize the specific components and processes for the survey tool. DDRS appreciates the support expressed by various

commenters. While the specific suggestions listed above will not be incorporated into the preliminary transition plan, the state will incorporate the suggestions within the specific processes to the greatest extent possible.

SUBJECT: Proposed Remediation Strategies

Comment: The Comprehensive Transition Plan states that a Comprehensive Provider Survey will be conducted and results analyzed. The plan does not specify if (or how) results will be made available to individual providers. It would be beneficial for providers to have timely access to survey results specific to their agency's compliance. This would allow providers to begin making systematic changes that facilitate compliance.

Comment: The Transition Plans call for assessment components to be completed by an individual or another person that "knows them best." It is understood that the state may likely look to providers to facilitate identifying an appropriate person to assist the individual through the assessment process. To that end, it is recommended that a single point of contact be established at each provider agency to coordinate with the support teams to determine who should be involved in individual surveys.

Comment: With regard to the survey tool being developed by the IIDC to target specific HCBS requirements, there is concern with vesting the administration of the survey through the residential provider. There is a concern that the provider could manipulate or influence resident responses. Due to the survey's importance, whereby its results will be used to determine sites for site specific assessments, the survey tool should be as free from bias and influence as possible. Commenter would also request that the key stakeholders be included in the survey design process. In that same vein, requests that the participant/resident survey be accessible and meaningful. For example, rather than asking generally whether the resident/participant has access to food, asking whether he or she can get a snack whenever they want.

Comment: The Participant Rights and Responsibilities Policy is not scheduled to be modified until 12/2017. Commenter would request that this be done earlier in the process – participants should be aware of their rights as early as possible so that they may better participate in the process going forward.

Comment: One commenter suggested a clearer process for sanctions and provider dis-enrollments. Specifically, timeframes for notice, action steps and procedural safe guards to ensure consumers and their teams are provided adequate notice.

Comment: One commenter suggested the remedial section of the plan is lacking. It appears to be primarily policy change or provider corrective action/sanctions. The state should realize that this is the most important part of the plan and should be afforded enough time for implementation. As noted previously, the state appears to be taking over half of the allowable time to identify the issues but the real work lies in correcting and taking action to make changes in Individuals' lives. Please allow enough time within this plan for the remedial work.

Comment: One commenter suggested a BDDS transition task force will need to be established for individuals identified that will require major changes including relocation, adjustments to allocations, and mediation to resolve internal conflicts and compliance issues that cannot be handled by the individual and their team. In addition, any system that is developed should allow for external support and consultation for situations that are too difficult for the individual and their support team to handle without mediation or additional funding. It would be helpful for a process to be developed to request on-site consultations or team assistance.

Comment: These remedial strategies leave the Individual and the team out of this process entirely. For a true person-centered approach, most remedial issues, once identified, should be handled at the Individual and support team level.

Response: It is the state's intent to include the individual and team throughout the assessment and remediation process. Timelines allow for all settings to be assessed and remedial strategies to be addressed upon completion of identified issues. Final details on how, to whom, and by whom the site surveys will be administered and assessed, is still in the final planning stages and will be incorporated in future updates of the transition plan. The suggestion of a transition taskforce will be incorporated into the transition plan to allow for additional ongoing supports and consultation during the transition process. The state acknowledges that Remedial Strategies and processes may need to be altered based upon the pilot surveys as well as the actual survey findings, but assessments must be completed prior to determining how those strategies may need to change. While the process for sanctions and provider disenrollment's was not added to the high level Transition Plan, the state will incorporate the suggestions within specific policies and procedures. The state will review the suggestions listed above in order to finalize the specific components and processes for the survey tool. DDRS fully intends the survey to be meaningful and free from bias. Additionally, policies and procedures will be updated timely and appropriately once the survey findings have been analyzed and compared to the HCBS requirements.

SUBJECT: System Recommendations

Comment: A few commenters provided specific suggestions regarding system recommendations. Specific suggestions are listed below:

- Ensure choice in living situations and staff
- Ensure meaningful employment opportunities for individuals
- Provide more options in services that are individualized
- Ensure control of personal resources
- Wider range of residential opportunities
- Address the shortage of qualified Direct Care Staff
- System constraints will need to be addressed
- Address the limited access to community
- Extra protections for individuals without legal guardians or advocates should be considered
- Ensure a more collaborative effort between case management and community disability organizations

Response: The State acknowledges the concern with the system issues listed above. Through the individual experience survey and subsequent review of the HCBS requirements, Indiana will gather data on the current status of the system and identify areas of noncompliance. To the greatest extent possible, the specific comments listed above will be incorporated within the survey(s) to assess the current status of Indiana's HCBS settings.

Division of Mental Health and Addiction - Youth

Summary: No summary was provided for DMHA-Y in this version.

Comment: A commenter requested that DMHA Youth Programs conduct site visits to validate the assertions these programs are in compliance with the new rule. Other feedback received was related to the population served, not settings. Response: Site visits are conducted by DCS who certifies and licenses homes where children and youth will be placed as all participants reside in either a family home or foster home placement. Additionally, 100% of participants will receive a survey that will request further validation of this assumption.

Comment: A commenter requested that DMHA Youth Programs conduct site visits to validate the assertions these programs are in compliance with the new rule. Other feedback received was related to the population served, not settings.

Response: Site visits are conducted by DCS who certifies and licenses homes where children and youth will be placed as all participants reside in either a family home or foster home placement. Additionally, 100% of participants will receive a survey that will request further validation of this assumption.

Division of Mental Health and Addiction – Adult

Summary: The Division of Mental Health and Addiction solicited comments on the State Transition Plan as it applies to two adult 1915(i) programs; the Adult Mental Health Habilitation and Behavioral and Primary Healthcare Coordination programs. Comments were solicited and encouraged through an adult 1915(i) program provider training on Oct. 15, 2014, as well as on adult 1915(i) provider conference calls on Oct. 16 and Nov. 20, 2014. Providers were asked to reach out to members and other interested community partners to inform them of the state transition plan and comment period. E-mail notifications and a link to the state transition plan were made available to providers on Oct. 31, 2014. On Nov. 20, 2014, an additional reminder email was sent to adult 1915(i) program providers encouraging response during the comment period. The DMHA received all five comments from the Indiana Protection & Advocacy Services (IPAS). DMHA is including individual responses to these comments below. DMHA revised the Proposed Remediation Plan as a part of the transition plan to include Adult Day site visits to ensure compliance, see page 73 (Version One).

SUBJECT: Assessments of Settings and Compliance

Comment: “On page 67, the plan notes that Adult Day Services and Respite fully comply with the rules based on the agency’s analysis. This analysis only included a review of policies and procedures. IPAS is particularly concerned about the provision of Day Services, as this has been an area, anecdotally, with many problems.”

Response: The division will incorporate Adult Day site visits into the regular Quality Assurance Plan site visits. DMHA will add Adult Day site visits to the Proposed Remediation Plan for Adult Day to assure ongoing compliance.

SUBJECT: Proposed Remediation and Strategies

Comment: “It appears that site visits are only for residential providers and not for Adult Day Services. See page 73. Furthermore, the materials to assess Adult Day Services appear to be in development. IPAS would request that site visits be added to Adult Day Services and that key stakeholders be included in the process of developing measures that will be used to assess these providers.”

Response: As stated above, DMHA will incorporate Adult Day site visits into the regular Quality Assurance Plan site visits. DMHA will add this to the Proposed Remediation Plan for Adult Day to assure ongoing compliance.

Comment: “There is a lack of service recipient input into the process. Furthermore, more detail is needed regarding the use of annual provider trainings and Quality Assurance visits to ensure consistent application of HCBS residential standards.”

Response: Also as stated above and in the Proposed Remediation Plan, DMHA will be using member surveys and member focus groups to assess setting compliance across the state. These are intended to get direct member feedback on compliance with the final rule of CMS.

Comment: “With regard to Adult Day Services, the plan should address in more detail how the adult day services will be modified to assure that participants have the opportunity to interact routinely with people without disabilities, since these settings are designed exclusively or primarily for people with disabilities.”

Response: The AMHH program is intended to help facilitate improved community integration for all individuals. The intent of the program and services is to support and assist individuals to

participate in community activities and utilize natural supports and community resources to move them beyond behavioral health settings. It is expected that Adult Day programming will include opportunities for community integration. The Division will incorporate Adult Day site visits into the regular Quality Assurance Plan site visits. DMHA will add Adult Day site visits to the Proposed Remediation Plan for Adult Day to assure ongoing compliance.

Version II – March 2016

Division of Aging

Summary: The Division of Aging solicited comments on the Statewide Transition Plan as it applies to two adult 1915(c) programs; the Aged and Disabled Waiver and the Traumatic Brain Injury Waiver. The comments resulted in changes on pages 9, 11, 12, 15 and 39.

Comment: A letter was received from an Indiana advocacy agency with comments regarding Section 1: Assessment of Settings, Section 2: Proposed Remediation Strategies, and Section 3: Key Stakeholders and Outreach. Below are the responses from DA regarding each comment contained in the letter.

Comments: Section 1: Assessment of Settings

The commenter wrote that the Division declares in blanket fashion that 19 of its waiver services fully comply with the new federal home- and community-based services regulations. However, there is no indication that the Division evaluated these services for compliance beyond stating that they are “individualized services provided in a residential setting that is not provider owned or controlled.” The commenter finds this position overly conclusive, as service delivery in a setting neither owned nor controlled by a provider does not guarantee that a consumer will be integrated and have access to the greater community. Further, the concept of “provider control” is vague and undefined in the STP. A participant’s selection and ability to terminate services of a particular provider does not equate to control over the provision of that provider’s services. This is especially true in rural areas where participants have limited provider choices. The commenter urges the Division to critically examine all services provided under the Waiver and identify those chosen for further assessment.

Additionally, the Traumatic Brain Injury Waiver offers supported employment services, described as “[s]upervision and training for participants requiring support to be able to perform in a work setting.” The commenter fears that supported employment services may currently be delivered in sheltered, non-competitive, or provider-owned/controlled settings. The commenter suggested that these settings be assessed for compliance with the new HCBS regulations.

Similarly, while the Division does admit that the TBI Waiver’s Structured Day Program providers “typically ... serve individuals ... in congregate community-based settings,” it states that these settings have not been assessed for compliance with the new HCBS regulations. Although the Division indicates that it “will use an approach similar to that used to assess residential settings,” The commenter recommends that the assessment criteria be explicitly articulated and available for public comment.

The Division notes that, in regard to assisted living, the Indiana State Department of Health plays a regulatory role. Currently, the Aged & Disabled and TBI Waivers both require assisted living facilities to be licensed by ISDH, which licenses such facilities as residential care facilities. The Division notes that it has considered removing the requirement that ISDH license assisted living facilities, but has not decided whether it has the necessary capacity to oversee assisted living independently for Waiver purposes. The commenter believes that simply removing the “residential” designation from assisted living facilities is a semantic, rather than substantive, solution. More than phrasing will need to be altered before assisted living facilities comply with the new HCBS regulations.

The Division notes that “a group of providers, advocates, and state staff” have been engaged in conversations regarding the designation of assisted living facilities. Though discussions should certainly occur, the commenter requests more information regarding both the composition of this group and how

participants were selected. It is not clear that people with disabilities, nor actual Waiver participants, have been invited to the discussion table.

Lack of Waiver participant engagement throughout the transition process is a predominant concern of the commenter. For example, while describing its proposed heightened scrutiny process, the Division indicates that it will review “documentation provided by [the] provider, survey documentation from visits to the site by [the Division] and contractor staff, public input, and any other information the [Division] requires.” Notably absent from that list is individuals receiving services. The commenter also encourages that people with disabilities are included in the review process, either as Division employees or as contractors.

In a later section of the STP, the Division indicates that it monitors services through activities such as Provider Compliance Reviews and Participant-Centered Compliance Reviews. PCRs appear to be conducted only for those providers not licensed by ISDH. Therefore, the commenter is curious whether those providers licensed by ISDH are ever asked similar questions and, if so, how frequently. The Division indicates that PCCRs are “conducted for a statistically significant random sample of waiver participants each year.” The commenter would like to know the size of the sample, whether the number of respondents are statistically significant across Division-implemented Waivers and across the provider network, and how the samples are selected.

The commenter further questions the usefulness of the Person Centered Monitoring Tool and National Core Indicators survey questions for purposes of measuring provider adequacy. The problem is, in large part, due to yes-or-no responses demanded by the questions. For example, to assess whether a Waiver participant is given choice in services and service providers, the Division proposes asking the following questions from the NCI survey: “Can you choose or change what kind of services you get and determine how often and when you get them? Can you choose or change who provide their services if you want to? Do you feel in control of your life?” Respondents don’t have the opportunity to discuss services they may feel are missing from their care plan or to describe situations where services that were requested may have been denied by the State, case manager, or provider in question. Relatedly, the PCMT denies Waiver participants the opportunity to provide any feedback whatsoever, in that the questions are posed to case managers rather than participants (e.g., “Does the individual have choices in what food is available and when to eat?”).

Additionally, the commenter is concerned that the Division has not fully considered due process rights of individuals that may be receiving services in noncompliant settings. The Division indicates that transition plans will be developed for participants residing in Group 1 sites that will include “appropriate notice” and “procedural safeguards available to them.”

The commenter asserts that the details of the notice and procedural safeguards that will be provided to affected participants should be specified in the STP. Moreover, it is problematic that the Division has not yet determined the number of individuals that will be potentially affected, nor has it developed timelines for doing so, given that the exercise of appeal rights can be a significantly lengthy process. (In Section 2, the Division indicates that Waiver participants will be offered assistance transitioning from noncompliant providers by September 2018. The commenter believes this assistance should be offered much sooner.)

Response: The DA appreciates the thoughtful comments offered by the commenter on the STP. In the Assessment of Settings section, DA would first note that the Final Rule allows for a presumption that services provided in the individual’s home are in fact home and community-based. That does not relieve the State of any obligation to monitor such services and settings for HCBS

characteristics but as presumed HCBS settings DA does not believe private family homes should be part of the transition plan.

With regard to the TBI services of supported employment and structured day services, these are providers that also provide similar services under the DDRS waiver programs. As such, DA will coordinate with DDRS in the assessment of these settings so as to be consistent with these providers. DA certainly recognizes the issues the commenter has raised here with regard to these services. As very few TBI waiver participants utilize these services, DDRS will be the lead on issues with these providers and settings.

The commenter correctly points out that “more than phrasing will need to be altered before assisted living facilities comply with the new HCBS regulations.” DA is very aware of this. DA will clarify some of the language in the STP to explain the consideration being given to removal of the residential care facility licensure is about much more than changing the name or phrasing associated with these settings. The licensure rules can be in direct conflict with the requirements of an HCBS setting. Removing the licensure requirement will not in any way make these settings HCBS compliant. But it removes barriers to that compliance and makes it more likely that they can become compliant.

The commenter expressed some concern regarding DA’s monitoring tools the PCR and PCCR. They are correct in observing that the PCR is only administered to unlicensed providers but no PCR questions are used in the crosswalk as elements of monitoring HCBS settings characteristics. That process may be enhanced and expanded to more adequately address those issues. This is part of the consideration of whether or not to require assisted living providers to be licensed by ISDH. That licensure and survey process does not monitor for HCBS setting compliance so DA will have additional monitoring responsibilities either way. The PCCR is administered across all settings and providers, licensed and unlicensed so there is some DA monitoring of licensed providers through this survey process. The PCCR sample size is based on a 95% confidence level; 5% margin of error and 50% response distribution using the Raosoft tool. Distribution is proportionate to waiver participants by geographic areas of the state and all service types were included. TBI waiver sample size is approximately 132 using the above formula and a total population of 200. A&D Waiver is approximately 375 using the above formula and a total population of 15,000.

With respect to the NCI-AD and PCMT questions that have been cross-walked to the HCBS characteristics, DA offers a couple clarifications. First, the NCI-AD is NOT a yes or no response. DA included only the questions in the cross-walk and not the available responses. Second, on the PCMT, the commenter raises two primary issues. One is the case manager is asked these questions. That is not strictly accurate. The case manager is responsible for completing the checklist but they do so through a person centered interview with the participant and anyone else they identify in their circle of support. The commenter raises a second issue on the yes/no response format to the questions. That format has traditionally been used with this tool to simplify reporting of data primarily. DA would note that for many of the questions a negative response requires additional documentation in the form a corrective action plan. However, DA thinks the commenter has a valid point here. DA will study a change to the format of the tool, perhaps implement a more evidence based, person centered tool. DA also agrees that there needs to be a place to document the participant’s input in their own words. The DA will work to add this to the PCMT process.

Comments: Section 2: Proposed Remediation Strategies

The Division indicates that it will “[c]reate a work group, including waiver participants and advocates, to more clearly define requirements for privacy, choice, and other quality of life components...” by March 2016. To date, the commenter is unaware of any invitation to the public to participate in such a group. The commenter requests additional clarification from the Division on how participants will be identified and chosen. The commenter also asks that the Division ensure that Waiver participants have at least equal representation to any provider members of the work group.

The Division also indicates that provider policies, procedures, training, and relevant other documentation will be assessed for compliance with the new HCBS regulations. Although this responsibility is not delineated within the STP, the commenter recommends that attorneys from the FSSA Office of General Counsel be thoroughly involved in this process. Because new regulations require providers to offer documents, including binding and enforceable residential leases, legal expertise is crucial in assessing provider compliance.

Next, the Division offers proposed State rule changes, several of which the commenter believes are contrary to the spirit and the letter of the new HCBS regulations. The Division proposes general direct care service standards, which would require a provider to “[a]llow decision- making and self-determination to the fullest extent possible...” The commenter believes that “to the fullest extent possible” is ambiguous; it is not clear whether the Division envisions autonomy being hampered by the participant’s capacity or the provider’s unwillingness to offer broad choice. The commenter recommends that the Division clarify the meaning of “possible.”

The Division also proposes promulgating new rules regarding person centered service plans. The proposed rule would require case managers to use the 90-day monitoring tool, presumably the PCMT (an item with which the commenter raised concern above), to “review service deliverables.” The Division requires that the case manager meet with the Waiver participant in his or her home for their first appointment and for at least 50% of the remaining assessments. The commenter would remind the Division that many Waiver participants are fully productive members of the community, holding jobs and otherwise committed during normal work hours. As such, if the Division keeps this proposed rule, the commenter recommends mandating that case managers be available to meet with Waiver participants at times convenient for those participants.

To meet the HCBS regulatory requirement that individuals have free access to the community, the Division proposes several rule changes. Generally, across services, the Division would require providers to “include transportation for community activities that are therapeutic in nature or assist with maintaining natural supports.” It is not clear who determines whether an outing is therapeutic or essential to maintaining natural supports, but, in accordance with federal regulations, the Waiver participant should be permitted to go wherever he or she wishes. The Division further runs afoul of federal regulations when it proposes adult family care service providers offer activities “appropriate to the needs, preferences, age, and condition of the individual resident...” Again, who is the arbiter of what is “appropriate?” It should be the individual.

Relatedly, the Division proposes rules that are narrower than the new federal regulations. For example, the Division plans to promulgate a rule that would require adult family care and assisted living providers to “assure that residents have the ability to control their own schedule and to choose whether to participate in activities.” This proposed rule is not as broad as new federal regulations which permit participants to choose not just whether they participate in offered activities, but to actually select activities. Similarly, the Division would require the same providers to “assure that residents have a room

that is physically accessible to them.” Residents should not be limited to just a room; the overall facility should be accessible. The commenter believes the Division should amend its proposed rules to match the intent of the federal regulations.

New HCBS regulations require bedrooms to have locking doors. However, the Division indicates that it will amend existing State rules to provide that “only appropriate staff” will have keys. Permitting staff to have keys negates the purpose of the regulations. Similarly, “appropriate” is an ambiguous term, meaning that potentially all staff could have keys.

Response: The commenter requests more details on the due process protections that will be afforded participants who receive waiver services at a site found not to be compliant with the Final Rule and cannot be made to be compliant. The commenter notes concern with the September 2018 date for offering assistance to these individuals. In fact, that assistance will be offered earlier whenever possible. That is to say as soon as a site is determined to be non-compliant and it is determined it cannot be made compliant, support will be provided to those participants right away. The September 2018 date is a final date by which all of those individuals need to be identified and in process for any required transition but we would expected most to be much sooner.

In terms of the safeguards participants will have in the remediation and any transition processes, DA will utilize existing systems in both waivers for review of decisions and access to administrative hearings and appeals. The commenter is critical of DA’s inability to identify numbers of impacted consumers. DA has identified the numbers of participants in each setting in which DA has indicated Final Rule compliance issues. DA cannot yet determine how many of those sites will end up non-compliant either because the provider does not wish to make them compliant or they cannot be made compliant. Site surveys are being conducted now. Participants input and other information indicated in the plan will have to be considered for those sites subject to heightened scrutiny. It will simply take more time before DA can have exact numbers of individuals who may be impacted.

Comments: Section 3: Key Stakeholders and Outreach

The Division lists a number of outreach activities it has taken to date. Notably, all of these activities have been geared toward providers rather than participants. Although the Division indicates its desire to include participants “in the development and implementation” of the STP, the STP is already in the public comment period. The commenter recommends that the Division reach out to Waiver participants as quickly as possible to elicit critical input.

Response: DA would agree that input into the plan has largely come from providers. DA continues to struggle with ways to get more direct input from participants and their families. DA truly wishes to connect with the commenter and wishes DA had thought to include them as an important consumer advocacy voice. DA apologizes for that oversight. DA conducted consumer outreach sessions in assisted living settings through the state in the fall of 2014 but did not receive many comments during that process. DA has also included the Indiana Association of Area Agencies on Aging and the Alzheimer’s Association in these processes to offer more of a participant focus. DA is currently engaging the assistance of the University of Indianapolis to aid DA in improved participant engagement including the creation of an HCBS Advisory Group. DA will absolutely include the commenter in these efforts and again wish DA had thought to do so earlier. The commenter also has concerns with the process and content of the draft Aging Rule, currently 455 IAC 2. The FSSA Office of General Counsel has been very involved in this process. The OGC’s office prepared the crosswalk of rules contained in the STP. DA continues to work closely with OGC in all elements of the efforts around Final Rule compliance and transition plan activities. The

Rule is still in draft form and has not yet even been formally posted for public comment. DA is aware that a number of changes and additions still need to be made to the draft.

Comment: The same commenter requests that the Division disclose its plans to coordinate with the other State entities to ensure that individuals with “dual diagnoses” are not being unnecessarily served in settings that are non-compliant with or technically exempt from the HCBS Final Rule. Too often, the commenter hears reports from such individuals that they are essentially “punted” between Divisions and are unable to receive truly individualized treatment and services due to a lack of coordination among the Divisions.

Response: DA appreciates this concern expressed by the commenter. DA has been engaged with our sister divisions in FSSA in a planning process for a no wrong door system of access that addresses these concerns. DA will reach out to the commenter with information about this initiative and seek their participation in the process. DA also has a redesign of the State’s Pre-Admission Screening Resident Review system for nursing facility placement in progress that DA can send the commenter information about. DA truly wishes to connect with the commenter and wish DA had thought to include them as an important consumer advocacy voice. DA apologizes for that oversight.

Comment: One commenter recommended that the expansion of Adult Family Care occur if the program contains nursing oversight. Adult Family Care can provide personalized options for long term care for Hoosiers in a small, intimate setting of a specialized home. However, since the recipients for this service meet nursing home level of care, more clinical oversight is needed to maintain positive outcomes for this aged and disabled population. Home health agencies have the skill and experience to teach and train caregivers, observe and assess clinical conditions, and manage and evaluate care provided by non-skilled caregivers. Since most of the Hoosiers in these homes most probably meet the requirements for Medicare covered home health services, Indiana Medicaid would not be responsible for payment for such services. Though long term skilled care would most probably not be covered or needed, this is an opportunity for new residents of adult family care homes. Though some recipients may not have Medicare, Medicaid could cover the initial oversight.

Response: DA appreciates this comment from the commenter. DA does not find it to be directly related to the STP but more a comment on DA’s HCBS programs in general. DA will reach out to the commenter to discuss this and other issues outside of the STP process.

Comment: Indiana Medicaid should consider delegation of certain nursing services to home health aides under the fee-for-service and managed care programs. The services would be billed at the home health aide rate. Both the Indiana Nurse Practice Act and the Indiana State home Health regulations allow for nurse delegation to a trained and competent aide. Such procedures as in and out catheterization, bowel care, simple wound care, a simple G-tube feeding could be done by a certified home health aide under the supervision and training of a registered nurse. This process would allow the recipient to have one caregiver who could do all the required care. Not having to send a LPN to do a task that a trained and competency tested aide could do, would also be a cost savings to Medicaid.

Response: DA appreciates this comment from the commenter. DA does not find it to be directly related to the STP but more a comment on DA’s HCBS programs in general. DA will reach out to the commenter to discuss this and other issues outside of the STP process.

Comment: Nursing practitioners should be able to sign primary plans of care. The commenter believes this would alleviate provider capacity concerns in rural areas. The Indiana home health statute and the federal Conditions of Participation only allow physicians to sign medical plans of care. Currently there is

federal legislation to allow nurse practitioners and physician assistants to sign plan of care. For Indiana residents in rural and inner city, these practitioners are the primary care manager. It will be imperative that Indiana change its laws and regulations' to allow NPs and PAs to become the primary care provider.

Response: DA appreciates this comment from the commenter. DA does not find it to be directly related to the STP but more a comment on DA's HCBS programs in general. DA will reach out to the commenter to discuss this and other issues outside of the STP process.

Comment: Physical Therapy Assistants and Occupational Therapy Assistants under the supervision of a physical therapist and occupational therapist respectively should be covered services in the home setting. The commenter believes coverage should be consistent under Traditional Medicaid and the Medicaid managed care programs, such as Hoosier Care Connect and the Healthy Indiana Plan 2.0. PTAs and COTAs can provide therapies under the Medicare program and this benefit and coverage should be covered under Indiana Medicaid. The use of PTAs and COTAs are important due to the shortage of physical therapists and occupational therapists, particularly in the rural areas. This would alleviate the access to service issues for individuals in need of timely therapy services to promote the individual's functioning and independence.

Response: DA appreciates this comment from the commenter. DA does not find it to be directly related to the STP but more a comment on DA's HCBS programs in general. DA will reach out to the commenter to discuss this and other issues outside of the STP process.

Comment: One commenter shared that presumptive eligibility is currently performed by the following entities under the Medicaid program: Hospitals, Federally Qualified Health Centers, Rural Health Clinics, Community Mental Health Centers, Local Health Departments. At this time, the local Area Agencies on Aging are not identified as a qualified provider to make presumptive eligibility decisions. The commenter believes that there need to be procedures in place that allows for PE determinations for individuals when the home health nurse performs the nursing assessment and the individual has not received a PE determination in the hospital. FSSA should reach out to the Centers for Medicare and Medicaid Services to consider the local Area Agencies on Aging as qualified providers.

Response: DA appreciates this comment from the commenter. DA does not find it to be directly related to the STP but more a comment on DA's HCBS programs in general. DA will reach out to the commenter to discuss this and other issues outside of the STP process.

Comment: OPTIONS counseling should be performed during the first 100 days of an individual's Medicare nursing facility care to promote informed consumer choice and prepare for adequate discharge planning from the nursing facility to the community. This practice affords an individual the opportunity to be in the least restrictive environment in a HCBS setting.

Response: DA appreciates this comment from the commenter. DA does not find it to be directly related to the STP but more a comment on DA's HCBS programs in general. DA will reach out to the commenter to discuss this and other issues outside of the STP process.

Comment: One commenter shared a concern that the managed care model may not be the most appropriate to provide the necessary comprehensive care for Medicaid home health recipients who have a skilled need or whose limitations in activities of daily living would make them eligible for the medical model waivers administered by the DA. There is a concern that comprehensive care will not be provided for this population under the managed care model. These individuals have been served well under the fee-for-service model. Currently, Medicaid waiver recipients are excluded from Hoosier Care Connect. It is

important to note that many waiver recipients benefit from the combination of Traditional Medicaid home health services and waiver services.

Response: DA appreciates this comment from the commenter. DA does not find it to be directly related to the STP but more a comment on DA's HCBS programs in general. DA will reach out to the commenter to discuss this and other issues outside of the STP process.

Comment: The commenter expressed a concern that current reimbursement and administrative procedures set by Indiana Medicaid impact provider capacity and create lack of willing providers. Home health agencies have operated under a Medicaid rate cost reduction since SFY 2011. At this time, home health rates for SFY 2016 reflect a 3% reimbursement cut.

In addition to cost reductions, home health agencies are faced with administrative burdens that impact their day to day operations. Indiana Medicaid has implemented Hoosier Care Connect and HIP 2.0 and awarded contracts to Anthem, MHS and MDWise. Each MCE is permitted to have its own prior authorization and claims billing procedures. Providers often encounter an administrative burden and possible slowdown of care provision when there is not a consistency in prior authorization guidelines or claims billing among health plans.

Reimbursement for licensed home health agencies that provide respite nursing and respite home health aides and licensed personal services agencies that provide services under the Aged and Disabled Waiver Waiver, Traumatic Brain Injury Waiver, and Money Follow the Person Grant is inadequate to hire staff as other industries are able to hire staff. An increase in waiver rates is necessary to promote hiring and staff retention for home health agencies and PSAs under these waiver programs.

Response: DA appreciates this comment from the commenter. DA does not find it to be directly related to the STP but more a comment on DA's HCBS programs in general. DA will reach out to the commenter to discuss this and other issues outside of the STP process.

Comment: One commenter expressed a concern with the fairness to families who currently have loved ones in memory care units, requesting that the transition process allow for a grandfathering of patients who currently reside in those units to remain on the HCBS waiver and for those who become eligible for the waiver during this period of rule promulgation. The commenter also shared a concern with the Medicaid application process and that forcing an existing waiver recipient's family to find a new facility for their loved one is cruel.

Response: DA appreciates the concerns of the commenter regarding any potential that individuals would have to be moved from current settings that are perhaps both co-located with an institutional setting and/or have a secure memory care unit. DA acknowledges that these settings offer opportunities for spouses with different care needs to still be in close proximity to one another. It is certainly not the goal of the state to disrupt these or other participants of waiver programs. DA will work with providers to assure compliance with the Final Rule wherever possible. If there are instances where settings are simply found to not be home and community based, the state will work with providers, consumers, families, and advocates to explore all possible options providing individuals with person centered counseling in order to assist them with making their own well-informed decisions about their care options.

Division of Disability and Rehabilitative Services

Summary: The Division of Disability and Rehabilitative Services solicited comments on the Statewide Transition Plan as it applies to two adult 1915(c) programs; Community Integration and Habilitation and Family Supports Waiver. The comments resulted in changes on pages 51, 55, 56 and 57.

Comment: A commenter suggested that strong language is needed to protect parents/guardians from provider agencies that threaten to issue a 60 day termination of services if the parents/guardians file a complaint or initiate an incident report related to their child's services.

Response: Thank you for the suggestion. This information is useful for the revisions/development of policies and procedures. While the STP will not be updated with this specific language, policies/procedures can be modified to incorporate additional protections.

Comment: Another commenter suggested that familial services, if allowed, should be capped at no more than 40 hours a week across all services in total. The opportunity for exploitation occurs when family members, who are controlling the services, decide they will provide all the services and select Community Based Habilitation-Individual for all day funds rather than a mix of day programming and/or therapies. By capping the hours allowed by family, this issue will be mitigated.

Response: Thank you for your comment.

Comment: One commenter provided a list of items (e.g. History of Consumer, Natural Supports, Diagnosis of Consumer, Short-term Goals, Long-term Goals, Services Receiving, Behaviors, and Incident Reports) and two questions: 1) What is working for this consumer? 2) What is not working for this consumer?

Response: Thank you for the suggestion. This information is useful for the revisions/development of forms.

Comment: A comment was received regarding specific language in the STP as follows: 1) There is a reference to a new document titled "Individual Rights and Responsibilities." 2) There is a comment that says any question on the 90 Day checklist that is marked "no" will have remediation. The commenter pointed out that this is not true given the revision that is planned to be rolled out around 7/1/16. 3) Additional "in depth analysis" is noted as being needed in the majority of these comments. 4) The second paragraph ends with a sentence that references the PCP document, but I think you really mean the ISP document. 5) What role does the Waiver Case Manager play in the Site Specific Assessment?

Response: Thank you for the feedback. On page 51, the STP will be modified to read "if the response to any questions related to HCBS requirements is evaluated to be out of compliance, the case managers will notify the responsible party that a corrective action plan is required to be completed and submitted." In regards to page 51, the "in depth analysis" refers to the results of the IES survey. Page 55 does reference the PCP. Language will be updated to the "Person Centered Service Plan" to reflect CMS criteria. Page 57 language will be updated to reflect "DDRS or its contracted entity." Case Managers may be involved in this process. Final determination of who will complete site visits has yet to be determined.

Comment: A letter was received from an Indiana advocacy agency with comments regarding Section 1: Systemic Assessments, Section 2: Site Specific Setting Assessment, Section 4: Proposed Remediation Strategies, and Section 5: Key Stakeholders and Outreach. Below are the responses from DDRS regarding each comment contained in the letter.

As requested by an Oct. 8, 2015 letter from the Centers for Medicare and Medicaid Services to State Medicaid Director Joe Moser, the division has identified several sections of the Indiana Administrative Code that will need to be modified in order to comply with the new HCBS standards. However, no proposed modifications to these sections are provided. The commenter requests that the Division publish proposed amendments to the identified sections so that participants and others can provide meaningful feedback prior to federal STP approval.

Response: Through the Systemic Settings Crosswalk, the state has identified areas of within the Indiana Administrative Code that will necessitate modifications to assure the State’s compliance with HCBS requirements. Specific language will be added to mirror HCBS requirements. Any proposed modifications will follow the Administrative Rules drafting procedure and will be published for a public comment period to ensure meaningful feedback from all stakeholders.

Regarding employment services, the commenter is concerned that methods of collecting data (i.e., the 90-day Checklist) are inadequate to capture important evidence regarding the status of competitive, integrated employment. For example, the Checklist asks caseworkers to “[c]onfirm the individual is free from work without pay that benefits others.” This question appears to forbid Waiver participants from engaging in volunteer work. The new HCBS regulations do not preclude Medicaid beneficiaries from volunteering in their communities. Instead, the Division should create a tailored survey tool designed to assess how many Waiver participants are actually engaged in competitive, integrated employment; how many would like to be, but have not yet become employed; barriers to employment in Indiana; etc. These findings should be made available, in accessible formats, on an annual basis.

Response: Thank you for the suggestions. The 90 day check list as an ongoing monitoring tool will be modified from the current content to measure HCBS Requirement on an ongoing basis. The information provided above will be helpful as the State incorporates the suggestions within specific policies and procedures.

Further, the commenter asks that the Division include more specifics regarding its own role in helping Waiver participants achieve competitive, integrated employment. For example, the commenter recommends that the Division broaden the availability of individualized employment services, increase education and outreach to providers and Waiver participants about employment options and work incentives, and include other State agencies in achieving employment goals. The commenter also suggests that the STP explicitly forbid the use of Waiver funding for non-integrated employment settings, including sheltered workshops, and noncompetitive jobs, including those where individuals earn subminimum wage. To that end, the Division will need to address prevocational services, set measurable outcomes, create timelines, and change funding methodologies accordingly.

Response: DDRS appreciates the support expressed by commenters and will review the suggestions listed above. While the specific suggestions listed above will not be incorporated into the transition plan, the State will incorporate the suggestions within the specific processes to the greatest extent possible.

In regard to the new HCBS regulation regarding the receipt of community services, the Division points to 460 IAC 7-3-12, which “empowers an individual and the individual’s family to create a life plan and corresponding ISP for the individual...” the commenter believes the State rule needs to be amended to explicitly provide that the individual, rather than his or her family, leads the planning process. Certainly, a Waiver participant is free to include family members in the plan development process if he or she chooses, but any such inclusion should be at the option of the participant.

Response: Specific language will be added to mirror HCBS requirements. Any proposed modifications will follow the Administrative Rules drafting procedure and will be published for a public comment period to ensure meaningful feedback from all stakeholders. Additionally, policies and procedures will be updated timely and appropriately to comport to the HCBS requirements.

The Division notes that measurables for determining if an individual has access to the community are captured by asking whether “adequate Transportation [is] being provided” and using the Checklist to determine if he or she participates in the community. These measures are insufficient to achieve compliance with the new HCBS regulations. The Waiver participant should have the ability to leave his or her home as he or she wishes. The measuring tools only assess whether transportation is “adequate.” The Division does not provide any definition for “adequate.” Further, evidence of a presence outside the home does not guarantee that the participant is actually exercising choice in his or her daily agenda. Current Checklist inquiries for several other service criteria are similarly insufficient.

Response: The state agrees the current 90 day check list does not adequately address HCBS requirements. For this reason, the Individual Experience Survey was administered to give a clearer picture on how individuals experience their day to day life including accessing the community. The 90 day check list as an ongoing monitoring tool will be modified from the current content to measure HCBS Requirements on an ongoing basis. The information provided above will be helpful as the State incorporates the suggestions within specific policies and procedures.

The Division also should amend the Indiana Administrative Code to reflect outings are at the discretion of the Waiver participant. Currently, 460 IAC 6-19-1(1) provides that the case manager should determine “[t]he wants and needs of an individual, including the health, safety and behavioral needs of an individual.” The Division proposes that the current rule mandates that Waiver participants have control of their schedule. However, the existing rule falls short. A participant may wish to travel somewhere outside the scope of his or her health and safety needs. Similarly, providers are unlikely to interpret this rule as mandating that they assist clients with transportation and other services needed to obtain and maintain competitive, integrated employment.

Response: Specific language will be added to mirror HCBS requirements. Any proposed modifications will follow the Administrative Rules drafting procedure and will be published for a public comment period to ensure meaningful feedback from all stakeholders.

The commenter is also concerned that such heavy reliance on the Checklist will have the result of excluding organic feedback from Waiver participants. First, the Checklist is completed by caseworkers rather than participants. Second, the Checklist does not mirror new HCBS regulatory requirements, but instead skirts around salient compliance information. The commenter recommends that the Division include Waiver participants and advocates in the planned redesign of the Checklist, targeted for completion in December 2017. Additionally, the Division should integrate regularly occurring face-to-face interviews with a statistically significant population of participants as an additional monitoring tool and means to verify data gathered through the Checklist. This should be carried out by an independent third party. The commenter is skeptical of any monitoring efforts that do not include strategic efforts to seek direct input from consumers themselves.

Response: Thank you for the comment. The information provided above will be helpful as the state incorporates the suggestions within specific policies and procedures. The state will ensure stakeholders have an opportunity to review any policy/process changes and, to the greatest extent possible, the state will incorporate the suggestions within the specific processes.

Comments: Section 2: Site Specific Setting Assessment.

The commenter is concerned with the Division's proposed strategy for achieving compliance when noncompliance is determined through use of the 90 day checklist. The Division proposes case managers require providers to submit a corrective action plan. Case managers are responsible for determining whether providers comply with these plans. If they do not, the Division will become involved. Importantly, no timelines are provided. How long will a Waiver participant be forced to forgo their rights while the provider may or may not attempt to take corrective action? How does the Division plan to achieve statewide continuity if individual case managers are making compliance determinations? How does the Division plan to limit managerial discretion? Who has due process rights during this process, and how are they invoked? Will the Division impose any sanctions on providers that continuously take advantage of the corrective action plan process and repeatedly violate participant rights?

Response: The state will review the suggestions listed above in order to identify areas inadequacy or weakness within the 90 day check list and develop necessary modifications to assure the state's compliance with HCBS requirements. Case managers will continue to be trained and held accountable for following proper procedure in the completion of this task. While the specific suggestions will not be incorporated into the high level Transition Plan, the state will ensure stakeholders have an opportunity to review any policy/process changes listed above and, to the greatest extent possible, the State will incorporate the suggestions within the specific processes.

The commenter also requests the Division provide details regarding notice and procedural safeguards that will be provided to participants who will potentially face relocation. These details were explicitly requested by CMS in its October letter, but are not provided in the updated STP.

Response: The STP will be updated to incorporate the procedural safeguards provided to participants who would potentially face relocation. Thank you for the suggestion.

Comments: Section 4: Proposed Remediation Strategies.

The Division provides that an updated STP will be offered to CMS after survey results are examined. The commenter recommends that the Division provide its methodology and a timeline for evaluating data. These updated STP provisions should be made available for public comment.

Response: Thank you for the suggestion, the STP will be modified to include a timeline for evaluation of collected data. The updated STP is projected to be submitted in September 2016 and will include the results of the IES survey. Per CMS Requirements, any substantive changes to the STP will require a public comment period, and the addition of this information will be considered as substantive.

The commenter has substantial concerns regarding the manner in which the Division proposes administering the statewide survey created by the Indiana Institute on Disability and Community. The STP provides that, "[o]nce the survey has been validated IIDC will disseminate it electronically to providers throughout Indiana to complete, with the individuals they serve." The commenter believes this methodology permits providers to severely bias survey results. Additionally, the Division provides no information regarding how it intends to protect the privacy of neither respondents nor potential retaliatory action by providers. The commenter proposes that the Division contract with an independent third party to assist individuals in completing their surveys.

Response: The IES Survey has been closed as of Jan. 31, 2016. It was completed by the individual or guardian during the individual's Quarterly meeting with the case manager presenting the survey and then entering the information into an electronic system. Dissemination of the summary of the survey will not include consumer or provider names, rather an overview of the results. Individuals and providers will be notified separately of site specific validations that result in the need for corrective action in order to protect privacy.

The Division also provides that survey results will be disseminated. The commenter questions how the results will be shared with Waiver participants, and suggests that the Division make a concerted effort to present survey data in an easily comprehensible format.

Response: Thank you for the suggestions. DDRS will work with IIDC to ensure presentation of the survey results are understandable and shared with all waiver participants and stakeholders via bulletins and postings, as well as providing printed copies upon request.

Finally, the commenter requests additional information regarding the plan to convene a "Transition Taskforce." How will members of the Taskforce be identified and selected? Does the Division plan to simply seek input from the listed key stakeholders or will there be designated outreach to and representation by self-advocates participants, providers, and advocacy groups?

Response: Members of the Transition Task force have yet to be determined. DDRS intent is to have representation of all stakeholders on the Taskforce including, but not limited to participants, family members, advocacy groups, providers, and State staff. DDRS plans to reach out to these groups via announcements, meetings, and other means of communication in order to ensure appropriate representation.

Comments: Section 5: Key Stakeholders and Outreach.

The Division states that its "intent is to engage in a collaborative process which will involve a high level of inclusion of all stakeholders." Yet, to date, the Division indicates that it has predominantly worked with the Arc of Indiana, INARF, and providers. The commenter believes the Division should strive to include both Waiver participants and consumer advocacy groups. The commenter believes participants are also being denied opportunity for public comment, in that the STP states announcements for public comment are provided on the BDDS Provider Portal and BDDS Case Management System. How are participants notified of opportunity for public comment?

Response: DDRS intent is to have all individuals provided an opportunity for feedback. In addition to a bulletin that went out to the DDRS list Serve of over 7,000 people, DDRS made a concerted effort to reach all waiver participants by an announcement to case managers requesting them to ensure individuals on their caseload were aware of the posting and encouraged to provide feedback. We also requested case managers assist individuals.

Comment: The same Indiana advocacy group also requests that the Division disclose its plans to coordinate with the other State entities to ensure that individuals with "dual diagnoses" are not being unnecessarily served in settings that are noncompliant with or technically exempt from the HCBS Final Rule.

Response: FSSA divisions will work together to ensure each individual's needs are identified and met in the least restrictive most appropriate setting of their choice. FSSA has established cross-division meetings for this purpose.

Division of Mental Health and Addiction – Youth

The Division of Mental Health and Addiction solicited comments on the Statewide Transition Plan as it applies to youth 1915(c) program Psychiatric Residential Treatment Facility Transition Waiver and the 1915(i) Child Mental Health Wraparound program. The comments did not directly result in any changes to the Statewide Transition Plan.

Comment: One commenter requests that the Division disclose its plans to coordinate with the other State entities to ensure that individuals with “dual diagnoses” are not being unnecessarily served in settings that are non-compliant with or technically exempt from the HCBS Final Rule. Too often, the commenter hears reports from such individuals that they are essentially punted between Divisions and are unable to receive truly individualized treatment and services due to a lack of coordination among the Divisions.

Response: Thank you for your comments and the contributions your organization makes to persons with disabilities each day. The Division of Mental Health and Addiction is committed to securing the most effective and appropriate supports for Hoosier youth in need of services. For this reason several avenues currently exists to facilitation this, and are listed below:

MDT – Multidisciplinary Team consists of multiple state agencies that come together every other week to review and staff cases submitted by child welfare case managers. The cases submitted are usually involved in multiple systems and have already exhausted services that are readily available or known. The case manager and other family providers participate in the review. The MDT has the ability to support referrals to the Bureau of Developmental Disability Services waivers when there is a developmental diagnosis. In addition, the team can assist with referrals to residential or state operated facilities when appropriate. State agencies included are Division of Disability and Rehabilitative Services, Division of Mental Health and Addiction, Department of Child Services, Office of Medicaid Policy and Planning and Department of Corrections.

EMDT – Enhanced Multidisciplinary Team consists of the agencies listed above as well as the Department of Education, and meets every other week to discuss system level barriers. Most of the barriers discussed are brought to our attention through the MDT when an individual is in need of support but there is nothing available statewide. The Team works to develop solutions or implement policy change that will help to overcome barriers identified.

INConnect – an interactive web portal currently in development which will provide information for the public seeking services from all of the State’s Family and Social Services Administration programs. Included will be a survey for consumers which will gather information about their needs and guide them to the appropriate resources.

While individuals presenting with dual diagnoses are not eligible for DMHA’s Child Mental Health Wraparound Services program and the PRTF Transition Waiver accepts no new applicants, the following features are in place to assure participants applying for or enrolled in our programs receive assistance to access resources and to successfully transition from services.

Access sites—Access sites, the point of entry to CMHW Services, are positioned in the community throughout the State and assist families to access services and supports appropriate to their needs, in addition to processing applications for the CMHW program.

Wraparound Facilitators—Wraparound Facilitators among many other responsibilities function as care coordinators for the CMHW program recipients, and assist families to access the services and supports within the family’s System of Care as well as within the CMHW program. They assist families transitioning out of services. As part of the Wraparound Facilitator cohort training, Transition planning is covered throughout the entire curriculum. Wraparound is composed of Four Phases;

- **Phase 1- Engagement and Team Prep.**
- **Phase 2- Initial Plan Development.**
- **Phase 3- Implementation.**
- **Phase 4- Transition.**

The curriculum the State of IN uses has been developed by the National Wraparound Implementation Center. Training around Phase Four of Wraparound includes looking for the following benchmarks and progress made by families and youth.

- **Progress towards Underlying Needs being met.**
- **Progress towards established outcome statements and behavior change.**
- **Progress towards caregiver self-efficacy and empowerment.**
- **Care Plans shifting to overtly monitor progress and changes in the plan to move towards sustainable supports, natural supports, and community supports.**
- **The development of a formalized transition plan that links families and youth to the most appropriate service level to meet their needs. This transition plan would include a transition to a lower level of care, or a transition to adult services upon the youth’s 18th birthday. Wraparound Facilitators must start transition to adult services at least 90 days prior to the youth’s 18th birthday.**
- **The development of a formalized transition crisis plan.**

Each transition plan is individualized to that person’s needs and strengths.

Division of Mental Health and Addiction – Adult

Summary: The Division of Mental Health and Addiction solicited comments on the Statewide Transition Plan as it applies to two adult 1915(i) programs; the Adult Mental Health Habilitation and Behavioral and Primary Healthcare Coordination programs. The comments resulted in changes on pages 76, 77 and 78.

Comment: One commenter has apartment buildings which are owned by an outside company, i.e. Volunteers of America, but the commenter has an office in that building to provide services to the clients. The commenter wanted to know if the lease is just for office space is it still considered to be [provider] owned/operated?

Response: Since the agency leases the office space, the offices would be “POCO non-residential” and must comply with the “Big 5” HCBS setting requirements, the same as any other community-based outpatient/clinic setting operated by the agency. If the member’s apartment units are leased through [the agency], or if there is a requirement that members who live there receive services from [the agency], then it will likely meet criteria for a POCO residential setting.

Comment: One commenter wanted to know if POCO [provider owned, controlled, or operated] is only for CMHCs or if they are also for nursing homes like some RCAPs.

Response: Provider owned, controlled or operated applies to any Medicaid enrolled HCBS provider who provides services to members utilizing HCBS programming. Each setting must be assessed based on CMS standards. Some setting types/categories (like RCAP) may or may not be fully compliant with the HCBS Settings Rule, and the relationship between a RCAP facility with a given CMHC may vary. Therefore, each must be assessed based on that setting and the relationship with the CMHC.

Comment: One commenter wanted a list of settings DMHA has determined do not meet compliance for HCBS compliance.

Response: Initial compliance designations for POCO residential settings will be communicated to individual providers as they become available, no later than May 30, 2016 (for settings which need modifications to become fully HCBS compliant) or Dec. 31, 2016 (for settings presumed institutional and will be referred for heightened scrutiny).

Comment: One commenter wanted to know how to handle a coordination of transfer if a client is receiving services and meets HCBS requirements, however, medical health creates an (almost overnight) transition to nursing facility.

Response: As noted, coordination of transfers is a critical component of continuity of care and must be done. However, per the AMHH and BPHC 1915(i) State Plan Amendment 3.1-I and 405 IAC 5-21.6/405 IAC 5-21.8, HCBS are not reimbursable if provided in an institutional setting.

Comment: One commenter wanted more information about clients who are on commitment to stay in a group home.

Response: Involuntary commitment does not affect the requirement that a member receiving HCBS lives in a fully compliant setting, and their participation in making informed choices about rights/responsibilities, and choosing to participate in HCBS services must be documented in all cases.

Comment: One commenter wanted to confirm the April 1 is the date for implementing RSST and DARMHA modifications.

Response: Yes the April 1 date for implementation of HCBS Residential Setting Screening Tool (RSST) is firm, due to CMS’s requirement for data collection before next STP submission (anticipated September 2016).

Comment: One commenter wanted to confirm if assisted living participants can get AMHH or BPHC if in a nursing home and also if the assisted living is on the same grounds as a nursing home but not in the nursing home. Does that also fall under presumed institutional?

Response: Whether the individual is eligible for AMHH or BPHC programs will depend on whether the assisted living facility is determined to be an HCBS compliant setting or an institutional setting. If the setting is assessed to have qualities of an institution (including being in or adjacent to an institutional setting), it may be referred for heightened scrutiny. The following is an excerpt from a CMS presentation in Nov 2015: “At a minimum, states should submit information clarifying that there is a meaningful distinction between the [institutional] facility and the community-based setting such that the latter is integrated in and supports full access of individuals receiving HCBS to the greater community. This could include documentation that the home and community-based setting is not operationally interrelated with the facility setting.”

Comment: One commenter questioned if a presumed institution is receiving BPHC, will they be denied or eligible?

Response: Members receiving HCBS who live in a setting preliminary designated by DMHA as “Potential Presumed Institutional” are currently eligible to continue to receive services until a final determination is made. For settings which are presumed institutional and for which the presumption is allowed to stand, Member Transitions Plans will be initiated for any affected members. The Member Transition Plan process and any relocations or termination of HCBS will be guided by person-centered planning.

Comment: One commenter asked how county homes are identified on the application and if they would be identified as nonPOCO.

Response: County homes like all other settings are considered non-POCO, as long as they are not owned/controlled/operated by an HCBS provider. However, if the setting is owned by a governmental unit (like the county), it meets criteria for “Potential Presumed Institutional” and needs to be referred for heightened scrutiny.

Comment: One commenter asked if homeless shelters are exempt from HCBS.

Response: During an HCBS conference call, a verbal response from CMS indicated homeless shelters are exempt from HCBS. However, FSSA/DMHA has not received this information in writing. Will advise as more information is available.

Comment: One commenter inquired if providers can scan surveys, such as the HCBS Resident Survey to DMHA through email.

Response: No. FSSA/DMHA needs the hard copies to protect member confidentiality.

Comment: One agency had a question regarding building compliance. Their agency has an inpatient unit, which they understand is considered an institution, and in a separate part of the building the agency

providers skills in training groups. The agency wanted to know if they would be out of compliance even though these programs are separate from each other.

Response: If the setting is assessed to have qualities of an institution (including being in or adjacent to an institutional setting), it may be referred for heightened scrutiny. The following is an excerpt from a CMS presentation in Nov 2015: “At a minimum, states should submit information clarifying that there is a meaningful distinction between the [institutional] facility and the community-based setting such that the latter is integrated in and supports full access of individuals receiving HCBS to the greater community. This could include documentation that the home and community-based setting is not operationally interrelated with the facility setting.”

Comment: One commenter asked how the application will be approved if the POCO 5 are not met, meaning the Screen Tool and application identify this, but there is justification in the Treatment Plan?

Response: If a modification(s) to one or more of the “POCO 5” requirements are substantiated through the person-centered treatment plan, then the setting will be considered compliant with that particular requirement.

Comment: One commenter wanted to know where the slides from the DMHA Webinar training would be posted and if they will include answers to the questions that were posed during the training.

Response: Slides from the 3/10/16 training were distributed on 3/21/16, and are posted on the DMHA AMHH and BPHC webpages. Responses to questions will be provided following the public comment period, which ends 4/6/16. The FSSA [HCBS Final Rule Transition Plan website](https://www.in.gov/fssa/4917.htm) contains links to valuable information located at <https://www.in.gov/fssa/4917.htm>.

Comment: One commenter asked if the surveys that providers completed online are different from the surveys that DMHA is requesting from the clients.

Response: Yes. The provider surveys completed on-line were the provider self-assessments of POCO residential settings. The surveys members are completing during February/March 2016 are resident surveys, which will be used to validate the results from the provider self-assessments of POCO residential settings.

Comment: One commenter asked if vignette examples will be given from which they can learn about applied classifications, (*i.e.* examples of specific cases of how someone in a certain situation would be classified).

Response: Good suggestion. DMHA will develop examples to help providers apply HCBS setting standards, to assist with the assessment process. In the meantime, refer to the HCBS Residential Setting Screening Tool for help in determining the setting type and the compliance requirements for a specific setting. Providers of HCBS are encouraged to review the [medicaid.gov](https://www.medicaid.gov) HCBS Final Rule page for additional information on settings as well.

Comment: One commenter asked if a group home is Joint Commission certified can it be assumed that it meets POCO 5.

Response: No. HCBS setting requirements are separate from and must be met whether or not a setting is Joint Commission certified.

Comment: One commenter asked what would happen if POCO-5 requirements violate Fire Marshal requirements.

Response: Conflicts between HCBS setting requirements and local fire marshal codes must be documented as a modification to the POCO 5 requirements on each individual resident’s person-centered treatment plan.

Comment: One commenter asked if support staff could enter survey response into Survey Monkey.

Response: No. Member responses are to remain private.

Comment: One commenter asked how members will be informed about the HCBS Final Rule and new settings requirements.

Response: Providers are responsible for informing members about HCBS setting requirements and compliance status. The FSSA HCBS Final Rule page is a resource for providers as well for members. DMHA will develop an information handout for providers to be able to give to members, as well.

Comment: One commenter asked if there will be an information sheet available for staff to give the client about the new requirements.

Response: Good suggestion. DMHA will develop an information handout for providers to be able to give to members, explaining the requirements of the HCBS Settings Final Rule, its expected impact on members receiving AMHH and BPHC services, and the addition of the HCBS Residential Setting Screening Tool to the application process. Providers are responsible for informing members about HCBS setting requirements and compliance status.

Comment: One commenter asked that in regard to the HCBS Residential Setting Screening Tool, if it would be possible to set up a form in our ECR that could be electronically signed to reduce the redundancy of a scanned form.

Response: Yes, as long as the electronic version of the RSST has all the same questions/information as the paper form, the signature is captured, and the outcome is entered correctly in DARMHA for applications beginning April 1.

Comment: One commenter stated that they liked the changes to the flow of the RSST tool.

Response: Thank you for your feedback.

Comment: One commenter wanted know how “adjacent” would be defined in regards to how it relates to presumed institutions.

Response: CMS has not specifically defined “adjacent” as pertains to the HCBS Settings Rule, but DMHA is interpreting “adjacent” in this context to mean sharing a property boundary.

Comment: One commenter wanted to know how “operated” is defined as it relates to POCO residential sites.

Response: Each site must be assessed individually for compliance with the HCBS Settings Rule, including whether the setting has qualities of an institution. [The site] was previously identified by your agency as a POCO residential setting, which is accurate since the agency is involved in management of the property.

Comment: One commenter asked if assessments can be completed if the patient is in an inpatient unit or in a Crisis Respite outpatient unit.

Response: The assessments may be completed while the member is in an institutional setting, and are an important part of discharge planning and continuity of care. However, as with all home and community based services, agencies will not be reimbursed for HCBS provided in an institutional setting.

Comment: One commenter asked if further guidance and clarification could be provided regarding how rules will apply to all settings where HCBS are delivered and not just to residential services.

Response: All home and community based services are required to be delivered in settings which fully comply with the HCBS Settings Rule. This applies to POCO non-residential settings, such as clinics, day service sites, etc. In May 2016, providers will complete self-assessments on their non-residential facilities to determine compliance with the HCBS Settings Rule.

Comment: One commenter asked if an exception to the requirement for the “locked bedrooms” requirement could be made since it is seen as a safety risk for patients.

Response: The intent is that a member’s right to privacy is protected, as well as their right to choose whether to have visitors in their living space. Providers are reminded that all setting modifications must be based on an individual’s specific assessed need, and documented in the individual’s person-centered treatment plan. If a lockable bedroom door will not be provided for an individual member that modification must be clearly supported by documentation in that member’s person-centered treatment plan.

Comment: One commenter asked if it was acceptable to document checkpoints, which ensure modifications are still appropriate, at the time that the treatment plan is updated.

Response: Yes, at a minimum at least every 90 days. Review of modifications should also be done whenever there is a significant change in a member’s status.

Comment: One commenter requested that the Division provide more details regarding how stakeholders will be identified and selected and encourages the Division to include a significant number of Waiver participants, as well as their advocates, as task force members.

Response: DMHA has received over 1,000 responses from members who completed the HCBS Resident Survey, many of whom reached out to family members, friends, and other natural supports to help them complete the survey. This was an incredibly robust response, and speaks to DMHA’s commitment to engage members, their families, and other natural supports in an individual’s ongoing person-centered treatment planning. DMHA is assessing the most appropriate avenues and anticipates engaging some or all of the following groups/organizations in the ongoing process of refining and implementing the STP: DMHA Consumer Council; Mental Health and Addiction Planning and Advisory Council; NAMI Indiana; Indiana’s Key Consumer organization; Mental Health America, Indiana chapter (including the Mental Health Ombudsman program staff).

Comment: One commenter recommends, regarding the Division’s proposed Member Transition Plan, that an independent facilitator be added to the plan development process. The commenter is concerned that the proposed team members will provide the potential for troubling conflicts of interest, especially for participants who lack natural supports and states that it is not enough that the Division will be reviewing the MTPs after they have been enacted. Lastly, the commenter requests greater detail regarding the notice and procedural protections that will be provided to participants needing to change their living settings or service plans.

Response: Per the CMS-approved 1915(i) SPA, members applying for or enrolled in AMHH/BPHC are required to be provided information about their rights and responsibilities, consisting of both written materials and a verbal explanation. DMHA ensures that members receive rights and responsibilities information through the established QA/QI process for 1915(i) programs. Among the information required to be included in the member’s rights and responsibilities information are the phone numbers for the DMHA Consumer Support Line and Indiana Protection and Advocacy Services. In addition, the person-centered planning process ensures that an individual has the right to choose who will be a part of his or her treatment team, including family members, friends, natural supports, and advocates of the member’s choosing. DMHA will explore changes to program policies and procedures to add that required HCBS information must include contact information of the State’s Mental Health/Addiction Ombudsman program to ensure individuals without family or support systems have access to an independent party to assist and advocate for them if they choose.

Comment: One commenter requests that the Division disclose its plans to coordinate with the other state entities to ensure that individuals with “dual diagnoses” are not being unnecessarily served in settings that are non-compliant with or technically exempt from the HCBS Final Rule. Too often, individuals are passed between Divisions and are unable to receive individualized treatment and services due to a lack of coordination.

Response: FSSA divisions will work together to ensure each individual’s needs are identified and met in the least restrictive most appropriate setting of their choice. FSSA has established cross-division meetings for this purpose.

Comment: Several questions were received about how the HCBS Settings Rule affects members who are homeless, specifically, how to document and assess the living situation for homeless members enrolled in or applying for HCBS programs.

Response: DMHA refers providers to the following guidance from CMS: “If a recipient is ‘homeless,’ that does not impact service delivery through the various authorities covered by the HCBS Settings Rule and transition process. The recipient has not been placed in a residential setting under the rule. Any nonresidential services would treat homeless and people with homes in the same manner. The additional requirements for provider owned and controlled residential settings do not apply as a homeless person is not served in that type of setting.” To assist providers in documenting a member’s homelessness, DMHA will establish a “Homeless” category on an updated version of the HCBS Residential Setting Screening Tool, and will add a “Homeless” choice to the available options in the “Current Living Situation” section of the DARMHA application for 1915(i) services. DMHA will also explore policy and procedural changes regarding ongoing residential assessment.

Comment: Several questions, comments and suggests were received from AMHH and BPHC providers regarding the HCBS Residential Setting Screening Tool. Providers requested further guidance on the implementation of this new tool, and made good suggestions for improving future versions of the tool.

Response: DMHA will develop and distribute an updated version of the RSST, to include a comprehensive definitions and instruction sheet. DMHA will compile and distribute an FAQ list for providers with responses to questions received about proper completion of the RSST, based on unique member residential situations encountered by provider agencies.

Version III – September 2016

Division of Aging

Summary: The Division of Aging solicited comments on the Statewide Transition Plan as it applies to the two 1915(c) programs; the Aged and Disabled Waiver and the Traumatic Brain Injury Waiver. The comments resulted in changes to pages 6-12, 15-20 and 21.

PUBLIC COMMENTS:

Comment: The commenter believes that the criteria for food stamps should be changed. The commenter states that they have a hard time scraping enough money together for groceries but see people using their food stamps for soda pop and candy.

Response: This comment is not relevant to the transition plan however, the DA appreciates your comment and, we will share with the appropriate FSSA staff.

Comment: A commenter inquired about how the amended transition plan would affect licensure of Residential Care Facilities. Specifically, there is a concern that there seems to be uncertainty around licensure requirements relating to the waivers that have traditionally been characterized as more institutional. The commenter asks if DA is in the predevelopment, can DA guidance as to whether the concept (affordable assisted living), which caters to the lowest of income residents will meet the criteria? The commenter would like to review and discuss their intentions to see if the new rule changes will be a barrier to their new developments. Additionally, the commenter notes that Indiana is providing public notice through the Indiana register of newsletter disseminated by advocacy groups and trade organizations, list serves, and other electronic newsletters. The commenter requests access or to be directed to where they can locate this information so they can become more actively involved.

Response: Access to affordable assisted living services is a key component to increasing HCBS options for consumers who may otherwise be at risk of institutionalization. A workgroup will begin meeting in October to finalize standards in compliance with the settings rule. Those standards will be completed by early 2017. The Division will contact you directly about how you can become involved.

Comment: A commenter raised concerns that they believe Division of Aging presumes multiple waiver services are compliant with HCBS regulations. For example, the TBI Waiver offers supported employment opportunities to participants. The commenter expressed concern that these employment services, in some circumstances, may be delivered to participants in sheltered, non-competitive settings. The commenter encourages the Division to assess programs individually for compliance with the HCBS regulations. The commenter also questions the usefulness of the Person Centered Monitoring Tool and National Core Indicators survey questions. The commenter cites issues with the yes-or-no responses and the thresholds inherent in certain questions (e.g., “In the last 90 days has the individual experienced harm and/or abuse that resulted in a report of any kind?”). The commenter believes a better-tailored survey could be developed, soliciting substantive information from waiver participants.

The commenter also raised questions about the assisted living portion of the STP as is currently written; however, the commenter understands that the Division is working toward a solution to permit individuals to continue receiving assisted living services without running afoul of the HCBS regulations. The commenter supports a solution in which the authority over and certification of assisted living providers is maintained by a single state agency. The commenter believes such a solution would streamline the

resolution of assisted living issues, increase accountability, and decrease both bureaucratic gridlock and lay confusion.

Response: Thank you for your reminder about supported employment services. You are correct that DA has not addressed that and will add it to the plan. DA only has two consumers currently receiving supported employment services under the TBI waiver. This is a service and a set of providers that is shared with DDRS. As they have considerably more consumers impacted DA will be following their lead in this area. In regard to the PCMT and NCI-AD tools, DA appreciates your concern about the format of the questions. DA will reach out to you directly for further review of these items and will consider changes to at least the PCMT which DA can control. On the NCI-AD, DA can suggest changes to the national advisory group and advocate for those as appropriate. Finally, thank for your recommendation regarding the certification process for assisted living providers. DA agrees that there are certainly benefits to eliminating duplication of effort as well as confusion from differing licensing and certification requirements and processes.

Comment: Regarding proposed mediation strategies, a commenter requested newly promulgated rules that grant waiver participants more expansive opportunity than offered by the draft rules. The commenter believes, as currently proposed, draft rules contain phrases like “to the fullest extent possible.” The commenter is concerned that providers may take advantage of this phrasing to deny waiver participants’ access to the community, deeming it impossible – whether because of funding, lack of transportation, or some other barrier. The commenter would like to see the Division diminish opportunities for providers to deny participant-directed requests.

Additionally, the commenter believes the draft rules would require case managers to “conduct at least two of the four required assessments in the home.” The commenter believes that this restriction limits participation in the community. For example, if a waiver participant is a full-time employee, the case manager may insist that the participant take time off of work to sit at home waiting for his or her arrival and conducting of the assessment. If assessments absolutely must be conducted in the home, the commenter would like to see the promulgated rule stipulate that the case manager must be available at times convenient for the waiver participant, including after-hours or on weekends.

Response: DA appreciates these notes related to the proposed rule language. As that draft rule is further revised, DA looks forward to working with the commenter and other stakeholders collaboratively on the final language.

Comment: The commenter expresses support for the Divisions’ intentions to create a more comprehensive plan regarding stakeholder involvement. The commenter expresses full support for any efforts by the Division to increase communication with and solicit feedback from waiver participants, individual caregivers, and advocacy agencies. The commenter believes that responsiveness to such feedback will significantly improve the provision of waiver services and give participants a greater sense of autonomy.

Response: DA appreciates commenters’ support and hopes to assemble the first meeting of DA’s advisory HCBS stakeholder group in October 2016 and is looking forward to the commenter’s participation in that group.

Comment: Regarding dementia training for caregivers, the commenter notes that DA has identified four services that are in provider owned settings: 1) Adult Day Services A&D and TBI waivers 2) Adult Family Care under the A&D and TBI Waivers 3) Assisted Living under the A&D and TBI Waivers 4) Structured Day Program (TBI). The commenter believes that individuals with dementia should be

afforded the opportunity that support full access to the greater community. The commenter believes that it is important that paid caregivers in the above-mentioned provider owned settings receive proper training to care for patients with dementia so that full access to the greater community can be achieved based on the stage the patient is in the disease process. The commenter recommends that DA pursue adequate educational requirements for paid caregivers in these settings to meet this goal. The commenter recommends that training include the following:

- Understanding dementia: This would include brain anatomy and physiology, common co-morbidities, and types of dementia
- Proper communication with the patient and the family.
- Personal Care and Behaviors: This would include bathing strategies, typical behavior triggers and redirection strategies, sleeping issues, eating and ideas for activities and boredom.
- Safety and Environment: This would include caregiver and client safety, maximizing independence, and identifying environmental red flags.

Response: Thank you for your thoughts on dementia care training. While this topic is not directly part of the transition plan for compliance with the settings rule, it could certainly be a part of person centered planning efforts and alternative ways to address wandering and other issues encountered among those with dementia diagnoses. The DA agrees that having a dementia-capable workforce is important to ensuring a high quality of care as well as compliance with the settings rule.

Comment: The commenter states that, in order to be compliant with the statewide transition plan, service plans must take into account personal preferences for activities, individualized schedules and routines and provide avenues for activities outside the service site to promote interaction with the general community. The commenter further notes that, as the disease process for dementia progresses, the service plan may need to be adjusted. For example, the client may reach the stage in the disease process where the outing in the general community may have to be in less crowded areas as the noise level and large number of people in the setting would upset the client. Therefore, the service plan must be modified accordingly to ensure that the individual can have access to the greater community while also addressing appropriate modifications for safety issues with wandering due to dementia.

Response: Thank you for your thoughts on dementia care training. While this topic is not directly part of the transition plan for compliance with the settings rule, it could certainly be a part of person centered planning efforts and alternative ways to address wandering and other issues encountered among those with dementia diagnoses. The DA agrees that having a dementia-capable workforce is important to ensuring a high quality of care as well as compliance with the settings rule.

Comment: With regard to adult family care homes, the commenter notes that clients receive residential services in a family-like setting. AFC homes are approved to serve no more than four residents in a residential community with a live in caregiver. The commenter believes that the AFC home live-in caregiver should have the same training as staff providing Adult Day Services to develop activities and promote interaction with the general community. Further, the commenter believes that the AFC home must also implement the following standards to be compliant with the HCBS Transition Plan:

- The individual can have visitors at any time
- The individual controls his/her own schedule, including access to food at any time

Response: Thank you for your comments on AFC. The DA agrees that AFC providers must meet all of the requirements of a home and community-based setting.

Comment: With regard to AFC homes and the standard of visitors at any time, the commenter notes that a client with dementia experiences different stages in the disease process that will affect how he/she can have visitors at any time. The AFC caregiver will need to have the proper training to ensure that this standard is met in a manner that takes into consideration client's stage of dementia. For example, a client may reach a point in the disease process where visitors may have to be limited to a small group at a time and a quiet location since the large groups and an environment with a lot of background noise would be overwhelming. On the other hand, an individual in the early stages of dementia would be able to handle having a larger group of visitors in a public location in the general community.

Response: Thank you for your comments on AFC. The DA agrees that AFC providers must be dementia capable and meet all of the requirements of a home and community-based setting.

Comment: With regard to AFC homes and the standard of individual control over his/her own schedule, including access to food at any time, the commenter notes that the live-in caregiver must have adequate dementia training to ensure that the client has access to food at any time but still meets the needs for proper nutrition. At each stage of the disease process, an individual with dementia may need more supervision to ensure that they eat regularly and the foods they eat afford him/her the proper nutrition. A trained caregiver knows how to strike the balance in meeting this standard while still ensuring that the clients eating and nutritional needs are met during each stage of the disease process.

Response: Thank you for your comments on AFC. The DA agrees that AFC providers would benefit from dementia-capable training and they must meet all of the requirements of a home and community-based setting.

Comment: Regarding assisted living, the commenter notes that, in this setting, clients receive residential services offering an increased level of support in a home or apartment-like setting. As mentioned in the Transition Plan, assisted living facilities are somewhat isolating as they provide a full range of services within a facility. Eighty-four assisted living locations were surveyed as part of the site assessments. Of those 84 locations, a total of 27 (15 co-located to nursing facilities and 12 not collocated) have secure memory care. Twenty-four sites were not co-located and did not have a secure memory care unit. The comments that we have previously made for ADS and AFC providers apply to this section. The State Transition Plan has the standard that Assisted Living providers must ensure that the setting provides individual rights of privacy, dignity and respect and freedom from coercion and restraint.

Response: Thank you for your comments on Assisted Living. The DA agrees that AL settings must meet all of the requirements of a home and community-based setting.

Comment: Regarding the standard for freedom from restraint, the commenter notes that a trained caregiver in dementia has knowledge and skills to identify typical behavior triggers and redirection strategies at each stage of the client's dementia. The trained caregiver also has the skills to promote client safety and environmental red flags. Therefore, the caregiver can ensure that the client is not improperly restrained in a residential setting and promote participation in activities within the facility and outside community while ensuring the client's safety.

Response: Thank you for your comments on AFC. The DA agrees that AL settings must have a dementia capable staff and meet all of the requirements of a home and community-based setting.

Comment: The commenter notes that Structured Day Programs provide activities and rehabilitative services provided in a group setting. DA has indicated that they have not yet assessed SDP to determine their level of compliance with the final rule. At this time, the commenter does not have any public comments regarding dementia training for staff in these settings.

Response: Thank you for your comments.

Comment: Regarding provider capacity and reimbursement, the commenter raised concerns that the current reimbursement and administrative procedures set by Indiana Medicaid impact provider capacity and create a lack of willing providers. Home health agencies have operated under a Medicaid rate cost reduction since SFY 2011. The commenter states that the Office of Medicaid Policy and Planning made the decision not to implement SFY2017 rates based on its recent review of the home health rate methodology and to ensure continuity of care and access to home health services for Medicaid members. The rates have been maintained as established for SFY 2016.

Response: This comment is not relevant to the transition plan however, DA appreciates your comment and, DA will share with the appropriate FSSA staff.

Comment: The commenter believes the plan should clearly state that assisted living communities licensed as residential care facilities will be allowed to participate in the waiver program. If DA is contemplating changing the current requirement that waiver providers be licensed by the Indiana State Department of Health, the commenter requests that the transition plan explicitly address how providers are to be licensed and how it intends to resolve conflict between DA oversight and ISDH oversight.

Response: Thank you for your comment on the licensing requirements for AL providers. The DA will be adding additional details to the plan on the licensing and/or certification of AL providers in the waiver program.

Comment: The commenter states that, per the DA website, there is currently a moratorium on approving any new providers whose services are presumed institutional and require heightened scrutiny. Applications will not be accepted until CMS approves the transition plan and established a heightened scrutiny process. Per the website, new applications will be subject to heightened scrutiny and approval by CMS. The commenter requests that the transition plan address this moratorium, its impact on consumers, a proposed timeline for action on new applications and whether all new applications are subject to heightened scrutiny and approval by CMS.

Response: Thank you for your comment on the provider certification process. The DA will be adding more details on the certification timeline to the plan.

Comment: The commenter states that, based on the transition plan, there are no assisted living providers in the state of Indiana who are fully compliant. Per the plan, at most there are 24 locations who are partially compliant. PCG assessors visited waiver communities this spring and subsequently did a presentation about their report. The report itself has not been made available. The commenter requests that the PCG report be made available now rather than being available for public comment after the date on which comments for the transition plan closes.

Response: Thank you for your comment. While it is true that currently there is no AL provider who is fully compliant with the settings rule, the DA believes that many, if not most will be able to complete remediation during the transition period in order to become compliant. In regards to the site survey report, the results will eventually be posted online once the report and results are finalized.

Comment: The commenter states that detail about the heightened scrutiny process is lacking. The commenter expressed concern that the system may lack objective criteria for determining which communities meet criteria to participate in the program. The criteria cannot be “we will know it when we see it.” The commenter requests the exact process and evaluation criteria be included and open for comment.

Response: Thank you for your comment on heightened scrutiny. More details will be added to the plan about the process.

Comment: The commenter states that the provision of assisted living services within the current A&D Waiver has long been tied to the provider being licensed as a Residential Care Facility under regulations promulgated by the Indiana State Department of Health. The DA’s statement on RCF licensure, that the regulations “clearly force providers towards institutional characteristics” is not necessarily disagreed upon by RCF providers. However, the commenter states that the process described in the ASTP concerning coordination between the DA, ISDH and provider groups on changes to the RCF licensure requirements is not as aligned as the ASTP appears to suggest.

Response: Thank you for your comment. The DA has had extensive conversation with ISDH and has participated in the ISDH provider workgroup conversations regarding changes to the RCF licensure requirements. DA has noted that modifications to that licensure impact all ALs, private pay and Medicaid waiver, in the state, while Medicaid waiver accounts for less than 15% of the licensed AL capacity in the state. There does not seem to be interest at ISDH or in the provider community for the overhaul to the RCF licensure that the settings rule would require for Medicaid HCBS participation. The DA agrees that it does not seem appropriate to significantly modify this licensure impacting what is predominantly a private pay market.

Comment: The commenter stated that, while the DA and ISDH have attended and participated in a provider-led effort to recommend amendments to the RCF regulations, it does not appear that either State agency wants to use the RCF licensure, as potentially amended, as the vehicle for oversight of assisted living providers in an HCBS program. The commenter further states that RCF providers have invested greatly over the years to comply with the RCF licensure requirements, and those that are looking to invest in Indiana to become assisted living waiver providers are also investing to meet that standard. The commenter believes that moving away from that standard, and creating a second one for HCBS purposes only, is inefficient and will put at risk substantial private capital that has been and continues to be invested. Instead, the commenter believes it would be beneficial for the State agencies to align on reform to the RCF licensure standard and how that standard is enforced/overseen, rather than have two separate standards for assisted living services. This leads to an open question as to what are “assisted living services,” which the DA states are not necessarily services that require RCF licensure, or at least RCF licensure as it exists today. The commenter believes this question is critical to understanding how current A&D Waiver providers are to transition from the structure that today requires RCF licensure to a new system that is either an amended RCF licensure requirement or an entirely different oversight structure. The commenter requests this question include an assessment of patient acuity and the services that are necessary and proper to keep patients safe and healthy. Secured memory care units also fit into this dialogue of acuity, and the commenter expresses concern with the lack of specificity in the ASTP on this point.

Response: DA appreciates your comments on the provider community’s investment in RCF licensure. Forcing alignment on the licensure of RCFs that serve a largely private pay market for the sake of compliance on Medicaid HCBS requirements has some inefficiency. These factors must

all be weighed with Medicaid HCBS settings requirements being the primary goal of this transition plan. The DA agrees with your question as to how DA defines assisted living services. DA looks forward to engaging with the provider community on this issue.

Comment: The commenter notes that, because the current A&D Waiver requires nursing facility level of care for eligibility, by definition these individuals have a higher level of need. The commenter believes this level of care requirement contradicts the current RCF licensure requirement, which limits RCFs from providing comprehensive nursing care (i.e. nursing facility level of care) in most instances (410 IAC 16.2-5-0.5(e) and (f)). The commenter stated that, despite the contradiction, RCFs are serving the current A&D Waiver clients in assisted living and in many cases the acuity of the clients necessitates coordination of higher levels of care. The commenter further noted that in some cases, individuals are denied an A&D Waiver slot under today's assessment criteria for not meeting level of care and are later admitted to a hospital then a nursing facility because of a downstream health complication.

Response: Thank you for your comment. You have highlighted here one of the primary conflicts between the RCF licensure and its use in the Medicaid waiver HCBS program.

Comment: The commenter notes that there appears to be an error in the opening sentence of the third paragraph on page 6. The first sentence says the ISDH regulations are significant in the service of assisted living, then the second sentence says the ISDH does not have licensure or regulations specific to the service of assisted living. The commenter believes the first sentence was meant to use "residential care" rather than assisted living.

Response: Thank you for noting this. It is not an error really but is not well stated. The point is that ISDH does not really recognize the service DA calls assisted living under the waiver. So, providers are licensed under residential care facility requirements. So, it is significant to the service of assisted living even though ISDH never refers to the term assisted living. DA will re-write this language.

Comment: The commenter notes that the STP lists 7 areas in which current AL providers have a high rate of compliance with the new HCBS standards, but then indicates several key areas of "widespread lack of compliance" without specifying what those key areas are. These key areas should be specified.

Response: Thank you for your comment. DA will add some additional detail to the plan regarding the areas of current non-compliance.

Comment: A commenter made the following suggestions/recommended changes to the STP:

- The number of sites/participants for AL listed in the chart does not appear to equal the total number of AL participants noted on page 8. Clarification should be made.
- Clarification on the definition of co-location for ALs being co-located with nursing facilities. Is co-location being on the same property or adjacent to a nursing facility, being within the same physical structure (either under the same roof-line or being connected via hallway) as a nursing facility, or both?
- Assisted Living sites with secured memory care are listed as settings that are presumed not to be home and community based. This categorization is overly broad as no details of the site assessments have been made available in the ASTP. For example, are all of the sites so categorized operating locked memory care units? Do any currently employ delayed egress mechanisms? The ASTP makes no mention of what standard the DA or CMS is discussing concerning compliance with secured memory care units. The commenter believes this categorization threatens a key goal of state and federal government, which is to encourage provision of services in the community, as without secured memory care in assisted living many residents will be required to obtain those services in nursing facilities.
- Both charts on page 10 group facilities based upon facility characteristics that were collected during an assessment process. None of the details of those assessments are included in the ASTP or otherwise available. These reports and details should be made available so that comments can be made on those reports, which are the basis for the charts.
- The chart that lists the 4 groups includes a row indicating there will be a segment of providers placed in Group 1 because they will “still be found to be institutional in nature” even though modifications can remove characteristics that have the effect of isolating. Please provide examples of what providers would fit in this category, what authority the DA has and what objective criteria will be used to determine a provider to “still be found to be institutional in nature” even though modifications can be made to remove the isolating characteristics. The ASTP states that providers who are deemed out of compliance will be notified in December 2016 (page 18) and that decertification will be issued in December 2017 for providers unable/unwilling to comply (page 18). How are providers that are willing to comply and heavily invest to do so, yet are “still be found to be institutional in nature,” able to avoid unnecessary expense if they are still going to be excluded from the program based on this apparently loose standard?

Response: Thank you for your comments. The DA will verify the number of AL participants but the chart on page 11 is more current than the older number still listed in the remediation chart. The DA is using the term “colocation” in the context of the CMS list of presumed institutional settings. These are generally settings that are under the same roof or operated under the same license and administrator as a comprehensive care facility. CMS also provides guidance on the characteristics of settings that have the effect of isolating participants. This is also a consideration in co-located sites that may be a separate building but share common functions and may limit participant access to the larger community. Secure memory care becomes an issue as it has the effect of isolating individuals. Presumed institutional settings can overcome that presumption but will need to eliminate any institutional characteristics as well as be in full compliance with HCBS characteristics. When the DA is satisfied that those criteria are met then the submission would be made to CMS for a final decision. The DA will be making the site surveys and report available as soon as they are finalized. In terms of those providers who may still be institutional in nature, each provider will be evaluated and the DA will confer with the provider to determine whether adequate modifications can be made and whether the provider is willing to make such modification. Some

providers have already indicated that they will not be interested in making the required changes. Additional information will be added to the plan on the heightened scrutiny process.

Comment: The commenter states that the ASTP references heightened scrutiny, yet provides no details on the process. The commenter requests that the exact process and evaluation criteria be included in the ASTP and open for comment. The ASTP should be far more specific on enrollment of new providers that require heightened scrutiny in order to enroll. Current DA direction, per the DA website, places a moratorium on enrollment for providers requiring heightened scrutiny, yet provides no timeline for accepting new applications.

Response: Thank you for your comment regarding heightened scrutiny and provider enrollment. The DA will add additional details to the plan.

Comment: The commenter recommends that the DA consider how to streamline the PCCR or PCMT together, either through consolidation of both or elimination of one, as both measure person centeredness.

Response: The PCCR and the PCMT are very different tools, administered differently and for different purposes. Both are needed as part of DA's compliance monitoring not only for compliance with the settings rule but also for compliance with other health and safety requirements under the waiver.

Division of Disability and Rehabilitative Services:

Summary: The Division of Disability and Rehabilitative Services solicited comments on the Statewide Transition Plan as it applies to the two 1915(c) programs; Community Integration and Habilitation and Family Support Waiver. The comments resulted in changes to pages 51-55, 57, and 60-61.

PUBLIC COMMENTS:

Comment: A commenter requested that the waivers include more services and higher budgets, especially for support services.

Response: Thank you for your comment.

Comment: A commenter complimented the services his/her son is receiving at their new group home. The commenter noted the provider is already doing most of the things outlined in his/her son's plan. The commenter complimented the staff, and further noted that his/her son has privacy, can have visitors at any time, and the house is clean.

Response: Thank you for your comment.

Comment: A commenter expressed concern that the IES is reflective of a higher percentage of choice, integration, etc. than there is in actuality. Participant experience really relies on informed choice. A lack of experiences and clear understanding of options could lead some to answer that they had more choice and integration than they actually did. The commenter suggested DDRS keep this in mind when comparing the IES data to the site specific setting assessment.

Response: Thank you for your comment. DDRS recognizes challenges in interpreting data. While the IES data will be used as a validation/comparison to measure the Non-Residential Survey responses, it will not be the only factor utilized in determining HCBS compliance.

Comment: A commenter noted that they believe there is a lot of language in Section 3 about using the individual's PCP/ISP to ascertain if there is a reason for someone not being engaged in the community for example. They commented that the training and documents associated with the PCP/ISP do not outline all the examples that the transition plan gives in this section as being reflective in these plans. The commenter suggested DDRS note that the PCP/ISP process and forms are being reevaluated so they can be comprehensive of the outline of the new rules and any modifications of those rules.

Response: Thank you for your comment. DDRS is currently reviewing the PCP/ISP process through the Life Course Alignment Project. As part of this project the current process and forms will be reevaluated to ensure compliance to the new rules and any modifications of those rules. The information provided will be helpful as the State incorporates the suggestions within specific policies and procedures.

Comment: A commenter recommended DDRS review and potentially revise the provider enrollment and recertification process, and to provide training to new and existing providers to educate them on the HCBS requirements. The commenter further suggested the training timeframe be moved significantly forward to 2016/2017. The commenter further requested DDRS conduct ongoing webinars for all providers to cover the basics of the HCBS requirements. The recommended frequency was one webinar every six months to ensure providers are staying current on the regulations. The commenter also recommended regional, in person trainings that include a question and answer section to ensure stakeholders are understanding the requirements and not trying to find the information independently.

Response: Thank you for the suggestions. The timeframe for Reviewing and Revisions to Provider Enrollment and Provider Training will be adjusted in the STP to allow for ample time to train and educate all providers in Indiana. While the suggestion of hosting webinars and providing regional trainings will not be added to the high level STP, DDRS will incorporate the suggestions into the outreach and education process provided throughout the transition period.

Comment: A commenter suggested that DDRS incorporate more focus groups of individuals and families to gain input on the states transition plan. The commenter believes that requesting feedback in a 30-day comment period does not lend itself to being accessible to individuals and families. The commenter noted the following difficulties when seeking comment from this group. 1. Individuals and families need to find that there is a comment period. 2. They then need to read through the transition plan and understand what it means. 3. They then have to figure out how to write up their feedback and submit. The commenter believes that these barriers lend itself to not obtaining quality feedback from individuals and families. The commenter believes that focus groups allow for verbal feedback in a discussion format will generate valuable input for the revision of the transition plan.

Response: Thank you for the suggestions. DDRS will continue to look for ways to enhance stakeholder input and values any ideas that will enable us to garner feedback from individuals and families. Incorporating more focus groups is a viable way to accomplish this. While the suggestions will not be added to the high level STP, DDRS will review incorporating focus groups into the outreach and education process provided throughout the transition period.

Comment: A commenter suggested updating the 90 Day Checklist Data Review information to reflect the Monitoring Checklist tool and what components of that support the HCBS Settings rule. The commenter also noted that the PCP appears to be inclusive of many remediation efforts however the form and practice right now does not incorporate all the components outlined in the transition plan. The commenter requested addressing this in the transition plan. The commenter also requested a systematic sharing of the CMS guidance that is released on a regular basis, and shared with all stakeholders in an accessible way. The commenter further suggested training be presented on an ongoing basis for individuals and families in order to clarify the intent of the rules and the states plan to implement these rules, and that the trainings should be held in an accessible way for all individuals and families. Lastly, the commenter suggested that self-directed services should be considered with the amendment to the waivers as that service lends itself to fully meeting the requirements of the HCBS rule.

Response: Thank you for the response. While the timeframe outlined in the STP allows for the Monitoring Checklist questions to be updated by 2017, it is DDRS goal to have this accomplished much sooner. Once the HCBS related questions and guidance documents have been finalized, trainings will be conducted to ensure all case managers have a clear understanding of each HCBS related questions and process prior to implementation. A link to the guidance from CMS is posted on the State's Home and Community-Based Services Final Rule Statewide Transition Plan webpage. Individuals and families may request hard copies of this guidance from their case manager or from the state as desired. The potential addition of self-directed services would need further consideration, discussion and planning prior to inclusion in an amendment.

Comment: A commenter raised questions on DDRS's assertion that merely following the Administrative Orders and Procedures Act "ensure[s] meaningful feedback from all stakeholders." The commenter believes that providers and their trade organizations are in a far better position to comb the Indiana Register for public comment opportunities than waiver participants. Accordingly, the commenter encourages DDRS to implement a more direct means of soliciting feedback from waiver participants.

Response: DDRS appreciates the support expressed by commenters and will review the suggestions listed above. While the specific suggestions listed above will not be incorporated into the transition plan, the State will incorporate the suggestions within the specific processes to the greatest extent possible.

The commenter also expressed concerns that DDRS's methods of collecting data (e.g., the 90 day Checklist) are inadequate to capture certain data and may lead to improper outcomes. The commenter gave the example that the Checklist asks case managers to "[c]onfirm the individual is free from work without pay that benefits others." The commenter noted that the HCBS regulations do not preclude waiver participants from engaging in volunteer work, and believes DDRS should create a more tailored survey tool designed to answer relevant questions, such as whether employed waiver participants are engaged in competitive, integrated employment. The commenter believes such questions are especially critical, given WIOA's emphasis on competitive, integrated employment as a goal and the General Assembly's exploration of Employment First legislation.

Response: The State agrees the current 90 day check list does not adequately address HCBS requirements. The 90 day check list as a monitoring tool will be modified from the current content to measure HCBS Requirements on an ongoing basis. The information provided will be helpful as the State incorporates the suggestions within specific policies and procedures.

Comment: A commenter was pleased that DDRS plans to revise the Checklist by December 2017. The commenter suggested that DDRS garner more input from waiver participants than case managers in the revised Checklist. The commenter also suggested revising the Checklist to move away from yes-or-no questions. The commenter believes scale-based questions and open-ended questions will give DDRS more meaningful data.

The commenter also questioned why sheltered workshops are not reflected on page 64 of the draft STP as settings that have the effect of isolating individuals. The commenter noted that day service settings are on the list and many sheltered workshops are similar, in that people with disabilities are grouped together, spending their day in isolation from those without disabilities (service providers excluded). In addition, the commenter believes more rigorous data collection designed to measure services including transportation, are crucial to verifying that waiver participants have the sort of community access envisioned by the Centers for Medicaid & Medicare Services when promulgating the HCBS regulations. The commenter believes the Individualized Support Plan asking whether "adequate" transportation is provided is not a sufficient question. The commenter notes that the checklist asks only if the waiver participant has an ISP that includes community activities, and listing community activities in the ISP does not guarantee that the individual actually participates in those events. The commenter recommends DDRS develop more meaningful monitoring tools.

Response: Thank you for the comments. DDRS will consider utilizing focus groups that include participants to assist in revising the checklist to incorporate HCBS requirements. The format and content of the HCBS section of the monitoring checklist will be designed based on the ability to provide for ongoing monitoring and insurance of HCBS requirements. In regards to why sheltered workshops are not reflected on page 64, Medicaid funds cannot be used to pay for employment (or vocational) services in a sheltered workshop. Medicaid funding can be used to pay for pre-vocational services in a sheltered workshop, but only if the services are time-limited, and intended to help prepare the person to work in an integrated setting. Prevocational services will be assessed via the Non-Residential Survey to determine compliance with HCBS rule.

Comment: A commenter expressed concerned that DDRS has not determined a timeline for a provider remediation. The commenter expressed concerns regarding the lack of specificity. The commenter also wanted to know what types of sanctions DDRS plans to impose on providers who have not achieved compliance by deadlines established by DDRS. The commenter did also note that they believed the Transition Taskforce will be helpful in protecting the rights of those “identified as requiring significant changes,” and were appreciative that advocates and individuals will have representation on this Taskforce.

Response: Thank you for the comment. DDRS will revise the language to accurately reflect the responsibilities associated with the IES. DDRS is exploring having the identified residential settings providers complete the same assessment that the non-residential providers will be completing. This is a provider specific survey rather than individual specific. DDRS will then compare the results of the two surveys to determine if a site visit will be warranted to determine final compliance or the need for heightened scrutiny. In addition, a section of the case managers monitoring tool will address HCBS Residential requirements and allow for client specific remediation. DDRS is exploring when the IES survey should be re-administered and if it could be utilized as a means of ongoing compliance. It is anticipated the IES will be administered at least one more time, possibly more.

Comment: A commenter recommended revising the language “receive services in the most integrated setting” to “receive services in the most integrated setting consistent with individual needs.”

Response: Thank you for the suggestion. The language “receive services in the most integrated setting” is the language CMS has provided in communications.

The commenter also recommended revising the language from “full access to the greater community” to “access to the greater community.” The CMS guidance did not include “full” and this term is difficult to define.

Response: Thank you for the suggestion. This is the specific language provided in recent CMS guidance as well as in the Final Rule (part 441.301):

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

Comment: The commenter is encouraged by the inclusion of additional information concerning the Systemic Settings Crosswalk, particularly the discussion of needed revisions to Indiana Administrative Code 460, the Waivers, and service definitions and projected timelines for the changes. The commenter appreciates the process and the length of time required to change Indiana Code and Indiana Administrative Code. We recommend that DDRS should complete the code revisions prior to promulgating changes in policies, procedures, the Waivers, and service definitions. Completing revisions to the IC and IAC prior to the other changes will allow for greater continuity and consistency between these sources and avoid the development of conflicts between these sources which would cause confusion among providers, case managers, families, and individuals receiving services. Additionally, the proposed timeline for changes to IAC 460 was distributed during a recent Bureau of Quality Improvement Services (BQIS) Advisory Workgroup meeting. Based on this timeline, we understand that final edits and proposed changes to this section of Administrative Code will be complete by December, 2016. This

timeline seems relatively short and significantly different than the timeline of May, 2018 referenced on pg. 60 of the STP. The commenter requests clarification of the timeline for revisions to Administrative Code.

The commenter also recommends that stakeholders such as providers, advocacy organizations, case management organizations, and individuals receiving services be included in the revision process for IAC, policies, procedures, the Waivers, and the service definitions. These stakeholders will provide good insight and perspective concerning how modifications would impact individuals served by the industry and their advocates. The inclusion of stakeholders in these processes could also decrease the number of comments received during the public comment period and subsequent modifications needed before these policies and processes could be finalized.

In addition to these comments, the commenter would like clarification concerning the following questions:

- The Systemic Settings Crosswalk chart sites 460 IAC 6-20-2 concerning employment services and 460 IAC 6- 3-58 concerning transportation as code that needs to be modified in order to meet HCBS standards. How does DDRS plan to modify these Administrative Codes to meet the requirement? Could we provide recommendations concerning code revisions that would meet the standards?
- The chart lists Individual Rights and Responsibilities (4600221014) as new policies. The next sentence states that this policy is “in the process of being updated to enhance support of CMS regulations.” Could DDRS clarify if this is a new policy that is being developed or an existing policy that is being updated?
- We have observed reverse integration in approved Statewide Transition Plans, for example, Tennessee. Are there any circumstances in which reverse integration would be an acceptable approach to community integration? Does DDRS have guidance for what practices will allow agencies to be compliant with the rule?
- CMS has stated that the implementation date for the HCBS Rule is March 2019. Why is Indiana’s stated implementation deadline July 2018?
- Does DDRS anticipate an increase in the amount of community habilitation services an individual receives in order to achieve compliance? If so, how it will provide appropriate funding for community habilitation/integration?

Response: Thank you for your comments. Policies and procedures are being reviewed and updated to ensure confirmation of compliance with the final rule. DDRS anticipates any updates of policies and service definitions will align with any revisions to Indiana Administrative Code. While the timeframe for code revisions is greater than the timeframe for policy modification due to the extent of the process, DDRS is still expected to update any policies that are silent or conflict with the final rule in a timely manner.

DDRS is in the process of drafting language to ensure meeting HCBS standards. DDRS welcomes any recommendations. Recommendations can be submitted to BQIS.Help@fssa.IN.gov. DDRS is updating the existing policy “Individual and Guardian Responsibilities” with the addition of an individual’s rights. CMS has indicated reverse integration in itself will not ensure compliance with the final rule. DDRS will be issuing guidance to providers on innovative practices that will allow agencies to be compliant with the rule. In order to allow for proper notification and transition of effected individuals, DDRS has outlined a time frame of July 2018 for all provider to be in compliance. If any provider is found not to be in compliance at that time, DDRS will begin the

remediation and relocation process as outlined in the STP. Reimbursement rates, service definitions, budgets, funding parameters, codes, etc. are all being looked at to ensure we are able to support compliance.

Comment: A commenter requested clarification on how the NCI data will be used to triangulate data as a way to validate ongoing compliance with the HCBS final rule.

Response: While reviewing the NCI data it was determined the questions were not all inclusive of the HCBS requirements. Also, utilizing a sample size did not allow DDRS to clearly assess all setting. The data will still be used on an ongoing basis to compare against other measuring tools.

Comment: A commenter questioned the statistical thresholds, noting that NCI data was collected on approximately 740 individuals, which is about 4% of the population receiving waiver services.

Response: DDRS agrees, utilizing a sample size did not allow DDRS to clearly assess all setting. The data will still be used on an ongoing basis to compare against other measuring tools.

Comment: A commenter questioned if the 90-day checklist will be the only means of ensuring compliance with the rule following the deadline?

Response: DDRS will incorporate a variety of means of ensuring ongoing compliance. The monitoring checklist completed by case managers will be one tool to ensure ongoing compliance. Revisions to provider enrollment, re-certifications, policies and procedures as outlined in the STP will all be part of the ongoing monitoring process.

Comment: Regarding the Individual Experience Survey, a commenter noted that the plan states, “DDRS contracted with The Indiana Institute on Disability and Community to design, develop, and administer the survey to be completed by participants when able or the person who knows them best. This survey was administered by the participant’s waiver case manager to ensure all participants were reached.” The commenter noted that these statements are confusing because they state that both IIDC and case managers administered the survey. The commenter recommended revising this language to clarify that IIDC was contracted to “design, develop, and analyze” the survey while case managers administered it.

The commenter also raised questions on the following statement in the plan: “DDRS determined the need for providers of identified residential and all non-residential settings to complete a self-assessment of their current policies and procedures to report compliance of HCBS Final Rule to the State. DDRS also concluded responses garnered from the IES will be used to validate the responses from the provider self-assessment to gain a global prospective of compliance.” The commenter asked whether the IES will serve as the residential settings assessment, or if DDRS will develop an additional self-survey assessment for residential settings?

Lastly, regarding the IES, the commenter asked if the Individual Experience Survey will be administered and analyzed periodically to collect longitudinal data. If not, what other methods will be utilized to measure ongoing compliance?

Response: Thank you for your comments. DDRS will revise the language to accurately reflect the responsibilities associated with the IES. DDRS is exploring having the identified residential settings providers complete the same assessment that the non-residential providers will be completing. This is a provider specific survey rather than individual specific. DDRS will then compare the results of the two surveys to determine if a site visit will be warranted to determine final compliance or the need for heightened scrutiny. In addition, a section of the case managers monitoring tool will

address HCBS Residential requirements and allow for client specific remediation. DDRS is exploring when the IES survey should be re-administered and if it could be utilized as a means of ongoing compliance. It is anticipated the IES will be administered at least one more time, possibly more.

Comment: A commenter asked DDRS to clarify why community habilitation services in general are not presumed compliant. Additionally, the commenter asked if providers would be required to complete a self-assessment on community habilitation setting.

Response: Guidance from CMS has suggested that community-based habilitation provided in groups may not necessarily be presumed compliant. For this reason, only community-based habilitation individual can be presumed compliant.

Comment: A commenter noted that there were several typos to the word “reveled” in the site specific assessment chart.

Response: Thank you for the notification. This will be corrected.

Comment: A commenter noted that under the IES Data column, the plan states “Analysis of the IES data revealed less than 100% compliance.” The commenter asked whether DDRS expects that the settings will ever be 100% compliant.

Response: CMS feedback has indicated 100% of settings must be assessed for compliance and all settings must be complaint by March 2019.

Comment: Under the site-specific assessment, a commenter recommends noting that there may be provider-owned homes that do not require modifications to meet the settings rule.

Response: DDRS agrees that there may be settings that require no modifications. Modifications and updates to code and State polices will ensure compliance of these settings.

Comment: Under the site-specific assessment, a commenter noted that the plan lists approximately 10 sites as Settings identified that could meet the HCBS rule with Modifications; Homes with more than 4 individuals residing together. The commented asked if DDRS is referencing former group homes that were converted, and if so, if they need to be reduced to 4 clients.

Response: Yes, these are homes that were formally SGL’s. While there is not a current mandate they must be reduced to 4 clients, DDRS is required to validate they meet the HCBS requirements.

Comment: A commenter noted that, in residential settings where respondents to the IES indicated few social interactions outside of their home, the IES data may be problematic as providers have reported that IES survey outreach to provider personnel may be lower than reported on the individual surveys.

Response: DDRS recognizes the challenges with interpreting data. Those identified as having the effect of isolation will be validated to ensure responses are consistent with experiences.

Comment: A commenter noted that in the Department of Aging section on page 8 under Adult Day Services, providers are assumed to have a high level of compliance to the HCBS rule based on a list of criteria, which are also quite frequently present in Day Service settings regulated by DDRS. The commenter asked whether the criteria used by DA on page 8 of the STP for Adult Day Service settings will also be used by DRRS to assess compliance of facility habilitation settings since these Adult Day

Service settings and Facility Habilitation Service settings have much in common in their approach to services.

Response: The same criteria will be used although the wording may differ on specific questions. The criteria will be measured through the Non-Residential Provider Self Survey.

Comment: A commenter requested to know if a part of an individual's Facility Habilitation includes time in the community, will there be a threshold for the amount of community based services the individual needs to receive?

Response: Community integrations will not be measured in specific thresholds.

Comment: Under the site-specific assessment, a commenter asked several questions with regard to congregate settings of 4 or more homes. Those questions include, what constitutes close proximity with regard to compliance with the rule? Is the density on a neighborhood street or in an apartment required to be 51% non-disabled or 51% non-IDD? In addition, the commenter noted that HUD 811 programs and HUD 211 programs require serving people with disabilities in settings that may be categorically non-compliant with the settings rule. The commenter asked if DDRS reviewed the HUD rules to determine whether or not these service settings are compliant or can achieve compliance. Other housing programs and funding sources such as Section 42, HOME, and Federal Home Loan Bank reward and value maximizing housing opportunities for persons with disabilities. The commenter suggested DDRS speak with the Indiana Housing and Community Development Authority regarding funding for housing for persons with disabilities, and noted that State and Federal regulations already recognize settings funded through IHCDA as integrated settings.

Response: Congregate settings will not automatically be precluded from meeting the requirements. CMS has indicated they meet the criteria of settings that may be presumed as Non HCBS Compliant and will need to be reviewed to determine if Heightened Scrutiny is warranted. The State must verify these settings do not have the effects of isolation and meet all of the HCBS requirements.

Comment: A commenter notes that the Division of Aging section of the plan discusses concerns regarding the Adult Foster Care program not complying with the HCBS Rule, but the DDRS section of the plan does not discuss Structured Family Caregiving, a similar program. The commenter asked if DDRS anticipates that the Structured Family Caregiving program will comply with the HCBS rule.

Response: Structured Family Caregiving will be held to the same standard as other provider owned or controlled residential settings and must meet the same HCBS criteria.

Comment: A commenter asked if DDRS could provide clarification around the issue of what the State is looking for in regard to day services.

Response: DDRS is in the process of developing guidance documents for providers that will be disseminated for review. DDRS will be reviewing the organizations operational information to support current practices so the State can assess providers' landscape of compliance to determine technical assistance and transition needs for providers.

Comment: A commenter asked if providers will receive their individual data collected in the IES.

Response: Providers will not receive individualized IES data. The data collected did not include individuals' providers.

Comment: A commenter asked if DDRS could provide additional clarification concerning the development of the self-surveys for residential and non-residential settings.

Response: The self-surveys were developed by a HCBS workgroup group that consisted of service providers and State staff. The survey questions were developed based on CMS guiding questions as well as a review of other states' surveys.

Comment: A commenter asked what types of policies, procedures, and documentation will providers need to submit to prove compliance.

Response: Documentation can include any company policies, employee trainings, consumer rights or educational material, etc. that would address the key provisions of the final rule. The survey process has been developed not only to show initial compliance of settings, but for providers and DDRS to identify gaps that can be addressed by updating operational policies and procedures.

Comment: A commenter asked if DDRS could provide additional information concerning the desk review/validation process.

Response: DDRS or its contracted vendor will be reviewing the responses to the surveys and cross referencing them with responses to the IES. The desk validation process will also consist of reviewing the attached provider policies that support compliance to ensure accuracy of answers. The desk review will also allow DDRS to determine which areas will require modifications to come into compliance with the final rule and assist in determining which settings will require site visits.

Comment: A commenter asked if DDRS has a projected timeline for completion of the desk review/validation process.

Response: DDRS anticipates the desk review validation process will be completed by December 2016.

Comment: A commenter asked if DDRS has a projected timeline for completion of the site visits.

Response: DDRS anticipates site visits will be completed by mid-2017.

Comment: A commenter asked if the reviewers completing the site visits will be DDRS or BDDS personnel, or if DDRS anticipates contracting this service.

Response: DDRS plans to contract this service out while utilizing some BDDS personnel support. DDRS is continuing to assess the number of site visits and other factors.

Comment: Regarding the site-specific assessments, a commenter inquired as to whether providers who are subject to further review have been notified in order for them to begin the remediation process.

Response: Providers have not yet been notified of the need for further review. DDRS is in the process of finalizing the next steps prior to notification.

Comment: A commenter asked if the comprehensive settings result document will be posted for public review and comment.

Response: The comprehensive settings results document has been incorporated into the STP. The STP will continue to be updated with any settings requiring heightened scrutiny and posted for public comment.

Comment: A commenter asked if revisions to the DDRS Provider Policy and Procedure Manual will be completed in December 2017 without creating inconsistencies with the IAC if the IAC revisions are not complete until May 2018.

Response: DDRS is working simultaneously on revisions to policies, procedures and changes to the IAC. It takes a year to promulgate rule unless an emergency exists. For this reason, inconsistencies are not anticipated.

Comment: A commenter asked if all of the necessary IAC revisions will be finalized and promulgated in this timeframe.

Response: All necessary revision to IAC are anticipated to meet the timeline.

Comment: A commenter asked if the timeline for completion of the IAC revisions matches the timeline for completion of 460 revisions previously communicated in other DDRS communications.

Response: Rule promulgation takes a year to complete unless an emergency exists. DDRS has provided the timeline in the STP to allow for full promulgation.

Comment: Regarding the Transition Taskforce, a commenter asked if members of the transition task force have been identified and if the taskforce size has been determined. The commenter also asked how DDRS will insure against potential conflicts of interest with taskforce members, as well as how this taskforce will relate to the existing HCBS workgroup.

Response: Members have not yet been identified. DDRS would like a variety of stakeholders to participate in order to gain a global perspective. DDRS has not yet determined the size of the taskforce. The taskforce will be responsible for providing technical assistance and support. DDRS will mediate to ensure against potential conflicts of interest. Members of the existing HCBS workgroup may be participants of the Transition Taskforce.

Comment: A commenter noted that the plan states that DDRS will develop a process for provider sanctions and disenrollment for providers who have gone through remediation and continue to demonstrate non-compliance; however, there is already a process for provider sanctions and disenrollment. The commenter asked if DDRS could clarify the need to develop a new process and how this process will differ from the current process.

Response: DDRS will utilize its existing process as much as possible. Additional notifications and steps may need to be built into this process to ensure reasonable notice is given to the participant(s) and the Individual Support Team regarding the noncompliance, action steps, and procedural safeguards.

Comment: A commenter believes that addressing the issue of controlling personal resources may lead the State to review guardianship issues, especially as it relates to guardianship by provider. The commenter believes this being seen as a conflict of interest and as a “standard” should not be condoned. The commenter believes special circumstances may be allowed when guardian understands and are acting within the statutory requirements of guardianship.

Response: Thank you for the suggestion. This information is useful for the revisions/development of policies and procedures. While the STP will not be updated with this specific language, policies/procedures can be modified to incorporate additional protections.

Comment: A commenter noted that, while the issue of choice is addressed throughout the document, the idea behind choosing the program which will empower an individual in non-residential programs is broadly abused. The commenter believes DDRS should consider running a claims comparison for individuals who have chosen the same provider for DAYS and for RHS, and the commenter believes this is often a forced choice and the individual is not making this choice with informed consent.

Response: Thank you for the suggestion. This information is useful for the revisions/development of policies and procedures. While the STP will not be updated with this specific language, policies/procedures can be modified to incorporate additional protections.

Comment: A commenter requests that, in development of a DDRS policy around settings and residential housing, it will be important to outline from the HCBS waiver the idea that waiver participants have the right/choice to have their own bedroom. The commenter notes that this is different than ICF/DD rules and is not readily adhered to in the current waiver program.

Response: Thank you for the suggestion. This information is useful for the revisions/development of policies and procedures and trainings. While the STP will not be updated with this specific language, policies/procedures can be modified to incorporate additional protections.

Comment: A commenter believes that the State needs a comprehensive waiver rewrite. The commenter believes this will allow for consistency and decrease administrative burden and poor performance both internally and with providers. Additionally, the commenter suggesting determining the difference between supporting providers toward compliance and offering technical assistance, as well as how to discontinue providers that are not compliant or willing to become compliant.

Response: Thank you for the suggestions. DDRS is currently exploring a comprehensive waiver rewrite. This will include a review of reimbursement rates, service definitions, budgets, funding parameters, codes, etc. to ensure DDRS is able to support full compliance.

Comment: A commenter made several comments and recommendations for revisions to the STP. Those comments and recommendations include:

- Under “choice,” the State must continue to offer choices to people. Individuals in group homes and nursing homes needs to be contacted, interviewed and ensure there is follow through.
- Under Person-Centered Planning Case Management Project, initiation of this new effort to address PCP (and Case Management is very timely and important. The commenter believes we must have a robust person centered planning process that includes everyone and not just solely be the domain of the case manager.
- The commenter notes that as work in the Home and Community Based System grows, workforce issues will continue to grow more critical as demographics are showing a workforce shortage for all business including the human services sector. The commenter notes this must be addressed in the STP.
- Under ‘Training,’ the commenter requests DDRS develop a system much like the Unified Training System developed for First Steps. Training needs to be coordinated through provider organizations, advocacy organizations and the state, all developed in concert with a unified plan. Training must include all parts of the system if we are to achieve the goals stated in the transition plan. The commenter believes DDRS staff, providers, case managers, self-advocates, and families all must have access to the same training and be involved at the same time so all parts of the system are on the same page.

- DDRS should revisit the INTRAIN model of working with Ivy Tech State College and other venues to increase state training and knowledge as well as develop a wage increase plan that is tied to training received and completed. The commenter referenced the CMS advisory letter issued on 8/3/16.
- DDRS should study the number of unfilled supports in action plans for both CIH and FS waivers.
- Under ‘Wages and Benefits,’ there should be a long term plan to address wages and health care benefits for workers. The commenter also recommends DDRS develop an RFP to assist in developing a comprehensive workforce development proposal within the next four months.
- The current quarterly meetings demand a very labor intensive participation, and based on the results of the Individual Experience Survey and anecdotal experiences shared, the commenter believes it is not working as designed. The commenter recommends revamping the meetings and the 90 day checklist as they are an important part of the transition plan. The commenter recommends starting the agenda with the consumer comments/ recommendations/ issues of concerns and cover the three priority areas: their choices, person centered plan updates/additions, community-integration including employment and relationship building - with measureable goals.
- The transition plan must address crisis prevention and support along the lines of the Project Start study. The commenter further requests the State develop an integrated crisis prevention and support program that includes universal training, onsite support and access to emergency supports. The State should begin implementation of the Start Proposal with funding strategy and RFP for implementation by July 2017. A \$0.65 per day add on to the Medicaid Waiver budget for each person and the daily group home rate would more than pay for the entire Start Proposal.
- Shared living must be developed to offer a new alternative and to provide cost savings to address the overall cost effectiveness of the waiver. The State should issue an RFP for a model development project to identify successful shared living programs around the country, take key policy makers to those sites, and develop a policy and implementation plan for Indiana by July 2017.
- Children with intense medical needs must be addressed as too many remain in children’s nursing homes. The State should develop an RFI for a hospital-based transition program for children to be released and at risk for institutionalization.
- Peer to peer supports need to be included in the next waiver application. The State should develop an RFI for community integration in health and wellness plans with the community based organizations that provide greater wellness and overall cost savings. The State should also charge MCEs with greater participation in wellness and prevention funding activities for their members.
- The plan should target a regional demonstration project to test a new way to coordinate supports between providers in order to implement new models of person-centered integrated supports. The State should develop an RFI for a regional demonstration project to test models of effective care coordination for 2018.
- Integrating greater health care supports for people to improve outcomes and lower costs must be included. The addition of wellness coordination was a start, but only a start. The plan must address access to health and wellness supports that largely do not exist today. The State should develop an RFI for community integration in health and wellness plans with the community based organizations that provide greater wellness and overall cost savings. The State should also charge MCEs with greater participation in wellness and prevention funding activities for their members.
- The draft plan lays out a timetable for communication with stakeholders but the commenter believes DDRS needs a more robust effort to reach consumers, families, providers, and key policy makers. The commenter believes DDRS needs an aggressive communication plan that

reaches all stakeholders quickly with messages that will counteract rumors and fear. Communication needs to be designed to reach several target populations as part of this process. The Transition Plan is really dictated by CMS in content and format but is nearly impossible to ready without great diligence. To engage everyone, the commenter requests an investment in a true communication plan that reaches people in the system, provider staff of all types, families and self-advocates, and people who are part of the system - health care providers, educators, state staff, and community partners. Tools and messages must be constantly updated with critical issues and information to engage everyone in the common goal.

- DDRS is serving 3Xs the people it was decade ago with the same infrastructure and support that it had a decade ago. The services are more dispersed and as the Individual Experience Survey documented - the results for people vary widely. There needs to be a strategic and smart investment infrastructure to assure access, quality supports, choice and community integration are successful. Whether brought on as state employees, contracted, or both - there must be an investment. This can be included in the Medicaid reimbursement. The commenter requests the State develop an RFI for implementation of an OTAC type model to provide Hoosier based support for DDRS in developing the appropriate responses to the above items.

Response: DDRS greatly appreciates the recommendations for system enhancements. While the STP will not be updated with these suggestions, DDRS will review the suggestions for future planning.

Comment: Under the section entitled, “Person-Centered Language and Self-Directed Services,” a commenter recommended removing the word “routine” as they feel use of the word minimizes choice because people have the ability to change their daily activities and choose when they complete their tasks.

Response: Thank you for the comment. The language will be updated to remove routine.

Further, under the ‘Choice and Rights’ section, a commenter requested to include questions such as the following:

- Does the person attend their IST meetings?
- Does the person direct and lead their own IST meetings?
- Does the person choose their goals?
- Does the person provide informed consent for all services they receive?
- Does the person demonstrate autonomy and independence in making life choices (like daily activities, physical environment, and who they interact with)?

Response: Thank you for the suggestion, while the STP will not be updated with this specific language, the information provided will be helpful as the State incorporates the suggestions within specific policies and procedures.

Comment: A commenter noted that they thought the tables were well formatted and easy to read.

Response: Thank you for your comment.

The commenter further noted that they thought there was an over-reliance on the 90 day checklist throughout the tables as the checklist is over 100 items and is 26 pages long. The commenter suggested adding additional information on the validity of the checklist and the methods for training its use to assist with clarification. The commenter seconded these concerns with the pre/post monitoring checklist.

Response: The State agrees the current 90 day check list does not adequately address HCBS requirements. The 90 day check list as a monitoring tool will be modified from the current content to measure HCBS Requirements on an ongoing basis. The information provided will be helpful as the State incorporates the suggestions within specific policies and procedures. DDRS will incorporate a variety of means of ensuring ongoing compliance. The monitoring checklist completed by case managers will be one tool to ensure ongoing compliance. Revisions to provider enrollment, re-certifications, policies and procedures as outlined in the STP will all be part of the ongoing monitoring process.

The commenter also noted that the “Outcome of Review” column contains very minimal information and was hard to understand. The commenter expressed confusion in understanding what the analysis of “silence” meant in the crosswalk.

Response: Thank you for the suggestion, the STP outcome of review section will be updated to provide additional information that will clarify which polices/code were determined to be in compliance with, in conflict with, or silent on the final regulation.

Comment: The commenter expressed confusion of the following sentence on page 51: “The NCI data will not be used moving forward for purposes of measuring compliance with the settings rule, however, DDRS will use NCI data for purposes of triangulating data as a way to validate ongoing compliance with the HCBS Final Rule.”

Response: The NCI data was a starting point for DDRS to begin measuring compliance. After the initial review of the NCI data, it was found to be non-inclusive of measuring compliance due to the sample size as well as not covering all areas of HCBS compliance. DDRS will continue to review the NCI data for trends, but not to measure HCBS compliance.

Comment: A commenter recommended re-wording the following sentence for clarification: “In order to ascertain the level of compliance with the HCBS requirements, DDRS had chosen to utilize the NCI data to begin the process by which to evaluate compliance.”

Response: The NCI data was a starting point for DDRS to begin measuring compliance. After the initial review of the NCI data, it was found to be non-inclusive of measuring compliance due to the sample size as well as not covering all areas of HCBS compliance. DDRS will continue to review the NCI data for trends, but not to measure HCBS compliance.

Division of Mental Health and Addiction – Youth

Summary: The Division of Mental Health and Addiction solicited comments on the Statewide Transition Plan as it applies to youth 1915(c) program Psychiatric Residential Treatment Facility Transition Waiver and the 1915(i) Child Mental Health Wraparound program. The comments did not directly result in any changes to the Statewide Transition Plan.

PUBLIC COMMENTS:

Comment: Regarding Key Stakeholders and Outreach – DMHA notes that it will engage a variety of stakeholders by emailing them notice that the draft STP is available for comment. The commenter questions whether this is a meaningful way for youth and their families to offer commentary. This method of engagement appears geared more toward providers and advocacy groups than waiver participants.

Response: DMHA Youth reviewed the comment above and thanks the commenter for their input. In addition to the listed and required notification mechanisms, at DMHA’s instruction, Wraparound Facilitators (case managers) informed each family on their case load of the setting rule, including providing links to the STP and the STP newsletter during the survey process to explain its purpose. All families were and are encouraged to sign-up for the email distribution list which was used to provide updates including the posting for public comment period. Copies of the STP have been made available at Division of Family Resources offices, the point of entry to the IHCP/Medicaid system. DMHA also receives input from families by way of the Indiana Systems of Care Youth and Family Subcommittee, a body which approves and provides input to all new DMHA Youth policies related to programming, including policies generated as a result of the STP. DMHA supports and encourages substantial family involvement in programing development and design, and will continue to look for opportunities to be inclusive. Revisions made to the STP as a result of this comment were not necessary.

Division of Mental Health and Addiction – Adult

Summary: The Division of Mental Health and Addiction solicited comments on the Statewide Transition Plan as it applies to two adult 1915(i) programs; the Adult Mental Health Habilitation and Behavioral and Primary Healthcare Coordination programs. The comments did not directly result in any changes to the Statewide Transition Plan.

PUBLIC COMMENTS:

Comment: Please explain in more detail what is meant by “resources for room and board.”

Response: Per CMS guidance, providers of HCBS may consider a member’s financial resources, as well as any other natural supports such as family or friends, when identifying a member’s residential setting options. From CMS, “The regulatory requirement acknowledges that an individual may need to share a room due to the financial means available to pay for room and board”

Comment: What happens when a community-based service is no longer being provided in a facility (non-POCO residential facility)?

Response: HCBS settings requirements apply (1) to all settings where HCBS are delivered, and (2) to the setting where a member receiving Medicaid HCBS lives, regardless of where the service is delivered. Even if no home and community-based services are provided at a residential setting (POCO or non-POCO), if a member receiving or applying for AMHH or BPHC lives there, the setting must still be compliant with HCBS settings requirements.

Comment: Please provide examples/language that defines “controlled or operated.” Is this in the State Plan or federal regulations?

Response: Per CMS guidance issued 12/9/15, “A setting is provider-owned or controlled when the setting in which an individual resides is a specific physical place that is owned, co-owned, and/or operated by a provider of HCBS.”

Comment: How do you want providers to document the general modification assessed needs that is in residential agreements?

Response: Multiple providers have sent the DMHA team questions regarding “modifications,” and the appropriate place to document such modifications. DMHA has decided that the most efficient method for addressing these questions is to develop a training around the concept. We hope to have this training completed by the end of September or beginning of October 2016. The team will notify providers when this training is completed.

Comment: If an agency can mandate no smoking in any facilities, can they mandate no alcohol or illegal drugs?

Response: It would depend upon the scope and justification for the restriction against drugs, alcohol, and tobacco. Any restriction of residents’ rights and freedoms must be based on the assessed needs of the residents at a setting, not for the convenience of the provider agency/setting operating authority. A specific prohibition against drugs, alcohol, and tobacco must be supported by an assessed need of residents at a setting. State and local laws regarding possession and use of these substances also apply.

Comment: Clarify “private unit with roommate.”

Response: CMS defines a private unit as a bedroom plus any included amenities (attached bathroom, kitchenette, etc.) accessible by and intended for the private use of the individual(s) living there. CMS considers “roommate” as unrelated individuals sharing the same living quarters. The regulatory requirement acknowledges that an individual may need to share a room due to the financial means available to pay for room and board or may choose to share a room for other reasons. However, when a room is shared, the individual should have a choice in arranging for a roommate.

Comment: For all residents in a community-based apartment building, the premises are restricted for drugs, alcohol, and tobacco for all residents. Would this “disqualify” a setting for BPHC/AMHH?

Response: It would depend upon the scope and justification for the restriction against drugs, alcohol, and tobacco. Any restriction of residents’ rights and freedoms must be based on the assessed needs of the residents at a setting, not for the convenience of the provider agency/setting operating authority. A specific prohibition against drugs, alcohol, and tobacco must be supported by an assessed need of residents at a setting. State and local laws regarding possession and use of these substances also apply.

Comment: Who (CMS, Contractor, FSSA) will conduct audits of settings/services other than the State Evaluation Team?

Response: CMS has the authority to conduct audits of settings/services related to Medicaid programs at any time. At present, the DMHA Adult 1915(i) State Evaluation Team is the sole reviewing agency for providers and settings related to AMHH and BPHC.

Comment: If a consumer chooses to remain in a setting non-compliant with HCBS, will they continue to be eligible for MRO services under an MRO service package?

Response: Yes. Currently, HCBS compliance is a requirement for providing AMHH and/or BPHC services only.

Comment: Regarding Remedial Strategies – DMHA notes that, based on a comment received regarding the prior draft STP, it is currently “assessing the most appropriate avenues to engage stakeholders.” The commenter is among the organizations listed as a possible collaborator. The commenter is willing to take on this role, and would also encourage DMHA to reach out to waiver participants themselves for feedback.

Response: Thank you for your comment, and for your agency’s willingness to assist in reaching members impacted by the HCBS settings requirements.

Comment: Regarding Key Stakeholders and Outreach –The commenter understands that DMHA hosted regional trainings in which providers learned about the STP. We would remind DMHA that regional meetings for waiver participants is a great way to solicit feedback from those in the area, in more individualized and comfortable settings. Such meetings would also be a good opportunity for DMHA to alert participants of coming changes, including the potential need to relocate.

Response: Thank you for your comment and suggestion. As the focus of Indiana’s HCBS Statewide Transition Plan shifts from site-specific assessments to remediation activities, DMHA looks forward to partnering with the commenter and other advocacy agencies to develop and deliver information

sessions for members, particularly those who may experience changes to their living situation as a result of the HCBS settings requirements.

Comment: Where can I find the HCBS requirements in the rule and how do I know whether or not my setting is in compliance with the rule?

Response: Thank you for submitting your comments and concerns about the HCBS setting requirements. The DMHA Adult 1915(i) team is currently assisting agencies approved to provide HCBS services to adults (Adult Mental Health Habilitation and Behavioral and Primary Healthcare Coordination programs) to transition their settings into compliance with the Centers for Medicare and Medicaid's final rule standards related to Home and Community Based Services. Those regulations can be found in the Federal Register at 42 CFR 441.710(a)(1). DMHA recommends that you consult with the HCBS representative at your agency for further discussion and clarification of those requirements, and to refer to your agency's Setting Action Plan for the specific setting in question which outlines steps your agency will take to bring it into compliance. Additionally, the Adult 1915(i) team is available to provide technical assistance with yourself and your agency's HCBS representative so that we can further clarify the standards and HCBS expectations. DMHA encourages you and your agency's HCBS representative to email the Adult 1915(i) team at DMHAadultHCBS@fssa.in.gov to arrange a technical assistance call or visit for your agency.

Version IV – October 2016

Version IV contained technical corrections and CMS did not require public notice and comment.

Version V – November 2016

Version V contained technical corrections and CMS did not require public notice and comment.

Version VI – March 2017

Office of Medicaid Policy and Planning

Summary: The Office of Medicaid Policy and Planning solicited comments on the Statewide Transition Plan as it applies to administration of the Statewide Transition Plan.

PUBLIC COMMENTS:

Comment: Each time there are revisions to the State Transition Plan is there a location where I can see what revisions were made? Maybe highlighting the changes so it will be easy to locate?

Response: Thank you for your comment. If another version of the STP is required, the State will consider posting a version that reflects changes made for review during public comment.

Comment: One commenter noted whenever possible, the divisions within FSSA should coordinate rules, assessments, and procedural safeguards to ensure consistency and fairness across settings. The commenter understands that settings across divisions do not always line up, however, standards for things like procedural safeguards for participants can more easily be systematized across divisions.

Response: Thank you for your comment. The State currently coordinates efforts to the extent possible. CMS establishes some minimum requirements for procedural safeguards, but the divisions have freedom to incorporate enhanced or additional safeguards based on the needs of the populations they serve.

Division of Aging

Summary: The Division of Aging solicited comments on the Statewide Transition Plan as it applies to the two 1915(c) programs; the Aged and Disabled Waiver and the Traumatic Brain Injury Waiver. The comments resulted in changes to pages 7, 60, 64, and the Acronym table on page 173.

PUBLIC COMMENTS:

Comment: Commenter has concerns that the HCBS settings rule creates further limitations for residential options by denying true choice and potentially very beneficial opportunities.

Response: Thank you for your comments. DA agrees it is important to expand and not limit choices while working with the framework of the programs and services available.

Comment: Commenter requested to know the criteria Division of Aging will use to determine if the Structured Family Care giving is provider owned or controlled.

Response: Thank you for your comments. To your question on how DA will determine if SFC is provider owned and controlled, that will hinge primarily on whether the paid caregiver is a related or unrelated individual. But in either case, there are core provisions of the Settings Rule that apply in ALL settings and those will always be monitored for compliance...

Comment: Would like to encourage DA to include more people with disabilities or participants of those services and advocacy groups in the DA initiative to design a new program to replace or augment the service of assisted living.

Response: DA appreciates the need to involve consumers and their families in the stakeholder process. DA continues to work on ways to do that effectively and is always open to suggestions.

Comment: The continued use of a 90 day checklist may be limiting and not give the full picture of the individual's true needs and wants. Commenter recommends evaluating case management and the use of standardized tools like checklists to ensure they provide meaningful information about the participants wants and needs, especially if this tool is to be used to help determine a settings on-going compliance with HCBS rules.

Response: DA has appreciated your comments before on the limitations of the 90 day checklist and hope to engage with you and other stakeholders on a thorough review of this tool in the coming year.

Comment: Commenter cited the Federal Requirement: Right to privacy, dignity, respect, and freedom from coercion and restraint. Commenter would encourage DA to restrict a provider's ability to serve as a guardian over the participant. Commenter feels strongly that the direct conflict of interest organically creates a situation where coercion is more likely to happen. Apart from requiring a written record to be made when either measure is used, the statute does not contain reporting requirements or review measures. The application of the new HCBS requirements are an ideal time for the Division to take a stronger approach to protecting the dignity and well-being of consumers. DA should also include a prohibition against involuntary seclusion, or forced social isolation by any provider in code (not just in the ISDH health facilities rule). Federal Requirement: Settings optimize, but do not regiment individual initiative

455 IAC 2.1-6-4(2) - a provider should not "allow" the person to engage in decision-making and self-determination. Rather, that should be a given, automatic standard. Rather the facility should respect the

person's right to make decisions and engage in self-determination. "Allow" implies that the facility can remove that allowance.

455 IAC 2.1-6-6(b)(1) - participants should be able to lock their unit, not just their room. Physical accessibility – it's not just the room that would need to be accessible, but the entire unit, including common areas, the bathroom, kitchen, etc.

Response: DA agrees that it would be inappropriate for the provider to act as guardian and will consider language for DA's draft rule. A number of your suggestions are directly related to rule language and DA will consider them as comments in that process as well.

Comment: Commenter encourages the use of independent surveyors and those trained in communicating with individuals with disabilities to complete the participant surveys. Surveys should be conducted in a private setting of the participants' choice and participants should be allowed to opt-out if they choose. Commenter also encourages frequent input from participants through survey and/or town hall forums. Participants should be a part of the process early on and frequently throughout. Finally, commenter supports the coordination among the various FSSA agencies to ensure consistency for participants across settings.

Response: DA agrees that the use of trained surveyors and interviewers will be critical in obtaining reliable information.

Comment: Relocation of beneficiaries - participants should also be notified of potential sources of advocacy organizations along with their right to appeal. Whenever possible, procedural safeguards should be adequately explained and be consistent across FSSA agencies.

Response: Notifying individuals who may need to be relocated about advocacy organizations available to them is a great idea. DA has revised the STP on page 60 to add language pertaining to notifying beneficiaries about advocacy organizations.

Comment: Ongoing Compliance and Monitoring – Commenter recommends evaluating case management and the use of standardized tools like checklists to ensure they provide meaningful information about the participant's wants and needs and the setting's on-going compliance with HCBS. IDR continues to have reservations regarding the heavy reliance DA plans to place upon the 90 day Monitoring Checklist. As recommended in comments for a previous iteration of the STP, Commenter would like to assert that the DA should integrate regularly occurring face-to-face interviews with a statistically significant population of participants as an additional monitoring tool. This should be carried out by an independent third party, and can be utilized as a means to verify data gathered through the Checklist. Commenter also encourages inclusion of participants and advocacy groups in developing trainings as well.

Response: Thank you for your comments. DA appreciates the need to involve consumers and their families in the stakeholder process. We continue to work on ways to do that effectively and are always open to suggestions.

Comment: Commenter noted Indiana Protection & Advocacy Services on page 64 should be corrected to Indiana Disability Rights.

Response: DA will make the change on page 64 to reflect Indiana Disability Rights.

Comment: One commenter noted: implicit in the statewide transition plan is the assumption that providers cannot comply with both the current Indiana Residential Care Facility licensure rules and the Settings

Rule. However, a review of several individual provider reviews (mailed to providers in February 2017) failed to identify any instance where a provider’s remediation would conflict with RCF licensure rules.

Response: Thank you for your comments. DA would note that the Settings Rule requirement to provide for the responsibilities and rights of tenant, in a legally enforceable agreement (§441.301(c)(4)(vi)(A)) was not addressed in the survey tool and will need to be addressed in every remediation plan. That is one significant area of conflict. DA has specifically identified the following areas of conflict:

- 1. Transfer and Discharge of Residents (410 IAC 16.2-5-0.5(f) and 410 IAC 16.2-5-1.2(r))**
- 2. Residency Agreements (410 IAC 16.2-5-1.2(g))**
- 3. Person Centered Planning (410 IAC 16.2-5-1.2(j)(2))**
- 4. Visitors (410 IAC 16.2-5-1.2(cc))**

Comment: One commenter noted: while it may be appropriate to include proposed Division of Aging rule language, the STP should include recognition that Indiana’s rule promulgation process will be followed and in so doing, some of the proposed language may be revised.

Response: DA has included proposed rule language in the transition plan a timeline for rule promulgation. Some of that language has been refined already as a result of our assisted living workgroup. DA thanks you for being part of that group.

Comment: In the Statewide Transition Plan, Indiana has indicated that SFC is not a provider owned-or controlled setting as long as the participant lives in a home that is owned or rented by themselves or by a caregiver who is a family member. This interpretation of the Home and Community Based Services Final Rule (HCBS Final Rule) implies that when participants live in a private home that is owned or rented by an un-related caregiver, this home is considered a provider owned or controlled setting. When a setting is considered provider owned or controlled, additional components of the HCBS Final Rule apply. We strongly disagree with this interpretation of the HCBS Final Rule. SFC providers do not own or control the home where SFC is provided.

As you know, caregivers can be related or unrelated, and SFC pays for the care provided to participants and the clinical support provided to caregivers. SFC rules govern how care is provided to participants and how caregivers are supported by SFC agency providers, both components are based on individualized consumer and caregiver assessments and outlined in person centered care plans.

Response: Thank you for your comments on structured family care. DA has continued to seek clarification from CMS on its intent with regard to some of the relationships you have listed here as examples of “unrelated” caregivers.

Comment: One commenter noted as the DA designs a new Medicaid HCBS, bear in mind that the program needs to be some type of certification or license. The terms, certification or license, allow for the Residents to access their long term care benefits and VA benefits for “Assisted Living”.

Response: Thank you for your comments. Most of your comments related to specific language for new administrative code/rule language. Some of your comments are directed at current language which is in the draft process now for our new rule. DA will consider all your comments in drafting that language as well as in the transition plan.

Division of Disability and Rehabilitative Services

Summary: The Division of Disability and Rehabilitative Services solicited comments on the Statewide Transition Plan as it applies to the two 1915(c) programs; Community Integration and Habilitation and Family Support Waiver. The comments resulted in changes to pages to pages 83, 85, 87 and 89 of the plan.

PUBLIC COMMENTS:

Comment: Commenter noted that the ADA was not written to create further limitations. It was to allow, to the greatest extent possible, participation for all within community life. This rule simply creates further limitations for residential options by denying true choice and potentially very beneficial opportunities!! Why can't we let the individuals and those that love and support them decide which setting might offer them the best opportunities for a healthy, happy and fulfilling life working within the framework of the funds and services available. It has been our experience that when you attempt to force situations it often does not go well....but when you create an environment of respect and allow for opportunity....more good will flourish!

Response: Thank you for the comment, DDRS is committed to supporting families and improving available programs and supports. DDRS agrees with the importance of opportunity and individual choice.

Comment: Commenter noted there is language in the Systemic Assessment Crosswalk about using the individual's PCP/ISP to ascertain if there is compliance in the following areas: ensure choice of living arrangement, rights protection, and development of a life plan, and reason for someone not being engaged in the community. Currently, the training and documents associated with the PCP/ISP do not outline all the examples that the transition plan gives in this section as being reflective in these plans. In addition, the current PCP format is reflective of an individual's current and historical status, it does not fully encompass a life plan or hopes and dreams. It is suggested to note that the PCP/ISP process and forms are being reevaluated so they can be comprehensive of the outline of the new rules and any modifications of those rules.

Response: Thank you for your comments. DDRS will update the STP to include language that it is currently reviewing the PCP/ISP process through the Life Course Alignment Project. As part of this project the current process and forms will be reevaluated to ensure compliance to the new rules and any modifications of those rules.

Comment: Commenter noted the new BDDS Individual Rights and Responsibilities document is referenced several times as evidence of compliance. Historically, BDDS documents have only been available in English. Will this form be available in multiple languages and accessible formats so that it can be presented in an individual's typical mode of communication?

Response: Thank you for the suggestion to have forms available in multiple languages. While the STP will not be updated with this specific language, the information provided will be helpful as the State incorporates the suggestions within development of policies and procedures.

Comment: For the following, it is indicated that Indiana is in full compliance due to the statement that includes "access to food at any time" on the Monitoring Checklist: Does the individual have the freedom and support to control their schedules and activities and have access to food at any time? At this time, the Monitoring Checklist does not have language that addresses if food needs to be modified. Can the checklist be modified to include this?

Response: In regards to the Monitoring Checklist lacking specific language that addresses food modification, it is expected the ISP/PCP process will address and document any limitations. The monitoring checklist is a monitoring tool to ensure the PCP process is being followed.

Comment: Commenter noted from Transition Plan: The data derived from the Individual Experience Survey will be used to validate compliance of provider's responses to the self-survey of settings. Validation will be comprised of reviewing provider policies and procedures as well as person specific information such as: The individual's PCP/ISP (*is there a reason they are not engaging in the community and is that addressed in the Person Centered Planning process?) Are there Medical issues preventing community involvement? Are these addressed in the Person Centered Planning process? Are there Behavioral issues preventing community involvement? Are these addressed in PCP/ISP? There is concern that the IES is reflective of a higher percentage of choice, integration, etc. than there is in actuality. Participant experience really relies on informed choice. A lack of experiences and clear understanding of options could lead some to answer that they had more choice and integration than they actually did. For example, an individual could be asked, "did you get a choice in roommates?" The answer could be "yes" because they met them ahead of time once and were given the option to stay where they were or go with this new roommate. That is not choice in its truest form, but the choice as the individual may understand it. It is suggested to keep this in mind when comparing the IES data to the site-specific setting assessment. In addition, the responses received from the IES completed in 2015 would no longer be current data when compared to provider self-assessments and documentation provided in 2017.

Response: For validation of Preliminary Settings Inventory and Proposed Remediation Strategies section of the STP, DDRS recognizes challenges in interpreting data. While the IES data will be used as a validation/comparison to measure the survey responses, it will not be the only factor utilized in determining HCBS compliance. DDRS recognizes settings and experiences may have changed from the original responses provided. The IES data also will be validated to ensure consistency of answers. Measuring the responses against provider responses are just one way of validating the information.

Comment: Commenter noted that for sites that are determined to be compliant based on the provider self-assessment and provider supplied documentation, they would recommend additional verification be completed with individuals supported. Provider reports and documentation may not accurately reflect the actual experience of an individual.

Response: DDRS thanks you for your recommendation. DDRS will utilize site visits with individuals and providers to assist in determining compliance of HCBS delivery sites.

Comment: Commenter stated that it is noted that the process for provider sanctions and dis-enrollment will be complete by June 2018, however, relocation for individuals will not begin until March 2019. What steps will be implemented if a provider is dis-enrolled prior to March 2019? In the review of the transition task force, can clarity be added to advise who will be part of that task force?

Response: If a provider is dis-enrolled prior to March 2019, DDRS will follow the same steps outlined in the STP for Relocation of Beneficiaries on page 95. It is anticipated in the STP by 2018 that sites found to be in non-compliance after all remedial activities will be notified upon determination in order to allow ample time for individuals to follow this process. DDRS is in the process of identifying members of the taskforce. It is anticipated that the taskforce will be convened in late March 2017.

Comment: Commenter noted from Transition Plan: Throughout the five-year transition process DDRS will continually seek out and incorporate stakeholder and other public input. It is suggested to incorporate additional focus groups of individuals and families to gain input on the state's transition plan. Requesting feedback in a 30-day comment period does not lend itself to being accessible to individuals and families. There are some inherent challenges in obtaining feedback from this group. Individuals and families need to find that there is a comment period. They then need to read through the transition plan and understand what it means. They then have to figure out how to write up their feedback and submit. These barriers lend themselves to not obtaining quality feedback from individuals and families. Sponsoring focus groups that can give verbal feedback in discussion format would generate valuable input as this plan continues to be revised, updated and ultimately implemented.

Response: For the section Key Stakeholders and Outreach, the information provided will be helpful as the State incorporates the suggestions within a communication plan. The State will ensure stakeholders have an opportunity to review any policy/process changes and, to the greatest extent possible, the State will incorporate the suggestions within the specific processes.

Comment: Commenter noted the PCP appears to be inclusive of many remediation efforts however the form and practice right now does not incorporate all the components outlined in the transition plan. This should be noted in the Transition plan along with how this is being addressed.

Response: Under General Suggestions for the STP, DDRS will update the STP to include language that it is currently reviewing the PCP/ISP process through the Life Course Alignment Project. As part of this project the current process and forms will be reevaluated to ensure compliance to the new rules and any modifications of those rules.

Comment: Commenter noted there should be a systematic sharing of the CMS guidance that they are putting out on a regular basis. This should be shared with all stakeholders in an accessible way.

Response: Thank you for the suggestion, while the STP will not be updated with this specific language, the suggestions provided will be helpful as the State incorporates the information within education and training on the HCBS Final Rule of all stakeholders.

Comment: Commenter noted Training should be presented on an ongoing basis for individuals and families in order to clarify the intent of the rules and the state's plan to implement these rules. These trainings should be held in an accessible way for all individuals and families.

Response: Thank you for the suggestion, while the STP will not be updated with this specific language, the information provided will be helpful as the State incorporates the suggestions within education and training on the HCBS Final Rule of all stakeholders.

Comment: Commenter noted Self-Directed Services should be considered with the amendment to the waivers as that service lends itself to fully meeting the requirements of the HCBS rule.

Response: While Self Directed Services are not specifically addressed in the high level STP, service definitions, budgets, funding parameters, codes, etc. are all being looked at to ensure we are able to support compliance.

Comment: Commenter has concerns regarding the lack of specificity provided as to how DDRS intends to amend its regulations to comply with the new HCBS requirements. Commenter will pay close attention to the proposed rules as they are released, and urges CMS to withhold approval of the STP until these amendments are completed. In the meantime, they would like to comment on some of the regulations

which the Division acknowledges are implicated by the new requirements, but asserts no remediation is necessary. Federal Requirement: Settings are integrated in and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS (p. 66) Page 66 suggests that because 460 IAC 6-20-2 states “community-based employment services will be provided in integrated setting,” the rule is already in compliance with the new HCBS regulations. While that may be true on paper, does DDRS still intend to provide pre-vocational services in nonintegrated settings, as it currently does (i.e., sheltered workshops)? Because, based on my reading, that placement would not comply with the HCBS regulations.

DDRS states that 460 IAC 6-9-4 is fully compliant “due to requirement of providers to ensure opportunity for individuals to engage in community life.” However, we must note there is a substantive distinction in the phrases “opportunities to...engage in community life” and “opportunity to participate in...community activities.” The former suggests the provision of opportunities allowing consumers to become contributing members of their communities, while the latter suggests consumers are simply provided a chance to “do things” in the community. Commenter supports the addition of language that would encourage providers to seek out opportunities for community engagement which reflect the choices and values of individual consumers. Commenter looks forward to release of the proposed regulation regarding Individual Rights and Responsibilities. We would like to stress the importance of the language within this regulation being written so as to appropriate for individual consumers. It is crucial the language is not so vague as to encourage technical compliance with the rule. Commenter continues to have reservations regarding the heavy reliance DDRS plans to place upon the 90-day Monitoring Checklist. As recommended in comments for a previous iteration of the STP, Commenter would like to assert that the Division should integrate regularly occurring face-to-face interviews with a statistically significant population of participants as an additional monitoring tool. This should be carried out by an independent third party, and can be utilized as a means to verify data gathered through the Checklist. Federal Requirement: Settings ensure an individual’s rights of privacy, dignity, respect, and freedom from coercion and restraint.

Commenter would encourage DDRS (and other FSSA agencies) to restrict a provider’s ability to serve as a guardian over the participant. Commenter feels strongly that the direct conflict of interest organically creates a situation where coercion is more likely to happen. Regarding the utilization of seclusion or restraint by providers, commenter finds the Division’s assertion that IC 12-27-4-1 is fully compliant with HCBS requirements, without supplementary regulations limiting and prescribing the appropriate use of each, to be insufficient. DDRS neglects to mention that the statute’s second clause (2) permits seclusion and restraint “[a]s a measure of therapeutic treatment.” This is an especially vague standard, and in the opinion of commenter, gives providers far too much discretion in determining when the use of seclusion and restraint is permissible. Although the Division does note its internal written policies regarding prohibitions of abuse and neglect of consumers, these would carry greater solemnity and would be far more accessible to the public were they formalized in the Indiana Administrative Code. Additionally, apart from requiring a written record to be made when either measure is used, the statute does not contain reporting requirements or review measures. The application of the new HCBS requirements are an ideal time for the Division to take a stronger approach to protecting the dignity and well-being of consumers. Federal Requirement: In provider-owned or controlled residential settings, each individual has privacy in their sleeping or living unit. 460 IAC 6-9-4 talks about the “opportunity for personal privacy” but that is not the same as privacy in a sleeping or living unit. Additionally, access via electronic communications should also be protected similar to mail and telephone calls. Federal Requirement: In provider-owned or

controlled residential or non-residential settings, the setting is physically accessible to the individual. The Division asserts that regulations within Rule 29 of Article 6 are sufficiently compliant with the HCBS requirement for provider-owned or controlled settings to be physically accessible. However, a reading of the apparent lone reference to physical accessibility within the Rule is found in 460 IAC 6-29-3, which refers to the responsibility of providers to “ensure that appropriate devices or home modifications” are provided in accordance with the consumer’s ISP and satisfy the requirements found in the Americans with Disabilities Act. This regulation, standing alone, is insufficient. First, it ignores the reality that for many consumers, most members of the support team responsible for formulating the ISP may rarely, if ever, visit the consumer’s home. Often, the consumer’s residential provider and case manager are the only team members who visit the home on a regular or even semi-regular basis. Second, consistent with Rule 29, the section of the form ISP that applies to a consumer’s home is almost exclusively concerned with safety. The lone question the support team is required to answer regarding accessibility is “If Special Devices and Home Modifications are required, are they present?” Commenter recommends the Division take steps to flesh out this process. The support team is currently required to confirm the presence of smoke and carbon monoxide detectors, fire extinguishers, anti-scalding devices, etc. In order to fully comply with the HCBS requirement of physical accessibility, there should be documentation requirements similar to those already in place regarding consumer safety.

Response: Thank you for the above comments and insights into the systemic assessment process. The feedback provided will be taken into consideration as the State revises policies and procedures to ensure full HCBS compliance. DDRS recognizes current policies and procedures require revision in order to fully establish HCBS-compliant rules. In addition, DDRS is currently reviewing the PCP/ISP process through the Life Course Alignment Project. As part of this project the current process and forms utilized in Person Centered Planning will be revised to ensure continued compliance to the new rules and any modifications of those rules. As outlined in the STP, any proposed modifications to Indiana Code will follow the Administrative Rules drafting procedure and will be published for a public comment period to ensure meaningful feedback from all stakeholders.

Comment: Commenter encourages the use of multiple mechanisms to determine a setting’s initial and ongoing compliance with HCBS rules. Commenter would also stress that settings should be 100% compliant before being found to be an HCBS setting.

Response: DDRS has determined a variety of mechanisms to determine a settings initial and ongoing compliance. Final determination will depend on results of surveys, site visits to validate findings, and completion of corrective action plans to bring settings into compliance. All settings are required to be 100% complaint by March 17, 2019.

Comment: Commenter encourages the use of independent surveyors and those trained in communicating with individuals with disabilities to complete the participant surveys. Surveys should be conducted in a private setting of the participant’s choice and participants should be allowed to opt-out if they choose.

Response: Thank you for the suggestion. DDRS may work in conjunction with a contracted entity on various components of the STP. While participants may opt out of the survey process, all sites will still be required to be assessed for HCBS compliance.

Comment: Commenter encourages frequent input from participants through survey and/or town hall forums. Participants should be a part of the process early on and frequently throughout.

Response: Thank you for the suggestion, DDRS agrees and will continue to seek frequent input from participants through various means.

Comment: Commenter supports the coordination among the various FSSA agencies to ensure consistency for participants across settings.

Response: Thank you for the suggestion, DDRS agrees with the coordination of divisions to ensure consistency for all participants.

Comment: Commenter noted for relocation of beneficiaries - participants should also be notified of potential sources of advocacy (including IDR, ombudsman, the Arc, other advocacy organizations) along with their right to appeal. Whenever possible, procedural safeguards should be adequately explained and be consistent across FSSA agencies.

Response: Thank you for the suggestion. DDRS will ensure notification of sources of advocacy be provided as part of the process.

Comment: Commenter recommends evaluating case management and the use of standardized tools like checklists to ensure they provide meaningful information about the participant's wants and needs and the setting's on-going compliance with HCBS. Commenter continues to have reservations regarding the heavy reliance DDRS plans to place upon the 90 day Monitoring Checklist. As recommended in comments for a previous iteration of the STP, Commenter would like to assert that the Division should integrate regularly occurring face-to-face interviews with a statistically significant population of participants as an additional monitoring tool. This should be carried out by an independent third party, and can be utilized as a means to verify data gathered through the Checklist.

Response: DDRS will incorporate a variety of means of ensuring ongoing compliance. The monitoring checklist completed by case managers will be one tool to ensure ongoing compliance. Revisions to provider enrollment, re-certifications, policies and procedures as outlined in the STP will all be part of the ongoing monitoring process.

Comment: Commenter encourages inclusion of participants and advocacy groups in developing trainings as well.

Response: Thank you for the suggestion.

Comment: Process for Provider Sanctions and Disenrollment - Commenter looks forward to reviewing the specific processes for issuing sanctions and provider disenrollment.

Response: Thank you. DDRS appreciates your feedback.

Comment: Commenter would like to encourage its inclusion in the convening of a Transition Taskforce. Commenter often assists individuals transitioning out of institutions.

Response: DDRS would be appreciative of commenter's assistance on the Transition Taskforce and will be reaching out to various stakeholders to form the taskforce.

Comment: Commenter applauds the changes to code, policies, and procedures that have been modified or drafted in pursuit of compliance with the rule. We note that some code, policies, and procedures state that language will be added, particularly 460 IAC citations. Commenter appreciates the process and the length of time required to change Indiana Code (IC) and Indiana Administrative Code (IAC), and we noted that the Systemic Assessment section lists the timeline for completion of changes to IAC as December 2017

and changes to IC as May 2018. This timeline seems aggressive for the amount of changes needed to achieve compliance. Commenter requests clarification of the timeline for revisions to Administrative Code and recommends that the timeline may need to be adjusted. Commenter continues to advocate for the inclusion of stakeholders such as providers, the Arc of Indiana, Case Management organizations, and individuals receiving services in the revision process for IAC, policies, procedures, the Waivers, and the service definitions. These stakeholders will provide good insight and perspective concerning how modifications would impact individuals served by the industry and their advocates. The inclusion of stakeholders in these processes could also decrease the number of comments received during the public comment period and subsequent modifications needed before these policies and processes could be finalized.

Response: Thank you for the comment. DDRS will continue to seek out ways to engage stakeholders in the process in order to allow for meaningful feedback.

Comment: Will stakeholders have the opportunity to review and provide feedback concerning changes that have been made to code, policies, and procedures before these changes are fully implemented?

Response: As outlined in the STP, any proposed modifications to Indiana Administrative Code will follow the Administrative Rules drafting procedure and will be published for a public comment period to ensure meaningful feedback from all stakeholders.

Comment: Many items related to the 90 day Checklist/Monitoring Checklist are marked as fully compliant or partially compliant. The link to this document in the STP currently does not work, so stakeholders cannot access this document to review it and provide their feedback concerning compliance. Could the link to this document be fixed or the document be shared with stakeholders prior to the comment period for the next version of the STP?

Response: Thank you for the comment. DDRS will ensure the document is available prior to the next public comment period.

Comment: The timeline for completion of many remediation activities for the 90 Day Checklist/Monitoring Checklist is listed as August 2016, yet one item is still stated to be partially compliant with language to be added (see STP page 67). Should the timeline for this item be revised to state the timeline when changes are expected to be completed?

Response: The 90 day checklist was modified in August 2016 and is now called the Monitoring Checklist. While that one area is not currently addressed in the Monitoring Checklist, DDRS will update the STP to include language that it is currently reviewing the PCP/ISP process through the Life Course Alignment Project. As part of this project the current process and forms, including the monitoring checklist will be reevaluated to ensure ongoing compliance to the new rules and any modifications of those rules.

Comment: Concerning the Individual Rights and Responsibilities (4600221014) policy, the chart states that Language has been drafted to include all aspects of HCBS rule surrounding individual rights containing the right to make choices in life. Will stakeholders have the opportunity to review this draft language and provide feedback?

Response: Any Policy that is substantially modified will be posted for review.

Comment: The chart lists one IC citation related to seclusion and restraint that already fully complies with the HCBS Rule. Has DDRS identified any other specific Indiana Code changes that will be needed to achieve full compliance, particularly related to client rights? If so, when those changes will occur?

Response: While DDRS does not draft Indiana Code, sub regulatory guidance changes such as Administrative Code, policies and procedures will address all HCBS requirements.

Comment: Commenter appreciates the additional information included in this version of the STP concerning the revisions to the 90 day Checklist/Monitoring Checklist and its use for compliance measurement. We would appreciate additional clarification and detail concerning the requirements for “No” answers to be supported by a specific need and justified in the person-centered service plan. We would also request the addition of specific information concerning the enhancements to the Person Centered Planning process and the corresponding annual systemic verification process that DDRS will implement to ensure ongoing monitoring and compliance.

Response: Thank you for the suggestion, while the STP will not be updated with this specific language, information requested will be distributed through various provider trainings and guidance.

Comment: What would the minimum requirement be for a specific need that would support or justify a No answer?

Response: A “no” answer would be determined by following the Monitoring Checklist Interpretive Guidelines. Each HCBS related question has a criteria that should be met.

Comment: Who decides if the specific need provides sufficient justification for the No answer?

Response: The case manager completes the Monitoring checklist and will be the one making the determination.

Comment: For cases in which the provider and the case manager do not agree, who would make the final decision concerning the need to submit a corrective action plan?

Response: In cases where there is a disagreement between team members, BDDS will make the final determination as outlined in 460 IAC 6-10-8 Resolution of disputes.

Comment: Will the additional monitoring and compliance activities outlined in the STP significantly add to the workload of case managers? If so, what actions will be taken to address this?

Response: DDRS does not expect individual remediation will significantly increase the workload of case managers. If it is found to have a significant impact, DDRS can review and adjust the activities if warranted.

Comment: What kinds of revisions will be made to the provider enrollment process and the Compliance Evaluation and Review Tool to measure ongoing compliance? Will stakeholders have the opportunity to provide feedback concerning these changes?

Response: DDRS has not yet finalized the proposed changes to the enrollment process or CERT to measure ongoing compliance of HCBS settings.

Comment: Commenter appreciates the additional information and clarification provided concerning the design, development, administration, and analysis of the Individual Experience Survey, including the details concerning which entities were responsible for the completion of specific activities. While we

acknowledge that the information concerning activities related to the survey describes how the survey process was designed to be completed, we question if the description reflects the reality of how the survey was completed. For example, the narrative in the STP states that “[t]he individual’s case manager was responsible for ensuring completion of the survey with the individual during their quarterly meeting.” However, the IES report indicates that only 70% of surveys were completed with case managers and the consumer participated in the completion of only 60% of the surveys. In addition, the data gleaned from the IES is now dated as it was collected from late 2015 to early 2016. While information for some waiver participants will be the same, it may be different for many. Although the IES does provide data that serves as a starting point, the survey had some significant limitations and the data gleaned from it must be considered through the lens of these limitations. Because of the limitations of the data, we recommend that DDRS rely more on provider surveys and self-assessments, documentation received from providers, and site visits for determinations of compliance.

Response: While the IES data will be validated, it will not be the only factor utilized in determining HCBS compliance. DDRS recognizes settings and experiences may have changed from the original responses provided. Measuring the responses against other information will allow for determination of compliance.

Comment: Commenter applauds the inclusion of additional information concerning the tiered evaluation process for determining each setting’s compliance. Commenter appreciates the webinars, technical assistance sessions, tutorials, and FAQs issued by DDRS for the self-assessment and validation processes. We recommend including a brief explanation of the tiered evaluation process before the explanation of the provider self-assessments to provide greater clarity for stakeholders who are unfamiliar with the full process.

Response: The STP will be modified to include the explanation of the tiered process before the explanation of the provider self-assessments.

Comment: The plan lists 1,044 sites as Settings identified that could meet the HCBS rule with Modifications; Provider owned or controlled residential settings. Commenter recommends noting that there may be provider owned homes that require no modifications to meet the settings rule.

Response: STP language will be updated to include noting that there may be provider owned homes that require no modifications to meet the settings rule.

Comment: The plan lists approximately 10 sites as Settings identified that could meet the HCBS rule with Modifications; Homes with more than 4 individuals residing together. Could DDRS provide clarification concerning why homes with more than 4 individuals residing together are specifically identified as a potential issue?

Response: Even though CMS opted not to use the four person definition in their final version of the CMS settings final rule, from Indiana Code 12-11-1.1-1, unless the supported living services arrangement was once a supervised group living setting that converted to a waiver program setting, no more than four unrelated individuals may reside in any one setting as part of the waiver program. In order to ensure these sites do not have the qualities of an institution, DDRS has opted to categorize these settings as having the potential of those that could meet with modifications. Final determination will depend on results of surveys, site visits to validate findings, and completion of corrective action plans to bring settings into compliance. All settings are required to be 100% compliant by March 17, 2019.

Comment: Regarding Settings located on the ground of or immediately adjacent to a public institution, could DDRS provide additional information concerning what these settings are and to what kinds of institutions they are adjacent?

Response: The settings identified are self-reported. DDRS will conduct site visits to verify they meet CMS definition of being located on the ground of or immediately adjacent to a public institution. Medicaid regulations in Title 42 of the Code of Federal Regulations (42 CFR §435.1010) specify that the term public institution means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

Comment: Regarding “Settings that have the effect of isolating individuals; Residential settings where respondents to the IES indicated few social interactions outside of their home:” Since site visits have not yet occurred to review these settings, we recommend changing the language to “Settings that may have the effect of isolating individuals.” The current language implies that they have already been found to be isolating. In addition, we have already noted the limitations of the IES and the data gleaned from this survey. We request additional information concerning these settings and how they may have the effect of isolating individuals.

Response: Thank you for the comment. The language will be revised to “Settings that may have the effect of isolating individuals.”

Comment: Regarding Day Service Settings, Approximately 182 sites and Congregate Settings of 4 or more homes located close together, Approximately 50 sites: Commenter requests additional information concerning these settings and how they have the effect of isolating individuals. In addition, apartments are typically built close together. Individuals can choose to live in apartments or homes that are located close to the residences of other individuals with disabilities. How will DDRS determine if these instances are congregate settings, and why is 4 or more homes located close together cited as the threshold?

Response: DDRS will revise the language to “Settings that may have the effect of isolating” as they have not yet been determined as such. CMS has defined examples of settings that may have the effect of isolating individuals as multiple settings co-located and operationally related that congregate people with disabilities together such that people’s ability to interact with the broader community is limited. Final determination will depend on results of surveys, site visits to validate findings, and completion of corrective action plans to bring settings into compliance.

Comment: Commenter appreciates the inclusion of additional information about the validation process for residential and non-residential settings, especially the data concerning the Tier 1 analysis and the associated preliminary determinations of compliance. Commenter asked: The language in the setting assessment chart and the narrative information regarding the 1,044 and 1,011 sites is inconsistent. The chart lists 1,044 sites that are provider owned or controlled while the narrative lists 1,011, with 1,044 sites requiring additional information before a determination can be made. We would appreciate clarification concerning the number of sites in each category.

Response: Thank you. The number 1,011 reflects the Residential settings where respondents to the IES indicated few social interactions outside of their home (potentially isolating). Approximately 500 sites with 1,011 individuals residing there. The 1,044 sites, represents the total number of provider owned or controlled sites. The STP will be amended to clarify.

Comment: The narrative states that 18% of non-residential sites were found to be in compliance. Is it realistic to expect that the other 82% will be able to achieve compliance by the current stated deadline?

Response: DDRS expects all sites to be in compliance by the March 17, 2019, deadline as mandated by CMS.

Comment: Is the DDRS contracted entity completing all of the validation of the non-residential provider self-assessment responses and site visits?

Response: DDRS may work in conjunction with a contracted entity on various components of the STP.

Comment: Could DDRS provide additional information concerning the comprehensive training and guidance staff of DDRS and the contracted entity did/will receive in order to complete the validation process and site visits?

Response: Additional information will be presented to providers via web trainings and posted guidance prior to the implementation stage of validation.

Comment: With 172 initially requiring a site visit, 109 sites requiring additional information, and an additional 19 that did not complete the survey likely requiring a site visit, does the contracted entity have the capacity to complete the validations and site visits? When are the site visits expected to be completed? Will there be sufficient time for the site visits to be completed, the results to be compiled and disseminated, and the corrective action plans to be developed and approved by DDRS by December 2017?

Response: DDRS anticipates all steps to be accomplished by the stated time lime. If it is found additional time is needed, DDRS may request a modification upon CMS approval.

Comment: When does DDRS anticipate that the secondary determinations of compliance and need for site visits will be completed and sent to providers?

Response: For non-residential providers, it is anticipated secondary determinations of compliance will be made and sites identified for visits will be identified by April 2017.

Comment: Could DDRS provide additional information concerning the site visits and what will occur during site visits? Has a comprehensive tool been developed for site assessors to complete at each site? How will accuracy and consistency be ensured?

Response: DDRS's contracted entity has a comprehensive tool that site assessors will utilize. It is anticipated the same tool or a modification of the tool will be used for residential sites in order to ensure consistency.

Comment: Again, due to the limitations of the IES, commenter recommends not relying too heavily on the data from the IES to validate compliance of providers' responses.

Response: DDRS recognizes challenges in interpreting data. While the IES data will be used as a validation/comparison to measure the Non-Residential Survey responses, it will not be the only factor utilized in determining HCBS compliance. DDRS is exploring having the identified residential settings providers complete the same assessment that the non-residential providers completed. This is a provider specific survey rather than individual specific. DDRS will then compare the results of the two surveys to determine if a site visit will be warranted to determine final compliance or the need for heightened scrutiny. In addition, a section of the case managers monitoring tool will address HCBS Residential requirements and allow for client specific remediation. DDRS is exploring when the IES survey should be re-administered and if it could be

utilized as a means of ongoing compliance. It is expected the IES will be administered at least one more time, possibly more.

Comment: Commenter appreciates the additional information concerning remediation strategies included in this version of the STP. Commenter asked: Could DDRS provide additional information concerning the template that will be developed for provider specific transition plans?

Response: Additional information will be presented to providers via web trainings and posted guidance prior to the implementation stage of remediation.

Comment: How will findings of non-compliance be communicated to providers? How long will providers have after they receive their findings of areas of non-compliance to develop their provider specific transition plan/corrective action timeline and plan?

Response: Additional information will be presented to providers via web trainings and posted guidance prior to the implementation stage of remediation.

Comment: Will providers have access to the tracking database to review the status of their remedial plans and the associated timelines, or will they have to request status updates from DDRS if they want to check on the status of their plans more often than the quarterly communications?

Response: It is not anticipated providers would have access to a data base. DDRS will be responsible for monitoring the timeliness and completion of remediation. A provider may request a review of their status at any time.

Comment: Will DDRS or a contracted entity provide the technical guidance concerning completion of remedial plans?

Response: DDRS may work in conjunction with a contracted entity on various components of the STP.

Comment: Will DDRS or a contracted entity complete the verification of completion activities including site visits and documentation review?

Response: DDRS may work in conjunction with a contracted entity on various components of the STP.

Comment: Does DDRS anticipate that verifying completion of corrective actions for individual-specific remediation activities will significantly increase the workload of case managers?

Response: DDRS does not expect individual remediation will significantly increase the workload of case managers. If it is found to have a significant impact, DDRS can review and adjust the activities if warranted.

Comment: Commenter recommends reviewing the dates outlined in the action item chart and revising the timeline for completion chart as needed to reflect updated timelines and dates of completion.

Response: Thank you for the comment.

Comment: Commenter notes that there are several significant action items with a timeline for completion of December 2017. We recommend reviewing these action items and their timelines for completion to ensure that the identified timelines for completion are realistic. If not, COMMENTER recommends revising them as needed.

Response: In order to timely meet HCBS criteria, DDRS has set the timeline for completion of certain steps for 2017. This is to allow for a full year to remediate any issues.

Comment: The timeline for completion of the Transition Taskforce is March 2017. Have members of the Transition Taskforce been identified? When will the taskforce be convened, and will meetings be open to the public? Will information and proposals from these meetings be disseminated to stakeholders for feedback?

Response: DDRS is in the process of identifying members of the taskforce. It is anticipated that the taskforce will be convened in late March 2017. It has not yet been determined if meetings will be open to the public.

Comment: CMS has set the deadline for compliance with the HCBS Rule on March 17, 2019. DDRS has a significant amount of action steps to complete prior to this date. Commenter believes that a lengthened timeline for compliance with the HCBS Rule in Indiana would enable providers to more easily achieve compliance and allow the transition period to be smoother and more successful for individuals, families, providers, and the state.

Response: CMS has set the date for compliance at March 17, 2019.

Comment: Commenter appreciates the additional information provided concerning heightened scrutiny, particularly the steps to determine if Heightened Scrutiny will be submitted to CMS. Commenter requests that additional information concerning CMS' role in the Heightened Scrutiny process be added to the STP.

Response: As outlined in the STP, CMS will make the final determination when the State submits sites for Heightened Scrutiny.

Division of Mental Health and Addiction – Youth

Summary: The Division of Mental Health and Addiction solicited comments on the Statewide Transition Plan as it applies to youth 1915(c) program Psychiatric Residential Treatment Facility Transition Waiver and the 1915(i) Child Mental Health Wraparound program. The comments resulted in no changes to this portion of the STP.

PUBLIC COMMENTS:

Comment: One commenter noted: I am writing to urge those in governing positions to allow for options and choice! The ADA was not written to CREATE further limitations. It was to allow, to the greatest extent possible, participation for all within community life. This rule simply creates further limitations for residential options by denying true choice and potentially very beneficial opportunities! Why can't we let the individuals and those that love and support them decide which setting might offer them the best opportunities for a healthy, happy and fulfilling life working within the framework of the funds and services available. It has been our experience that when you attempt to force situations it often does not go well...but when you create an environment of respect and allow for opportunity...more good will flourish!

Response: Thank you for your input. The DMHA Youth Services shares your commitment to respecting individual choice to the fullest extent allowed.

Comment: One commenter shared that their organization has concerns regarding the lack of specificity provided as to how DMHA intends to amend some of its regulations to comply with the new HCBS requirements. The commenter will pay close attention to the proposed rules as they are released, and urges CMS to withhold approval of the STP until these amendments are completed. Federal Requirement: In provider-owned or controlled residential and non-residential settings, the setting is physically accessible to the individual. The commenter is concerned by DMHA's note that it will amend IAC to provide that children have settings which are physically accessible to the individual to the same degree as children not receiving Medicaid HCBS. Physical accessibility is specifically defined by law and is not comparable to children not receiving Medicaid HCBS.

Response: DMHA Youth would like to thank the commenter for your input regarding the Statewide Transition Plan. DMHA Youth Team welcomes the input of the commenter, and invites representative to a seat at our table for review of and recommendations for changes to the proposed regulations. A DMHA representative will contact the commenter to arrange; or the commenter may contact us at DMHAYouthServices@fssa.in.gov.

Comment: One commenter shared that their organization encourages the inclusion of its organization as an advocacy stakeholder for children with mental illness.

Response: DMHA welcomes the commenter as an advocacy stakeholder for children with SED. A DMHA representative will contact the commenter to arrange; or the commenter may contact us at DMHAYouthServices@fssa.in.gov.

Division of Mental Health and Addiction – Adult

Summary: The Division of Mental Health and Addiction solicited comments on the Statewide Transition Plan as it applies to two adult 1915(i) programs; the Adult Mental Health Habilitation and Behavioral and Primary Healthcare Coordination programs. The comments resulted in no changes to this portion of the STP.

PUBLIC COMMENTS:

Comment: I am writing to urge those in governing positions to allow for options and choice!! The ADA was not written to CREATE further limitations. It was to allow, to the greatest extent possible, participation for all within community life. This rule simply creates further limitations for residential options by denying true choice and potentially very beneficial opportunities! Why can't we let the individuals and those that love and support them decide which setting might offer them the best opportunities for a healthy, happy and fulfilling life working within the framework of the funds and services available. It has been our experience that when you attempt to force situations it often does not go well...but when you create an environment of respect and allow for opportunity...more good will flourish!

Response: Thank you for your comment. The Adult DMHA supports treating members in integrated settings.

Comment: One commenter is concerned with the methodology for site-specific assessments. On-site assessments should be done for each POCO setting to ensure compliance with HCBS.

Response: The Adult 1915(i) DMHA State Evaluation Team appreciates the comments from the commenter regarding the STP. According to the STP, settings requiring physical modifications will receive an on-site visitation. Settings requiring policy modifications will receive a desk audit. On an on-going basis, a setting's compliance will be verified by an on-site visit in conjunction with regular, annual Quality Assurance visits. Currently, DMHA staff have visited approximately 60 of the 200 settings statewide. As such, the STP does allow for visits at each site.

Comment: One Commenter would like to see participant/resident surveys be conducted independently without the involvement of the provider.

Response: In 2015 and 2016, initial assessment was conducted through member and provider surveys. DMHA Adult 1915(i) SET used multiple mechanisms to determine initial compliance as mandated by CMS. These mechanisms included client surveys, provider surveys, preliminary designation reports and setting action plans in which the provider described their plan for remediation. Additionally, the client surveys were administered with instructions to providers that explicitly requested providers not aid the client with the survey or influence the results in any manner. The survey results indicated a significant disparity between member results and provider results. DMHA believes this disparity in results is a strong indication that providers did not influence the member's survey results.

Comment: One commenter encourages the use of multiple mechanisms to determine a setting's initial and on-going compliance with HCBS rules. The commenter would also stress that settings should be 100% compliant before being found to be an HCBS setting. Compliance should not be granted until any remediation has been completed and re-assessed by DMHA to ensure compliance.

Response: DMHA Adult 1915(i) SET used multiple mechanisms to determine initial compliance as mandated by CMS. These mechanisms included client surveys, provider surveys, preliminary designation reports and setting action plans in which the provider described their plan for remediation. The SET team does not designate a setting compliant prior to the completion of remediation.

Comment: DMHA lists Indiana Disability Rights as a member of the DMHA Consumer Council. However, IDR is not currently aware of a staff member tasked with attending these meetings or when the meetings are to occur. IDR would greatly appreciate the opportunity to participate and looks forward to the invitation from DMHA.

Response: Thank you for your interest. This request will be shared with the state staff responsible for the DMHA Consumer Council.

Comment: One commenter is concerned that the heightened scrutiny packets do not contain information from service participants themselves through surveys or on-site participant interviews.

Response: Concerning heightened scrutiny, the evidence packets are based largely on participant interviews conducted by DMHA staff. Each residential Provider Owned, Controlled, and/or Operated setting was visited by DMHA staff, and consisted of site observations and member interviews. The evidence packets will contain the results of these member interviews.

Comment: One commenter shared: We work with our CMHC but are unable to utilize a lot of the great services that they offer because we aren't deemed a facility to use this type of Medicaid. I spoke with other county homes in Indiana that do use the BPCCH Medicaid in their facilities, and don't understand why we cannot here. How do we become an acceptable facility and our CMHC can get our residents who qualify for these Medicaid? Any help or guidance you can give would be greatly appreciate it!

Response: Thank you for your comment, and for your efforts to ensure that individuals in St. Joseph County with mental health issues have a place to live and recover. A bit of background information might be useful in understanding the current situation.

The Behavioral and Primary Healthcare Coordination program was implemented in 2014, as a way for vulnerable Hoosiers with high behavioral health needs who were not otherwise eligible for traditional Medicaid to gain access to the full array of Medicaid-funded health services. Eligible participants for BPHC have mental health and physical health issues. Their mental health condition impairs their ability to manage their physical health issues, and they frequently experience difficulty in accessing and coordinating their physical health care.

Individuals participating in BPHC must live in a setting which is compliant with requirements set forth by the Centers for Medicare and Medicaid Services Home and Community Based Services Settings Final Rule ("the Final Rule"). The Final Rule became effective in 2014, and it specifies certain standards for the residential setting of individuals participating in HCBS programs, which includes BPHC. The requirements of the CMS HCBS Final Rule apply to all residential settings, including those not owned, controlled, or operated by a community mental health center like Oaklawn. While the Division of Mental Health and Addiction has been heavily involved in the assessment and compliance process for those settings which are owned, controlled, or operated by a CMHC, it is the responsibility of each CMHC to assess and ensure compliance for residential settings the CMHC does not own, control, or operate.

HCBS participants are not eligible to receive HCBS services if they live in a CMS defined institutional setting (nursing home, ICF/IID, IMD, etc.). One of the requirements of the CMS HCBS Final Rule is that settings must not have any qualities typically associated with an institution, namely:

- 1. The setting is located in a facility which also provides inpatient institutional care;**
- 2. The setting is located on the grounds of, or adjacent to, a public institution; or**
- 3. The setting has the effect of isolating individual receiving Medicaid HCBS from the greater community of individuals not receiving Medicaid HCBS.**

Settings which have one or more of these qualities are defined by CMS as “Presumed Institutional”, and are therefore ineligible settings for individuals to live and receive home and community based services such as BPHC. There is a process by which a setting determined to be “Presumed Institutional” can submit evidence to CMS to demonstrate that the setting is in fact a home and community based setting and should be an eligible site for HCBS delivery. This process, known as heightened scrutiny, requires sufficient evidence to demonstrate that the setting (a) overcomes the institutional presumption, and (b) is otherwise fully compliant with the requirements of the Final Rule.

DMHA had been focusing primarily on assisting and supporting CMHCs to assess their own residential settings and bring them into CMS HCBS compliance. The next phase of CMS HCBS compliance work will be to support and assist CMHCs to assess residential settings which they do not own, control, or operate. DMHA will do this in conjunction with other FSSA agencies who administer HCBS programs. Again, thank you for your email, for the work you and your staff do every day, and for your role in providing care to Hoosiers in St. Joseph County.

Version VII – September 2017

Version VII contained technical corrections and CMS did not require public notice and comment.

Version VIII – October 2018

Office of Medicaid Policy and Planning

Summary: The Office of Medicaid Policy and Planning solicited comments on the Statewide Transition Plan as it applies to administration of the Statewide Transition Plan.

PUBLIC COMMENTS:

There were no public comments on the administration of the Statewide Transition Plan.

Division of Aging

Summary: The Division of Aging solicited comments on the Statewide Transition Plan as it applies to the two 1915(c) programs; the Aged and Disabled Waiver and the Traumatic Brain Injury Waiver. The comments resulted in no changes to the Statewide Transition Plan.

PUBLIC COMMENTS:

Comment: Commenter requested that FSSA coordinate rules, systems, assessments, and procedural safeguards to ensure consistency and fairness as much as possible. Commenter recommends that settings should not be certified HCBS compliant until all of the criteria for the Settings Rule are met.

Response: Thank you for your comment. The divisions within FSSA work together as much as possible given the noted setting differences. Only settings deemed to meet all the requirements of the Settings Rule are considered compliant.

Comment: Multiple tools should be used for Settings Rule compliance and participants should be included in the compliance process. Commenter expressed concern that there can sometimes be disconnect between what is written in policy and what participants actually experience in the program.

Response: Thank you for your comment. The DA will use multiple tools for post-certification monitoring, such as surveys, provider compliance reviews, site visit validations, and the person-centered monitoring tool; the DA welcomes participant feedback and inclusion as part of ongoing compliance monitoring to ensure that the participant experience matches written policy.

Comment: Commenter expressed that participants should be given the option of providers that offer private rooms.

Response: Thank you for your comment. The Settings Rule at 42 CFR § 441.301(c)(4)(vi)(B) requires that participants sharing units have a choice of roommates in that setting. Participants may choose settings with private rooms.

Comment: Commenter inquired about the absence of Senate Enrolled Act 421 in the cross-walk and believes that the provisions of this statute conflict with the Settings Rule.

Response: Thank you for your feedback. The DA believes that Senate Enrolled Act 421 can comply with the requirements of the Settings Rule.

Comment: Commenter inquired as to the criteria DA will use to determine if Structured Family Care is provider owned and controlled.

Response: The DA will work with the Structured Family Care providers to assess whether the individual setting is owned and/or controlled by the participant or whether the setting is owned and/or controlled by the caregiver.

Comment: Commenter encouraged the DA to include more people with disabilities, advocacy groups, and participants in the Settings Rule compliance process for Assisted Living. Commenter noted Assisted Living should be fully compliant with HCBS.

Response: Thank you for your comment. Changes to assisted living will be pursuant to the Settings Rule requirements and transition process. The DA values feedback from all our stakeholders. The Statewide Transition Plan and upcoming revisions of the administrative rule are a chance for stakeholders to participate in Settings Rule initiatives. Additionally, the DA welcomes participant

and stakeholder feedback outside of the rulemaking and STP process. Participants will have pick list options available to them that include private rooms.

Comment: Commenter believes the use of a 90 day checklist may be limiting and not give the full picture of the individual's true needs and wants. Commenter recommends evaluating case management and the use of standardized tools.

Response: Thank you for your feedback. The DA will keep your suggestion in mind.

Comment: Commenter encouraged the DA to restrict provider ability to serve as guardian over a participant because it is a conflict of interest that interferes with a participant's right to dignity, respect, and freedom from coercion and restraint. Commenter believes the application of the new HCBS requirements are an ideal time for the DA to take a stronger approach to protecting the dignity and well-being of participants.

Response: The DA agrees that providers serving as participant guardians is troubling, if consent is not granted by the participant. The DA will look further into this issue. The DA will take into consideration your comments on greater participant protections.

Comment: Commenter noted that the entire unit in a provider owned or controlled setting should be accessible and there should be encouragement to make common areas accessible.

Response: The DA, when validating approved remediation plans, is looking for accessibility of the entire facility.

Comment: Commenter requested further clarification on "reasonable lease limitations" to ensure that participants have the ability to decorate their homes in a way they so choose.

Response: The DA believes "reasonable lease limitations" is an appropriate standard and will be addressed on a case-by-case basis by the DA in provider remediation plans.

Comment: Commenter urged optional participant surveys in a private setting of the participant's choice and the use of independent surveyors and those trained in communicating with disabled individuals to conduct the surveys. Commenter asked for more opportunities for participant input through various means.

Response: Thank you for the feedback on the importance of communicating with participants and stakeholders; it will be taken into consideration for future participant surveys.

Comment: Commenter encouraged the inclusion of people with disabilities or advocacy groups in the Provider Relations Team. Commenter asked where locked memory units fall on the spectrum of presumed institutional settings and believe it should be addressed in the transition plan.

Response: All stakeholders are welcome to participate in the heightened scrutiny process. Locked memory units will not per se be presumed institutional if they meet certain requirements which will be addressed in upcoming rulemaking.

Comment: When relocating participants, they should be notified of potential sources of advocacy and their rights to appeal and procedural safeguards should be consistent across FSSA.

Response: Thank you for your comment. The DA will work with providers in transitioning these participants to compliant settings and will work with these providers to ensure participants are

aware of their rights. The DA is committed to coordinating with other divisions of FSSA as much as possible.

Comment: Commenter recommends evaluating DA's case management and standardized tools and recommends include regular face-to-face participant interviews carried out by an independent third party.

Response: The DA is confident that its current care management process is adequate to fulfill Settings Rule requirements. There are currently requirements for face-to-face meetings twice a year. In addition to the person-centered monitoring tool, the DA is also conducting provider compliance reviews, site visit validation, and conducts an annual survey that in part addresses participant satisfaction -- which all assist in the Settings Rule compliance process.

Comment: Commenter expressed concern about the removal of Person Centered Compliance Reviews from the latest version of the STP.

Response: Thank you for your comment. The DA is confident that its current approach meets Settings Rule requirements.

Division of Disability and Rehabilitative Services

Summary: The Division of Disability and Rehabilitative Services solicited comments on the Statewide Transition Plan as it applies to the two 1915(c) programs; Community Integration and Habilitation and Family Support Waiver. The comments resulted in a change to page 83 of the plan.

PUBLIC COMMENTS:

Comment: Remediation Strategies: Pg. 84 Monitoring completion of remedial plans will be done through various means. It is suggested that “various means” is clearly outlined and identified. Case managers will be responsible for verifying completion of any outstanding compliance. Case Managers can note whether a provider has complied or not, however, it should be clear that DDRS is responsible for any remediation efforts related to being HCBS compliant. There should be a direct link between the reporting of failure to comply and DDRS then conducting all follow up to ensure remediation efforts. It is important that Case Management is not relied on as the policing agency for other providers.

Response: Thank you for the comment. The STP has been updated to reflect BDDS will be responsible for conducting follow up on remediation to ensure compliance.

Comment: Revisions to the provider enrollment process and the Compliance Evaluation and Review Tool: Pg. 92 Trainings will be scheduled for state staff, members, providers and case managers on any changes in policies, procedures, and the monitoring process of the HCBS rules. Timely and comprehensive trainings for all stakeholders would be greatly appreciated as changes are made. Delay of trainings or only training to certain groups can be detrimental to the overall implementation of the HCBS changes.

Response: Thank you for your comment. DDRS plans to conduct trainings to all stakeholders throughout the system in an ongoing basis to ensure a clear understanding of the HCBS changes and requirements for implementation.

Comment: DDRS has increased the cap on transportation rates in order to support community inclusion and will continue reviewing the service definitions outlined in the waivers in order to better support capacity to assure non-disability specific options. This change will go a long way to improve accessibility into the community.

Response: Thank you for your comment. DDRS continues to explore ways to improve accessibility into the community.

Comment: Page 79 - Related to the Federal Requirement of modification being thoroughly outlined in the PCISP: The state should consider providing a training to providers and Case Managers with examples of how this should be implemented, and documented consistently. The STP indicates current practice does not comply so it will be important for the state to work with stakeholders to design modifications.

Response: Thank you for your comment. DDRS plans to conduct ongoing trainings to all stakeholders throughout the system to ensure a clear understanding of the HCBS changes and requirements for implementation.

Comment: Page 84, “Case managers will be responsible for verifying completion of any outstanding compliance.” Case Manager Service definition does not include requirement for holding provider agencies accountable for compliance standards. This creates a hostile working relationship.

Response: Thank you for the comment. The STP has been updated to reflect BDDS will be responsible for conducting follow up on remediation to ensure compliance.

Comment: Commenter applauds the changes to code, policies, and procedures that have been modified or drafted in pursuit of compliance with the rule. Commenter appreciates adjustments made to the timeline for revisions to Indiana Code (IC) and Indiana Administrative Code to account for the significant amount of changes needed to achieve compliance and recommends continued collaboration with stakeholders. These stakeholders will provide good insight concerning how modifications would impact individuals served and their advocates and decrease modifications needed before these policies and processes could be finalized. Commenter also recommends that DDRS update the waiver manual as soon as possible to incorporate changes implemented in recent waiver amendments and ensure HCBS compliance. The STP indicates that any modifications of the additional conditions for provider-owned and controlled residential and nonresidential settings must be supported by a specific assessed need and justified with the requirements documented in the person-centered service plan. Commenter recommends that the State develop additional communications and trainings for all stakeholders concerning expectations for assessing modification needs and consistently documenting associated justifications in the Person-Centered Individualized Support Plan. The trainings should include examples of appropriate modifications and justifications.

Response: Thank you for your comment. DDRS will continue to collaborate with and conduct trainings to all stakeholders throughout the system to ensure a clear understanding of the HCBS changes and requirements for implementation.

Comment: Commenter appreciates the additional information included in this version of the STP concerning the revisions to the Individual Experience Survey, Provider Assessments, Validation Processes, and Remediation Strategies, and Heightened Scrutiny. Commenter applauds DDRS' engagement of stakeholders through the HCBS Workgroup. The Workgroup has had the opportunity to provide input about assessment results and needed remediation activities and transition plans, as well as communications to individuals and families regarding remediation and transition activities. We recommend that DDRS host a webinar for providers including an overview of the forthcoming communications regarding assessment results and findings, a review of the Remediation Tool template, a discussion of the timeline for completion of all remediation and transition activities, and a question and answer period. Following this webinar, we encourage DDRS to distribute assessment findings as soon as possible to allow providers as much time as possible to achieve compliance by the deadline.

Response: Thank you for your comment. The input from the HCBS workgroup has been invaluable in developing ongoing communications activities. DDRS plans to conduct trainings to all stakeholders throughout the system to ensure a clear understanding of the HCBS changes and requirements for implementation.

Comment: Commenter requests additional clarifications concerning which database will be used to track the status of provider remediation activities and the associated timelines, and how communications regarding requests for progress updates on milestone achievements will be distributed. Case Managers document compliance in residential settings using the Monitoring Checklist. Additional training should be provided to all case managers to ensure consistency of documentation and assure DDRS is notified to follow up when non-compliance is documented.

Response: Thank you for your comment. DDRS plans to conduct trainings to all stakeholders throughout the system to ensure a clear understanding of the HCBS changes and requirements for implementation. These trainings will include a through explanation of the remediation process,

expectations, timelines and tools that will be used in order to provide ongoing updates on compliance.

Comment: Commenter appreciates the additional information about ongoing monitoring activities. The recent enhancements to the Person-Centered Individualized Support Plan and Monitoring Checklist are a critical first step toward documenting compliance. Many areas of HCBS compliance are now documented in the Monitoring Checklist, which is completed by Case Managers. While this monitoring is the responsibility of Case Managers, BDDS should ensure that Case Management rates are sufficient to support the numerous activities delineated in the service definition, including annual development and update of the PCISP, convening team meetings, risk assessment, contacts with the individual, developing and updating CCBs, completing transitions and all documentation and monitoring activities.

Response: Thank you for the comment. Within the future waiver re-design, service definitions, budgets, funding parameters, codes, etc. are all being looked at to ensure we are able to support compliance.

Comment: The STP states “Case managers will be responsible for verifying completion of any outstanding compliance.” HCBS compliance should be verified and monitored by DDRS as they have regulatory authority over providers. Placing this responsibility with Case Managers creates a conflict between providers and Case Managers and is detrimental to their working relationship, which is critical for a collaborative Individual Support Team and the person-centered planning and support process. In the STP narrative, DDRS should clarify their role and specific plans for monitoring activities through revisions to the provider application and re-certification processes, as well as other internal state monitoring processes, to ensure ongoing compliance by all providers.

Response: Thank you for the comment. The STP has been updated to reflect BDDS will be responsible for conducting follow up on remediation to ensure compliance.

Comment: Commenter applauds DDRS’ intent to implement a phased approach to HCBS compliance, with the first phase involving certain expectations of preliminary compliance through incremental changes toward greater integration and individual informed choice within the current waivers and service definitions and the second phase involving greater expectations of integration and individual informed choice through implementation of redesigned waivers and service definitions. We applaud recent changes such as the increased cap on transportation, elimination of certain restrictions on individuals’ Objective Based Allocation, and changes to increase flexibility of service definitions. We encourage DDRS to continue to identify opportunities to increase service flexibility within the current waivers, such as increasing the use of technology.

Response: Thank you for the comment. Within the future waiver re-design, service definitions, budgets, funding parameters, codes, etc. are all being looked at to ensure we are able to support compliance.

Comment: Commenter agrees that waiver redesign is critical in achieving greater community access and inclusion for Hoosiers with disabilities, as well as better meet the needs of individuals and families and addressing service gaps. During the waiver redesign process, we encourage DDRS to ensure that rates incentivize community integration, innovation in service delivery, and individual choice and provide sufficient funding to provide the necessary staffing resources for these service models. For example, the current reimbursement system for day services based on staffing ratios is a deterrent to individual choice and is not person-centered. Commenter has previously provided a day service model that promotes

community integration and choice, and we recommend that DDRS consider this model when planning for redesigned day services.

Response: Thank you for the comment. Within the future waiver re-design, service definitions, budgets, funding parameters, codes, etc. are all being looked at to ensure we are able to support compliance.

Comment: Commenter encourages DDRS to convene a stakeholder group to assist with the waiver redesign process, and we look forward to the opportunity to collaborate with DDRS and provide input.

Response: Thank you for the comment. DDRS will offer opportunities throughout the process for feedback and input from stakeholders.

Comment: Commenter is encouraged by the inclusion of the LifeCourse Framework in the PCISP process.

Response: Thank you for your comment. DDRS is excited about the tools and philosophies of the LifeCourse Framework that allow individuals and families to create a plan that supports their vision of a good life.

Comment: Federal Requirement: Settings are integrated in and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. Commenter considered sheltered workshops to not meet HCBS compliance due to their segregated nature and reliance on sub-minimum wage.

Commenter is concerned about the removal of the regulation regarding Individual Rights and Responsibilities. We would like to stress the importance of the language within this regulation being written so as to encourage providers to truly empower consumers to make these decisions to the greatest extent appropriate for individual consumers. It is crucial the language is not so vague as to encourage technical compliance with the rule.

Response: Thank you for your comment. Within the future waiver re-design; service definitions, budgets, funding parameters, codes, etc. are all being looked at to ensure we are able to support compliance. While the proposed combined policy “Individual Rights and Responsibilities” has been removed from the STP, DDRS will continue to review and update current policies, including “Individual and Guardian Responsibilities” and “Protection of Individual Rights.” Your comments are helpful as DDRS makes revisions.

Comment: Commenter continues to have reservations regarding the heavy reliance DDRS plans to place upon the 90 day Monitoring Checklist. As recommended in comments for a previous iteration of the STP, commenter would like to assert that the Division should integrate regularly occurring face-to-face interviews with a statistically significant population of participants as an additional monitoring tool. This should be carried out by an independent third party, and can be utilized as a means to verify data gathered through the checklist.

Response: Thank you for your suggestion. DDRS may work in conjunction with other entities on various components of the STP to ensure ongoing compliance and data verification. DDRS will continue to explore additional monitoring mechanisms as the transition period continues to evolve.

Comment: Federal Requirement: Settings ensure an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint. Commenter would encourage DDRS (and other FSSA agencies) to restrict a provider's ability to serve as a guardian over the participant. Commenter feels strongly that the direct conflict of interest organically creates a situation where coercion is more likely to happen.

Response: Thank you for your comment.

Comment: Federal Requirement: In provider-owned or controlled residential settings, each individual has privacy in their sleeping or living unit. 460 IAC 6-9-4 talks about the "opportunity for personal privacy" but that is not the same as privacy in a sleeping or living unit. Additionally, access via electronic communications should also be protected similar to mail and telephone calls.

Response: Thank you for the comment. DDRS is in the process of revising Indiana Administrative Code to ensure HCBS compliance. Your comments are helpful as DDRS makes revisions.

Comment: Federal Requirement: In provider-owned or controlled residential or non-residential settings, the setting is physically accessible to the individual. Commenter recommends the Division take steps to flesh out this process. The support team is currently required to confirm the presence of smoke and carbon monoxide detectors, fire extinguishers, anti-scalding devices, etc. In order to fully comply with the HCBS requirement of physical accessibility, there should be documentation requirements similar to those already in place regarding consumer safety.

Response: Thank you. Your comment is helpful as DDRS revises policies and procedures to ensure HCBS compliance.

Comment: Commenter encourages the use of multiple mechanisms to determine a setting's initial and on-going compliance with HCBS rules. Commenter would also stress that settings should be 100% compliant before being found to be an HCBS setting. Commenter encourages the use of independent surveyors and those trained in communicating with individuals with disabilities to complete the participant surveys. Surveys should be conducted in a private setting of the participant's choice and participants should be allowed to opt-out if they choose. Commenter encourages frequent input from participants through survey and/or town hall forums. Participants should be a part of the process early on and frequently throughout. Commenter supports the coordination among the various FSSA agencies to ensure consistency for participants across settings.

Response: Thank you for your comment. DDRS will continue to explore additional monitoring mechanisms as the transition period continues to evolve and seek out additional ways to engage participants throughout the process. DDRS will continue to work in a coordinated effort with DMHA and Division of Aging to ensure consistency for participants across settings.

Comment: Relocation of beneficiaries - participants should also be notified of potential sources of advocacy (including IDR, ombudsman, the Arc, other advocacy organizations) along with their right to appeal. Whenever possible, procedural safeguards should be adequately explained and be consistent across FSSA agencies.

Response: Thank you for the suggestion, DDRS agrees and will continue to educate participants on procedural safeguards and potential sources of advocacy.

Comment: Commenter recommends evaluating case management and the use of standardized tools like checklists to ensure they provide meaningful information about the participant's wants and needs and the setting's on-going compliance with HCBS. Commenter continues to have reservations regarding the

heavy reliance DDRS plans to place upon the 90 day Monitoring Checklist. As recommended in comments for a previous iteration of the STP, Commenter would like to assert that the Division should integrate regularly occurring face-to-face interviews with a statistically significant population of participants as an additional monitoring tool. This should be carried out by an independent third party, and can be utilized as a means to verify data gathered through the Checklist. The reliance on the PCISP for ongoing compliance should ensure active participation by the participant. Independent on-site compliance reviews should also be considered to ensure that full compliance is maintained in practice. Commenter encourages the use of other participant advocacy organizations and people with disabilities in stakeholder groups.

Response: Thank you for the suggestions. DDRS will continue to explore evaluating and developing monitoring mechanisms as the transition period continues to evolve. DDRS will continue to seek opportunities to engage participant advocacy organizations and people with disabilities in stakeholder groups to gather feedback and implement new processes.

Division of Mental Health and Addiction – Youth

Summary: The Division of Mental Health and Addiction solicited comments on the Statewide Transition Plan as it applies to the 1915(i) Child Mental Health Wraparound program. The comments resulted in no changes to this portion of the STP.

PUBLIC COMMENTS:

Comment: IDR has concerns regarding the lack of specificity provided as to how DMHA intends to amend some of its regulations to comply with the new HCBS requirements.

Response: Thank you for the comment. IDR participated in drafting the updated regulations prior to submission and supported the language at that time. DMHA believes the updated regulations comply with HCBS requirements.

Comment: IDR encourages the inclusion of its organization as an advocacy stakeholder for children with mental illness.

Response: Thank you for the comment. DMHA continues to offer an open invitation to IDR to participate in the Indiana System of Care Board, and welcomes any and all advocacy efforts.

Comment: IDR noticed that it has a role to play in the heightened scrutiny process. However, IDR has little information or detail defining that role or the agency's responsibility. We look forward to further information from DMHA as this process develops.

Response: Thank you for the comment. DMHA is grateful for the offer of support and assistance. Further development of roles and responsibilities will be addressed as settings are found to be out of compliance.

Division of Mental Health and Addiction – Adult

Summary: The Division of Mental Health and Addiction solicited comments on the Statewide Transition Plan as it applies to two adult 1915(i) programs; the Adult Mental Health Habilitation and Behavioral and Primary Healthcare Coordination programs. The comments resulted in no changes to this portion of the STP.

PUBLIC COMMENTS:

There were no public comments concerning the two adult 1915(i) programs; the Adult Mental Health Habilitation and Behavioral and Primary Healthcare Coordination programs.

Version IX – August 2019

Summary: The Office of Medicaid Policy and Planning, Division of Aging, Division of Disability and Rehabilitative Services and Division of Mental Health and Addiction solicited comments on the Statewide Transition Plan as it applies to administration of the Statewide Transition Plan.

PUBLIC COMMENTS:

There were no public comments on the administration of the Statewide Transition Plan.

There were no public comments concerning the two 1915(c) Division of Aging (DS) programs; Aged and Disabled and Traumatic Brain Injury.

There were no public comments concerning the two 1915(c) Division of Disability and Rehabilitative Services programs; Community Integration and Habilitation and Family Supports Waiver.

There were no public comments concerning the Division of Mental Health and Addiction 1915(i) Child Mental Health Wraparound program.

There were no public comments concerning the two adult 1915(i) programs; the Adult Mental Health Habilitation and Behavioral and Primary Healthcare Coordination programs.