

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

Yes

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

--

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

The case manager will provide detailed information during the service planning development phase to individuals, caregivers, and families about the option to direct the following services:

- Attendant Care
- Home and Community Assistance
- Skilled Respite

If an individual chooses to self-direct any of these services, they are empowered to choose their own self-directed worker. This program allows individuals receiving care, or their representatives on their behalf, to select, schedule, train, supervise, and terminate their own self-directed workers. The individual directing care or their representative takes on all of the responsibilities of being an employer except for payroll management, which is handled by the financial management services (FMS) vendor.

Some of the opportunities afforded to the individual who is self-directing services include:

- An opportunity to exercise more autonomy, to arrange services more conveniently, and to work with self-directed workers who they choose.
- An alternative to agency-based services or services provided by independent care providers.
- The opportunity to arrange for services from more than one self-directed worker or from a combination of agency-based services and self-directed services, depending on their service plan.

Self-directed workers shall be recruited, hired, trained, paid, and supervised under the authority of the individual, the individual's parent(s) if the person is a minor or the individual's guardian. The individual may designate a representative to assist or assume their own self-direction of their services. The individual or their representative may assume the responsibility to initiate self-directed service(s) and exercise judgment regarding the manner in which those services are delivered, including the decision to employ, train, and dismiss a self-directed worker.

Case managers are an integral part of the success of the INCharge Self-Directed Program. The case manager is responsible for oversight and monitoring of the Service Plan of the individual; assisting the individual who is directing care; evaluating how participant-directed services can appropriately meet the individual's needs; and assessing whether the individual or the individual's representative is interested in taking on the responsibilities associated with participant-direction.

For participant-direction, the case manager is required to have face-to-face contact with the individual at least every ninety (90) days, or more often as the needs of the individual change. The case manager reviews the person-centered service plan with the individual for continuing use of participant-directed services every ninety (90) days. The case manager shall evaluate for quality and ask the individual to verify whether they are satisfied with the services they are receiving. Representatives directing care on behalf of the individual will be required to verify services provided by the self-directed worker to ensure appropriate time reporting and support to the individual.

The Division of Disability and Rehabilitative Services, a division under the single state Medicaid agency, contracts with

FMS vendors whose responsibilities serving as the payroll department include; obtaining limited criminal background history checks on providers; issuing paychecks per submitted timesheets; withholding all necessary taxes; filing monthly, quarterly, and annual tax and labor reports; issuing annual W-2 wage statements; managing service units; providing individuals, employers and case managers with monthly reports of spending on individual's behalf; and responding to all questions posed by DDRS, the individual, self-directed worker, and state officials.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver.
Select one:

Participant: Employer Authority. As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

Participant: Budget Authority. As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

Both Authorities. The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.

Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.

The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

Waiver is designed to support only individuals who want to direct their services.

The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.

The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

--

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

- e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Individuals residing in Indiana and receiving participant-directed services on the TBI Waiver are offered the option to self-direct by case managers. Information about the self-directed option will be provided in advance of service planning and at least annually. The Self-directed services toolkit will be provided to individuals, their families, and representatives (if applicable), which includes descriptions of benefits and responsibilities to help them make an informed choice. Information pertaining to individual/representative responsibilities is provided to individuals when they are contemplating accessing self-direction opportunities prior to beginning a new self-directed service arrangement. At that time, the case manager must make sure the individual receives appropriate training/support and understands these roles and responsibilities by providing the online training from Medicaid.gov for individuals who self-direct or wish to self-direct. The training series consists of six, self-guided modules, each covering a different aspect of direct service worker recruitment, training and retention and is available in multiple accessible formats. The series can be found at: <https://www.medicaid.gov/medicaid/long-term-services-supports/direct-care-workforce/online-training-for-self-directed-hcbs/index.html> The case manager must discuss what support is chosen by the individual to assist them to self-direct their services; if no support is needed or desired, case managers must, at a minimum, provide training on the following:

- How the self-directed option works.
- Employer of record duties, including hiring, firing, training, and timekeeping.
- How to engage with Indiana's FMS vendors.
- A written copy of the person-centered service plan and self-directed budget is provided to all members of the individual's support team.

Individuals are empowered to choose their own self-directed workers. This program enables individuals receiving care or their representatives to select, schedule, train, supervise, and dismiss their own self-directed workers. The individual, and/or the individual's representative (if applicable), directing care takes on all of the responsibilities of being an employer, except for payroll management, which is handled by the FMS vendor.

Case Managers are responsible for assessing individual interest in self-direction and providing them with information regarding the philosophy and availability of self-direction. The information provided must include:

- A clear explanation that participation in participant-direction is voluntary;
- An overview of the supports and resources available to assist individuals to participate to the extent desired in participant-direction; and
- An overview of the individual's rights and responsibilities, including actions that may result in removal of participation in the participant-direction, and the individual's right to participate in the grievance process.

The individual and the case manager will create a self-directed worker reimbursement budget based on the self-directed spend plan methodology. Individuals will receive monthly financial budget reports detailing the funds spent and remaining for the year.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative (*select one*):

The state does not provide for the direction of waiver services by a representative.

The state provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: *(check each that applies)*:

Waiver services may be directed by a legal representative of the participant.

Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Individuals are permitted to have a non-legal representative assist them in participating in participant-direction when they have the ability to designate a person to serve as their representative. Representatives must meet the following minimum requirements:

- Be at least 18 years of age;
- Have a personal relationship with the individual and understand their support needs;
- Know the individual's daily schedule and routine, medical and functional status, medication regimen, likes and dislikes, and strengths and weaknesses; and
- Be physically present in the individual's residence on a regular basis or at least at a frequency necessary to supervise and evaluate each self-directed worker. This frequency can be determined through the person-centered service planning process.
- Representatives have decision-making authority related to the role of employer or record for self-directed services included in the plan.

An individual's representative will not receive payment for serving in this capacity and will not serve as the individual's self-directed worker for participant-direction. Parents of minor children participants, spouses of participants, individuals with power of attorney, legal guardians, and health care representatives may not be hired as paid self-directed workers

The case manager is required to use a representative agreement developed by BDS to document an individual's choice of a representative for participant-direction, the representative's contact information, and to confirm the representative's agreement to serve as the representative and to accept the responsibilities and perform the associated duties defined therein. The representative agreement is signed by the individual (or person authorized to sign on individual's behalf) and the representative in the presence of the case manager.

Individuals may change their representative at any time. The case manager verifies the new representative meets the required qualifications and a new representative agreement is completed and signed, in the presence of the case manager, prior to the new representative assuming their respective responsibilities. The case manager is responsible for facilitating a seamless transition to the new representative. As part of the service plan development process, the case manager must educate the individual about the importance of notifying the case manager prior to changing a representative.

The case manager is required to monitor the individual's participation in participant-direction, including any patterns such as frequent turnover of representatives which may warrant intervention.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Skilled Respite		

Waiver Service	Employer Authority	Budget Authority
Attendant Care		
Home and Community Assistance		

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

Yes. Financial Management Services are furnished through a third party entity. (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

Governmental entities

Private entities

No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. Do not complete Item E-1-i.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

FMS are covered as the waiver service specified in Appendix C-1/C-3

The waiver service entitled:

FMS are provided as an administrative activity.

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The Bureau of Disabilities Services (BDS), through the procurement process, contracts with an FMS vendor for participant-directed services. The FMS vendor is responsible for serving as the payroll department; administering limited criminal history background checks; professional licensure checks; issuing paychecks per submitted timesheets; filing monthly, quarterly and annual tax and labor reports; issuing annual W-2 wage statements; managing service units; providing individuals, employers, contractors and case managers with monthly reports of FMS vendor spending on the individual's behalf; and responding to questions and issues concerning participant-direction.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The FMS vendor is compensated for administrative activities which include compensation for performing payroll and related functions for individuals who are self-directing their care. The administrative activity costs are divided equally per month throughout the length of the contract. The FMS vendor is also reimbursed based upon an established fee-for-service basis for each quarter hour of services provided by the individual's self-directed worker on the approved service plan. The ratio between the administrative activities and the fee-for-service activities is 1-4 or 25% to 75%. Therefore, the administrative activities equal 25% percent of the total cost of the self-directed care program and the fee for service equals 75% of the cost of the self-directed services.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

Assist participant in verifying support worker citizenship status

Collect and process timesheets of support workers

Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

Other

Specify:

Administers limited criminal history background check.

Supports furnished when the participant exercises budget authority:

Maintain a separate account for each participant's participant-directed budget

Track and report participant funds, disbursements and the balance of participant funds

Process and pay invoices for goods and services approved in the service plan

Provide participant with periodic reports of expenditures and the status of the participant-directed budget

Other services and supports

Specify:

Additional functions/activities:

Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency

Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency

Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget

Other

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of

FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

DDRS through its Bureau of Disabilities Services (BDS) is responsible for monitoring the performance of the FMS vendor through monthly and quarterly reports and meetings with FSSA.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Case managers are an integral part of the success of the participant-directed services as the case manager is responsible for oversight and monitoring of the individual's service plan. One of the case manager's responsibilities is to have face-to-face contact with the individual at least every ninety (90) days, or more often as the needs of the individual change. The role of the case manager is to empower the individual in directing care and in evaluating whether self-direction is appropriate for meeting the individual's needs and whether the individual or the individual's representative is able to fulfill all the responsibilities to manage the participant-directed services. The individual and the case manager will be asked to verify weekly face-to-face visits between the self-directed worker and the individual. The case manager also helps to provide administrative guidance to the individual, or the individual's representative, regarding the self-directed services implementation process. This process includes: training on the program; assisting with obtaining and/or completion of the employer and employee packets involved in hiring the self-directed worker; directing the employer to the FMS vendor's help line if assistance is needed with the completion of the FMS vendor forms and paperwork; and monitoring the outcomes of the participant-directed services.

Waiver Service Coverage.

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (*check each that applies*):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Extended Employment Services	
Skilled Respite	
Structured Day Program	
Attendant Care	
Home Modifications and Assessments (Beginning 12/31/2025)	
Vehicle Modifications	
Integrated Health Care Coordination	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Behavior Management/ Behavior Program and Counseling	
Benefits Counseling (Beginning 12/31/2025)	
Home Modification Assessment (Ending 12/30/2025)	
Pest Control	
Specialized Medical Equipment and Supplies	
Residential Based Habilitation	
Community Transition	
Structured Family Caregiving	
Home and Community Assistance	
Adult Day Services	
Home Modifications (Ending 12/30/2025)	
Home Delivered Meals	
Assisted Living	
Transportation	
Adult Family Care	
Nutritional Supplements	
Personal Emergency Response System	
Case Management	

Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (*select one*).

No. Arrangements have not been made for independent advocacy.

Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

An individual may voluntarily withdraw from participant-direction at any time. The individual and/or representative will be advised to notify the case manager as soon as they determine that they are no longer interested in participating in participant-direction. Upon receipt of an individual's request to withdraw from participant-direction, the case manager will conduct a face-to-face visit and update the individual's service plan, as appropriate, to initiate the process to transition the individual to agency-provided services. The case manager will provide information regarding other service options and assure selected services are able meet the individual's needs, according to service definitions.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Individuals shall be involuntarily terminated from participant-direction and offered traditional waiver services when it has been determined by the Bureau of Disabilities Services (BDS) the individual is unable to perform the functions and duties required to self-direct their services independently or with the support of a designated representative.

The case manager assists the individual with accessing needed and appropriate services through the traditional waiver services option, ensuring that no lapse in necessary services occurs for which the individual is eligible. The case manager will provide the individual with other service options, which will be provided to meet the needs of the individual and to assure continuity of services to meet the individual's needs. This process will not circumvent the individual's right to a fair hearing as detailed in Appendix F-1.

Self-directed workers shall be identified for involuntary termination from participant-direction when it has been determined by the case manager that any of the following exist: (A) An immediate health and safety risks associated with the individual, such as, imminent risk of death or irreversible or serious bodily injury related to the provision of Waiver services; or (B) misuse of funds following notification, assistance and support from the FMS vendor and/or case manager; or (C) failure to follow and implement policies of participant-direction after receiving technical assistance and guidance from the FMS vendor and/or case manager; or (D) providing false information and/or documentation; or (E) self-directed worker is in violation of 455 IAC 2-15- 2; or (F) individual abuse and/or neglect. Requests for involuntary termination must be sent by the case manager to BDS for review and approval.

When an individual or paid self-directed worker is involuntarily terminated, they shall be ineligible to reapply for participant-directed services as either a waiver participant or self-directed worker for twenty-four (24) months following the date of termination.

The case manager must work with the FMS vendor to ensure that the issues previously identified as reasons for termination have been adequately addressed prior to reinstatement.

Individuals who are determined for involuntary termination from self-direction may choose to reengage in self-direction under the following conditions:

- Designation of a representative when no representative existed at time of involuntary termination; or
- Designation of a new representative when representative at time of involuntary termination was determined to not be fulfilling duties; or
- Two years have elapsed since involuntary termination.

All individuals who wish to re-engage in self-direction after an involuntary termination must prior to re-engagement:

- Complete the Self-Direction Exploration Tool; and
- Complete the online training for Self-Directed HCBS.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction

opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		0
Year 2		0
Year 3		0
Year 4		4
Year 5		8

Appendix E: Participant Direction of Services

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

a. Participant - Employer Authority Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

Recruit staff

Refer staff to agency for hiring (co-employer)

Select staff from worker registry

Hire staff common law employer

Verify staff qualifications

Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

All self-directed workers must submit a criminal background check as required by 455 IAC 2-15-2. The criminal background check must not show any evidence of acts, offenses, or crimes affecting the applicant's character or fitness to care for waiver consumers in their homes or other locations. The FMS vendor verifies receipt of documentation as a part of the self-directed worker enrollment. Criminal history checks are maintained in the FMS vendor files and are available upon request.

Determine staff duties consistent with the service specifications in Appendix C-1/C-3.

Determine staff wages and benefits subject to state limits

Schedule staff

Orient and instruct staff in duties

Supervise staff

Evaluate staff performance

Verify time worked by staff and approve time sheets

Discharge staff (common law employer)

Discharge staff from providing services (co-employer)

Other

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

Reallocate funds among services included in the budget

Determine the amount paid for services within the state's established limits

Substitute service providers

Schedule the provision of services

Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3

Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3

Identify service providers and refer for provider enrollment

Authorize payment for waiver goods and services

Review and approve provider invoices for services rendered

Other

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

- ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Individuals who decide to self-direct their services will have a budget for each self-directed service in their service plan. During the person-centered planning process, units of service will be approved, based on assessed need, and those units will then be converted into a dollar amount that the individual can use to hire their own staff to provide the identified service. A percentage will be deducted from the resulting budget amount for the administrative costs associated with participant-direction. Individuals will determine the wage paid to their self-directed workers within a specified range according to the service.

The case manager is responsible for determining the appropriate and necessary number of hours through the person-centered planning process. That number of hours is then entered into the spend plan tool within the case management system and calculated consistently for each individual when determining the self-directed budget. Information about the self-directed budgets will be made publicly available on the state's website.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

- iii. Informing Participant of Budget Amount.** Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Individuals who decide to self-direct their services will have a budget for each self-directed service in their service plan. During the person-centered planning process, units of service will be approved, based on assessed need, and those units will then be converted into a dollar amount that the individual can use to hire their own staff to provide the identified service. A percentage will be deducted from the resulting budget amount for the administrative costs associated with participant-direction. Individuals will determine the wage paid to their self-directed workers within a specified range according to the service.

Adjustments to the self-directed budget may be made through the person-centered planning process. Participants retain fair hearing rights in accordance with 42 CFR Part 431, Subpart E as further described in Appendix F.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority**iv. Participant Exercise of Budget Flexibility.** *Select one:*

Modifications to the participant directed budget must be preceded by a change in the service plan.

The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

- v. Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Case managers are an integral part of safeguarding individual's depletion of a self-directed budget and are responsible for the following prevention activities:

- (A) discuss with individual or their representative the available amount in the budget;
- (B) assist the individual or their representative with the development and modification of the participant-directed budget;
- (C) submit request to the Bureau of Disabilities Services (BDS) for review and approval prior to the case manager's approval of the participant-directed budget;
- (D) approve the participant-directed budget and modifications;
- (E) assist the individual or their representative to develop or revise an emergency back-up plan;
- (F) provide the FMS vendor a copy of the authorized participant-directed budget and any modifications;
- (G) monitor implementation of the service plan;
- (H) ensure services are initiated within required time frames;
- (I) conduct ongoing monitoring of plan implementation and the individual's health and welfare;
- (J) specify additional self-directed worker qualifications in the service plan based on the individual's needs and preferences when such qualifications are consistent with approved waiver qualifications.

The individual and/or representative will have their own login with the FMS vendor to track their self-directed budget on a continuous basis. Case managers will be reviewing the self-directed budget status during 90 day check-ins. The state will have periodic audits of the self-directed budgets in the FMS vendor portal.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Waiver applicants and their legal representatives are provided oral explanations of the Medicaid Fair Hearing process (including an explanation of the types of decisions they may appeal) at the time of the waiver participant's initial eligibility assessment by the Level of Care Assessment Representative (LCAR) contractor.

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

- Denying functional level of care;

Case managers will send formal notification to waiver applicants and waiver participants of any action that affects the individual's Medicaid benefits related to service delivery, including the following adverse actions:

- Not providing an individual the choice of home and community-based services as an alternative to institutional care;
- Denying an individual the service(s) of their choice or the provider(s) of their choice; and
- Denying, suspending, reducing or terminating previously authorized services.

This formal notification of action will be provided in writing to the waiver applicant or waiver participant and their legal representatives within 10 business days of the issue date specified on the formal notification and in advance of the effective date of the action.

The notice will include the following information:

- Description of the decision that was made;
- Description of the waiver participant's appeal rights;
- Instructions for how the waiver applicant or waiver participant may appeal the decision/action by requesting a Fair Hearing;
- Timeliness requirements for an appeal – within 33 days of the issue date specified on the formal notification;
- Description of the appeal process and procedures; and
- Option for waiver applicants and waiver participants to have representation by an attorney, relative or other spokesperson.

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

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

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

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

- **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Division of Disability and Rehabilitative Services (DDRS) operates a separate dispute resolution process that is available when there is a disagreement about service provision. Resolution of the dispute is designed to address the waiver participant's needs.

Any issues that involve an individual's health and welfare are not addressed through the dispute resolution process but are instead immediately referred to the Bureau of Disabilities Services (BDS) for action in order to ensure individual health and welfare.

The parties to the dispute will first attempt to resolve the dispute informally through an exchange of information and proposed resolution(s). If the parties are not able to resolve the dispute within 15 days, each party must submit to the circle of support a description of the dispute, their positions, and their efforts to resolve the dispute. The support team will provide a decision and the parties must abide by that decision. If a support team cannot resolve the matter within 15 days after the dispute is referred to the support team, then the parties must refer the matter to designated FSSA staff for resolution of the dispute. The designated FSSA staff will make a decision within 15 days after the dispute is referred to the designated FSSA staff and give the parties notice of the designated FSSA staff decision pursuant to Indiana Code (IC) 4- 21.5. Any party adversely affected or aggrieved by the FSSA designated staff decision may request administrative review of the designated FSSA staff decision within 15 days after the party receives written notice of the designated FSSA staff decision. Administrative review shall be conducted pursuant to IC 4-21.5.

The dispute resolution process is available for the support team to use, but it is not required before a waiver participant or guardian can request an appeal. The case manager is responsible for the monitoring of services and ensuring that the waiver participant understands that the dispute process is not a prerequisite or substitute for the waiver participant's right to request an appeal. The dispute resolution process is not the appropriate avenue for addressing situations resulting from a HCBS waiver provider's unilateral actions that endanger the health or welfare of an individual such that an emergency exists. Under these circumstances, BDS takes actions to protect the health and welfare of the individual as described in Indiana Administrative Code.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

No. This Appendix does not apply

Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

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

The Division of Disability and Rehabilitative Services (DDRS) operates a complaint process system through BDS per IC 12-11-1.1.

- **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

a) TYPES OF GRIEVANCES/COMPLAINTS WAIVER PARTICIPANTS MAY REGISTER Bureau of Disabilities Services (BDS), a Bureau within DDRS, accepts complaints from any person or entity, when such complaints are related to waiver participants receiving HCBS services that are coordinated and administered by the DDRS. BDS will investigate allegations of violations of state and federal code, requirement, or regulation. Complaints not specific to the BDS are referred to the appropriate entity (agency/division/authority):

- Complaints concerning licensed providers' quality of care issues will be referred to the State Department of Health as appropriate within four (4) business days.
- Complaints alleging fraudulent billings or falsified time records will be researched through claims management and referred to Program Integrity/Service Utilization Review, as appropriate, for follow-up or action within four (4) business days.
- Systemic complaints may be referred to internal FSSA investigators or the Attorney General's office for consumer protection.

(b) and (c) PROCESS, TIMELINES, & MECHANISMS FOR ADDRESSING GRIEVANCES/COMPLAINTS

The DDRS complaint process is not a prerequisite or substitute for the waiver participant's right to request an appeal. In order to give the system an opportunity to work, BDS encourages complainants with individual-specific issues to approach their case managers to try to resolve the issues first. If this has not produced the desired outcome, BDS will initiate a complaint investigation.

BDS forwards complaints to the QA/QI contractor who reviews and categorizes the complaints as urgent, critical, or noncritical. The QA/QI contractor assigns a quality assurance/quality improvement specialist (QA/QI Specialist) to investigate the case within identified timeframes.

Complaint investigation activities include:

- Conducting site visits to the waiver participant's home or day program site;
- Conducting one-on-one interviews with the waiver participant and/or their staff, guardians, family members, and any other people involved in the complaint; and
- Requesting and reviewing documentation from involved providers.

Complaints are acted upon by the BDS and its QA/QI contractor in accordance with the nature of the complaint:

- Complaints that immediately affect an individual's health and welfare are classified as "Urgent." Urgent complaints require an immediate response to ensure the health and welfare of the individual. Within one business day, a Quality Reviewer will perform an unannounced onsite visit/phone contact to ensure the individual's health and welfare and to begin the investigation. A summary of investigation report of findings (allegations found/not found) is issued to the provider within 30 business days and contains a request for a Corrective Action Plan (CAP) for found issues.
- Complaints that do not immediately affect an individual's health and welfare are classified as "Critical". Within two business days, a Quality Reviewer will perform an unannounced onsite visit/phone contact to ensure the individual's health and welfare and to begin the investigation. A summary of investigation report of findings (allegations found/not found) is issued to the provider within 45 business days and contains a request for a CAP for found issues.

If a CAP is required, BDS or its QA/QI contractor issues the CAP to the provider. The provider must either complete the CAP as directed or submit an alternate CAP within the established timeframe. If an alternate CAP is submitted, the QA/QI Specialist reviews the CAP; documents a decision to accept/not accept the CAP; and communicates to provider whether the CAP is accepted/not accepted. Upon successful implementation of the CAP, the CAP is validated by BDS or its QA/QI contractor. Complaints are closed once the CAP is validated. If a CAP accepted or cannot be validated after two attempts, a recommendation is made to refer the provider to the sanctions committee. The provider is notified electronically of complaint closure/referral to the sanctions committee.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

Yes. The state operates a Critical Event or Incident Reporting and Management Process (*complete Items b through e*)

No. This Appendix does not apply (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Indiana's administrative code requires all providers of HCBS waiver services, including case managers, to submit incident reports to BDS when specific events occur.

Incidents that require reporting include, but are not limited to those listed below and are defined as any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual or death of an individual:

1) Alleged, suspected, or actual abuse, neglect, or exploitation (ANE) of an individual. An incident in this category must be reported to adult protective services (APS) or the department of child services (DCS) as applicable. The provider shall suspend from duty any staff suspected, alleged, or involved in an incident of ANE of an individual, pending investigation by the provider. If needed, the case manager coordinates replacement services for the individual. In the event that the case manager is the alleged perpetrator the individual will be given a new pick list from which a new case manager will be selected. If APS or DCS has reason to believe that an individual is endangered, they will investigate the complaint or cause the complaint to be investigated by law enforcement or another agency and make a determination as to whether the individual is endangered.

- "Abuse" is defined as:

1. Intentional or willful infliction of physical injury.
2. Unnecessary physical or chemical restraints or isolation.
3. Punishment with resulting physical harm or pain.
4. Sexual molestation, rape, sexual misconduct, sexual coercion, and sexual exploitation.
5. Verbal or demonstrative harm caused by oral or written language, or gestures with disparaging or derogatory implications.
6. Psychological, mental, or emotional harm caused by unreasonable confinement, intimidation, humiliation, harassment, threats of punishment, or deprivation.

- "Neglect" is defined as a failure to provide appropriate supervision, training, clean and sanitary environment, appropriate personal care, food, medical services including routine medical and specialty consultations, or medical supplies or safety devices to an individual as indicated in the service plan.

- "Exploitation" is defined as an unauthorized use of the personal services, the property, or the identity of an individual; any other type of criminal exploitation for one's own profit or advantage or for the profit or advantage of another.

2) The death of an individual. All deaths must be reported to APS or DCS as applicable. If the death is a result of alleged criminal activity, the death must be reported to law enforcement.

3) A service delivery site that compromises the health and safety of an individual while the individual is receiving

services:

a) A significant interruption of a major utility, such as electricity, heat, water, air conditioning, plumbing, fire alarm, carbon monoxide alarm or sprinkler system;

b) Environmental or structural problems associated with a service site that compromises the health and safety of an individual, including but not limited to inappropriate sanitation, serious lack of cleanliness, rodent or insect infestation, structural damage or failure, damage caused by flooding, tornado or other acts of nature, or environmental hazards such as toxic or noxious chemicals.

4) Fire, residential or service delivery site (e.g., day services), resulting in health and safety concerns for an individual receiving services. This includes but is not limited to relocation, personal injury, or property loss.

5) Elopement or missing person, including elopement of an individual where a provider or service delivery site fails to provide the required support as described in the service plan as necessary for the individual's health and safety.

6) Suspected, observed, or actual criminal activity by (a) a provider's staff member, employee, or agent of a provider when it affects or has the potential to affect the individual's care; (b) a family member of a individual receiving services when it affects or has the potential to affect the individual's care or services; or (c) the individual receiving services This may include:

☐ Police arrest of the individual or any person responsible for the care of the individual

☐ A major disturbance or threat to public safety created by the individual

7) An event with the potential for causing significant harm or injury and requiring medical or psychiatric treatments or services to or for an individual receiving services. Any unusual hospitalization due to a significant change in health and/or mental status may require a change in service provision.

8) Injury to an individual when the origin or cause of injury is unknown and may be indicative of abuse or requires medical intervention beyond first aid.

9) Any injury to an individual that requires medical intervention beyond basic first aid. This includes, but is not limited to, the following types of injuries and causes:

a) A fracture; or

b) A burn greater than first degree; or

c) Contusions or lacerations.

10) Any use of physical or mechanical restraints, and if any injury occurs while an individual is restrained the injury must also be specified in incident report.

11) Any threat or attempt of suicide made by the individual

12) A medication error except for refusal to take medications, including the following:

- a) Medication error occurring in a 24/7 or day setting
- b) Medication given that was not prescribed or ordered for the individual;
- c) Failure to administer medication as prescribed, including:
 - Incorrect dosage;
 - Medication administered incorrectly;
 - Missed medication; and
 - Failure to give medication at the appropriate time.

13) Inadequate staff support for an individual, including inadequate supervision, with the potential for:

- a) Significant harm or injury to an individual; or
- b) Death of an individual.

14) Use of any aversive technique, including but not limited to:

- a) Seclusion;
- b) Painful or noxious stimuli; and
- c) Denial of a health-related necessity.

15) A fall resulting in injury requiring more than first aid.

16) Admission of an individual to a nursing facility, excluding respite stays.

17) Inadequate medical support for an individual, including failure to obtain:

- a) Necessary medical services;
- b) Routine dental or physician services; or
- c) Medication timely resulting in missed medications.

18) Use of any PRN medication related to an individual's behavior. An incident report related to the use of PRN medication related to an individual's behavior must include the following information:

- a) The length of time of the individual's behavior that resulted in the use of the PRN medication related to the individual's behavior.
- b) A description of what precipitated the behavior resulting in the use of PRN medication related to the individual's behavior.
- c) A description of the steps that were taken prior to the use of the PRN medication to avoid the use of a PRN medication related to the individual's behavior.
- d) If a PRN medication was used before a medical or dental appointment, a description of the desensitization plan in place to lessen the need for a PRN medication for a medical or dental appointment.
- e) The criteria the provider has in place for use of a PRN medication related to an individual's behavior.
- f) A description of the provider's PRN medication protocol related to an individual's behavior, including the provider's:
 - i. Notification process regarding the use of a PRN medication related to an individual's behavior; and
 - ii. Approval process for the use of a PRN medication related to an individual's behavior.
- g) The name and title of the staff approving the use of the PRN medication related to the individual's behavior.
- h) The medication and dosage that was approved for the PRN medication related to the individual's behavior.

i) The date and time of any previous PRN medication given to the individual related to the individual's behavior based on current records.

An incident described in this section must be reported by a provider or an employee or agent of a provider who:

- Is providing services to the individual at the time of the incident; or
- Becomes aware of or receives information about an alleged incident.

When an incident involves the death of an individual, an initial report regarding the incident must be submitted within 24 hours of:

- The occurrence of the incident; or
- The reporter becoming aware of or receiving information about an incident

When an incident does not involve the death of an individual, an initial report regarding the incident must be submitted within 48 hours of:

- The occurrence of the incident; or
- The reporter becoming aware of or receiving information about an incident.

The case manager must submit a follow-up report to the Bureau of Disabilities Services (BDS) concerning the incident at the following timeframes:

- Within seven days of the date of the initial report; and
- Every seven days thereafter until the incident is resolved.

All information required to be submitted to BDS must also be submitted to the case manager.

The BDS uses a web-based system to report and manage incident reports. All incident reports are to be submitted using this web-based system. If the web-based system is down, the incident may be submitted via email. While providers encourage their staff to report incidents through their own internal systems, anyone with an internet connection can report an incident through the State's system.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including

how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

As a part of the service plan process, individuals, family members and/or legal guardians are advised by the case manager via written materials of BDS's abuse, neglect and exploitation reporting procedures. The Case Manager will discuss the information concerning who to contact, when to contact and how to report incidents with all persons involved in service plan development. The age appropriate toll-free hotline number is written inside of the individual's packet of service information. This number is also inside the front cover of all telephone books in the state. This information will be reviewed formally at 90 day face-to-face updates and informally during monthly telephone contacts with the individual and/or guardian.

Additionally, case management organizations are required to provide each waiver participant with a link to the Indiana Health Coverage Programs (IHCP) Division of Disability and Rehabilitative Services (DDRS) HCBS Module, a resource document for participants and support teams. When requested by the individual, guardian and/or family, a paper/hard copy of the IHCP DDRS HCBS Module will be provided by the case manager.

Individuals are required to sign and date that they received the grievance procedure and a link and/or copy of the above mentioned IHCP DDRS HCBS Module.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Bureau of Disabilities Services (BDS) is responsible for the oversight of the incident reporting system, which includes receiving and evaluating all incident reports. Incident reviewers use the web-based complaint and incident reporting systems to evaluate each of the incident reports to determine whether or not the provider has taken appropriate and sufficient actions to remedy the situation, prevent chances for reoccurrence, and to assure the individual's immediate safety.

Incident reviewers also evaluate whether incidents meet the criteria of being a critical event. Incidents of suspected abuse, neglect, or exploitation of an adult or child, or the death of an adult or child is reported to APS or DCS, as appropriate. The incident reporting system automatically generates an e-mail to the individual's case manager and a designated distribution list to alert them of the incident and to indicate whether or not a follow-up report is required. A follow-up report is required if immediate protective measures were not included in the initial incident report.

To ensure the individual's health and safety, the case manager makes either a face-to-face or phone contact with the provider within 24 hours of notification of the critical event and documents this interaction via a follow-up report submitted in the State's web-based incident reporting system within 72 hours of the incident. The Critical event remains open until protective measures are in place. The incident report remains open until there is documentation that the provider took the appropriate actions to resolve the issue.

Case managers are responsible for following-up on all incident reports while BDS oversees how timely and effectively case managers respond to incident reports. On a weekly basis the BDS QA/QI contractor's incident management staff reviews all unresolved critical events. When documentation ensuring health and safety is confirmed, the critical status is closed. The BDS QA/QI contractor submits a weekly report of unresolved critical events to BDS and BDS executive staff. All incident information is uploaded to the case management system and cases with open incidents display a message to facilitate follow-up.

All incidents which are not resolved require case manager follow-up and reporting every seven (7) calendar days until the incident is determined by the incident reviewer to be resolved. Follow-up reports are also submitted via the web-based incident reporting system. Follow-up reports for critical events are required every 72 hours and every 72 hours thereafter until protective measures are in place. Follow-up reports provide the necessary documentation of actions taken to address incident-related issues. To assist with this, providers are able to download incident report information, including outstanding incident reports, through the BDS QA/QI contractor's system. BDS ensures that case managers are completing required follow-up reports until incidents are closed.

Case managers continue to be responsible for notifying families/guardians of incidents reported and sharing results of the provider's investigation when the case manager is authorized to disclose such information with those parties.

To further clarify the role of the case manager:

- At a minimum, case managers will meet with waiver participants four times per year, not less than once every 90 calendar days. Case managers shall monitor the effectiveness of the service plan outcomes using documented review between the waiver participant or representative. Three of the four meetings may take place outside the home. One unannounced visit in the home is required for waiver participants residing in provider owned or controlled settings.
- For individuals with high risk or high health needs, case managers have monthly face-to-face interactions with the individual.

- Case managers are responsible for ensuring the individual's immediate protection from harm when individuals have had critical events which includes making contact with the provider and/or individual/guardian within 24 hours of receiving incident.
- Pre- and post-monitoring of transitions (movement to a new residential services provider or home) are the responsibility of the case manager.

BDS QA/QI contractor manages the state's web-based incident management system. The QA/QI contractor's incident management staff have 24 hours to review incident reports and code them according to potential for impacting individual's health or safety, and whether immediate follow-up is necessary. Providers are responsible for taking appropriate and effective measures to secure the individual's immediate safety, implementing preventative measures, and investigating reported incidents. Case managers then validate and use follow-up reports to document the provider's actions to safeguard the individual. Case managers enter follow-up reports into the state's web-based incident management system at minimum every seven calendar days until the incident is closed. The BDS QA/QI contractor's incident management staff review these follow-up reports to determine: 1) whether the individual's immediate safety has been secured, and 2) that plans are in place to prevent reoccurrences. Only when both of these criteria are satisfied will BDS QA/QI contractor's incident management staff close the incident report.

In emergency situations, Indiana Administrative Code allows the State the authority to remove an individual from the provider's services, issue a moratorium on the provider taking new waiver participants, and/or to terminate the provider's agreement to provide waiver services. The State also has the authority to issue civil sanctions. The DDRS sanctions committee (consisting of BDS, and members of DDRS executive leadership) recommends to the DDRS director specific sanctions to be issued against providers. The DDRS director (or designee) then communicates this decision to the provider.

DDRS requires all uses of restrictive interventions to be reported. Incident reports are required to be submitted within 24 hours of the incident occurring or the reporter becoming aware of the incident. Providers are responsible for investigating all incidents.

As a part of the State's required follow up reports, case managers indicate that they have notified the family/guardian of the incident outcome.

The investigation surrounding an incident report (IR) is conducted by the provider, but the case manager is responsible for ongoing follow up to ensure the investigation is completed and the incident can be closed by the State. As such, the timeframes for informing the individual of the investigation results would be dependent upon the unique range of activity required to complete each investigation and the policies of each individual case manager. Informing the individual of the investigation results is a requirement, but one for which a timeframe has not been identified. As teams meet at least once every 90 calendar days, it would be rare for the case manager to wait longer than 90 calendar days to report the results to the individual.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Bureau of Disabilities Services (BDS) oversees incident reporting and management and works closely with staff, case managers, and providers to assure that the same incidents do not continue to occur.

Providers are able to download incident report data through BDS QA/QI contractor's data management system. At least quarterly, the BDS QA/QI contractor compiles aggregate incident data and provides a trend analysis to BDS leadership. On a monthly basis, the incident management review committee reviews incident trends and proposes interventions for consideration.

BDS also oversees the mortality review process. All deaths are reviewed by BDS QA/QI contractor's mortality review triage team. Deaths with suspect circumstances are reviewed by the full mortality review committee (MRC) facilitated by BDS. While the review of deaths takes place on an ongoing basis, the MRC meets monthly.

BDS facilitates the quality improvement executive committee (QIEC), which is the decision-making body charged with identifying needed system improvements, and then designing, implementing, and monitoring the effectiveness of those improvements. Committee members include representatives from all of the entities involved in overseeing waiver services which include the Office of Medicaid Policy and Planning (OMPP), BDS, and the BDS QA/QI contractor.

When trends are identified, the QIEC uses a worksheet to document the opportunity for improvement, the data source to be improved, a desired outcome that is measurable, measurement criteria, and a draft mitigation strategy that identifies people responsible and timelines for implementation, and a timeframe to measure how the identified issue has changed. If no change or negative change has occurred, the plan is to develop another mitigation strategy to attempt to resolve the problem.

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

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

Bureau of Disabilities Services (BDS) prohibits the use of restraints by all service providers regardless of the setting under this waiver. Reporting of prohibited usage of restraints by a provider is reported through the web-based incident reporting system.

The prohibition of use of restraints including personal restraint, chemical restraint and/or mechanical restraint is included as a part of the required case manager training.

BDS has responsibility for oversight that these prohibitions are enforced. Case managers are responsible for initial oversight of individual's care, the thirty (30) calendar day follow up by phone and the ninety (90) calendar day face-to-face review of the care plan. These reviews will be utilized as opportunities to monitor for any prohibited usage of restraints of the individual to prevent reoccurrence.

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

- b. Use of Restrictive Interventions.** (*Select one*):

The state does not permit or prohibits the use of restrictive interventions

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

Bureau of Disabilities Services (BDS) prohibits the use of restrictive interventions by all service providers regardless of the setting under this waiver. Reporting of prohibited usage of restrictive interventions by a provider is reported through the web-based incident reporting procedure.

The prohibition of the use of restrictive interventions will be included as a part of the required case managers' training.

BDS has responsibility for oversight that these prohibitions are enforced. Case managers are responsible for initial oversight of individual's care, the thirty (30) calendar day follow up by phone and the ninety (90) calendar day face-to-face review of the care plan. These reviews will be utilized as opportunities to monitor for any prohibited usage of restrictive interventions of the individual to prevent reoccurrence.

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

Bureau of Disabilities Services (BDS) prohibits the use of seclusion by all service providers regardless of the setting under this waiver. Reporting of prohibited restraint and/or seclusion usage by a provider is reported through the web-based incident reporting system.

The prohibition of use of seclusion is included as a part of the required case manager training.

BDS has responsibility for oversight that these prohibitions are enforced. Case Managers are responsible for initial oversight of individual's care, the thirty (30) calendar day follow up by phone and the ninety (90) calendar day face-to-face review of the care plan. These reviews will be utilized as opportunities to monitor for any prohibited usage of seclusion of the individual to prevent reoccurrence.

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

- a. Applicability.** Select one:

No. This Appendix is not applicable (do not complete the remaining items)

Yes. This Appendix applies (complete the remaining items)

- **Medication Management and Follow-Up**

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Medication management and follow up responsibilities resides in this waiver with the approved waiver providers that provide twenty-four (24) hour services to the waiver participants. For the waiver, this includes the Assisted Living (AL) service, Structured Family Caregiving (SFC), Adult Family Care (AFC) service, and may include Adult Day Services (ADS) when individuals have medications that must be consumed during the times they are attending the ADS. These providers are responsible for the medication management and all necessary follow ups to ensure the health and welfare of the individuals within their care. For some individuals, the family or legal guardian provide medication management and follow up. As natural and un-paid providers of care, families are not required to monitor and document medication consumption.

In Indiana, medication management and oversight may include reminders, cues, opening of medication containers or providing assistance to the individual who is competent, but otherwise unable to accomplish the task. For approved service providers, medication management means the provision of reminders or cues, the opening of preset commercial medication containers or providing assistance in the handling of the medications (including prescription and over the counter medications). The provider must receive instructions from a doctor, nurse, or pharmacist on the management of controlled substances if they are prescribed for the individual and he/she requires assistance in the delivery of such medication. Additionally, the provider must demonstrate an understanding of the medication regimen, including the reason for the medication, medication actions, specific instructions, and common side effects. The providers must assure the security and safety of each individual's specific medications if medications are located in a common area such as kitchen or bathroom of the home.

AL, SFC, ADS and AFC waiver providers must include in their waiver provider application the procedures and forms they will use to monitor and document medication consumption. These providers must also adhere to the BDS rules and policies as well as the specific waiver definition which include activities that are allowed and not allowed, service standards, and documentation standards for each service. All providers must adhere to the BDS Incident Reporting (IR) policies and procedures related to unusual occurrences which includes medication errors. All approved waiver providers that are responsible for medication management are required to report specific medication errors as defined in BDS's incident reporting policy as outlined in Appendix G1-b of this application. Additionally, providers licensed by the Indiana Department of Health (IDOH) must also report medication errors to the IDOH.

The case manager conducts a face-to-face visit with the individual at least every ninety (90) calendar days to assure all services, including medication management, are within the expectations of the waiver program. Additionally, non-licensed providers will be surveyed by the BDS, or its designee, to assure compliance with all applicable rules and regulations.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

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

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

BDS is responsible for monitoring and oversight of medication management practices and conduct analysis of medication errors and potentially harmful practices as discovered through incident reporting, provider compliance review process, mortality review, and the complaint process. Data is analyzed at the individual level, the provider level, and the state level. The data allows for implementation of corrective action plans and could lead to disciplinary measures up to and including provider de-certification.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

Not applicable. *(do not complete the remaining items)*

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

- **State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Medication Administration is restricted within this waiver to waiver providers who are licensed by the Indiana Department of Health (IDOH) and are authorized to perform medication administration within the scope of their license. These IDOH-licensed waiver providers must follow State regulations concerning the administration of medications. All providers must receive instructions from a doctor, nurse, or pharmacist on the administration of controlled substances if they are prescribed for the individual and he/she requires assistance in the delivery of such medication. Additionally, all providers must demonstrate an understanding of the medication regimen, including the reason for the medication, medication actions, specific instructions, and common side effects. The providers must assure the security and safety of each individual's specific medications if medications are located in a common area such as kitchen or bathroom.

- **Medication Error Reporting.** *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).

Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

All approved waiver providers that are responsible for medication administration are required to report specific medication errors as defined in BDS's incident reporting policy. AL waiver service providers must also report medication errors to the Indiana State Department of Health (IDOH).

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

AL waiver service providers, by IDOH regulation, 410 IAC 16.2-5-4(e)(7), any error in medication shall be noted in the resident's record. All approved waiver providers that are responsible for medication administration are required to record medication errors, including refusal to take medication, in the individuals' record as per BDS's IR policy. This includes the following:

- a) Medication given that was not prescribed or ordered for the individual;
- b) Failure to administer medication as prescribed, including:
 - Incorrect dosage;
 - Medication administered incorrectly;
 - Missed medication; and
 - Failure to give medication at the appropriate time.

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

For AL waiver providers, the facilities are required to report to IDOH any unusual occurrences which may include medication errors if it directly threatens the welfare, safety or health of a resident as per 410 IAC 16.2-5-1.3(g)(1). The current IDOH policy on unusual occurrences includes the reporting of medication errors to IDOH that caused resident harm or require extensive monitoring for 24-48 hours. Waiver providers that are responsible for medication administration must report medication errors in accordance with the BDS's IR policy. Any medication error, except for refusal to take medications, must be reported to the state via the incident reporting process detailed within Appendix G-1-a of this application. Such errors including the following:

- a) Medication given that was not prescribed or ordered for the individual;
- b) Failure to administer medication as prescribed, including:
 - Incorrect dosage;
 - Medication administered incorrectly;
 - Missed medication; and
 - Failure to give medication at the appropriate time.

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

- **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

IDOH has responsibility for monitoring the licensed providers through survey and compliance review processes. Additionally, medication errors or inappropriate use of medications will be monitored by BDS through the incident reporting system or the complaint system. On a quarterly basis, a trend analysis of medication error data is completed by BDS QA/QI contractor and the data is reviewed by the QIEC. Depending on the specific situation and severity of the incident, immediate actions will be taken that range from provider contact, remediation through provider training and provider development of a CAP, up to and including referral to the sanctions committee for egregious violations of policies related to medication safeguards.

While the State utilizes one Appendix G Performance Measure to address sentinel critical events regarding medication administration errors that result in medical treatment, additional data related to a broader range of medication errors is also collected, reviewed, and analyzed by BDS. On a quarterly basis, data trends involving medication errors are reviewed and discussed as part of the work of the QIEC, which also includes BDS and OMPP. QIEC identifies potential activities and remedies to address and mitigate identified issues.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

i. Sub-Assurances:

- a. Sub-assurance:** *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.*

Performance Measures

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

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

Performance Measure:

G.1 Number and percent of substantiated complaint allegations of abuse, neglect, and exploitation (ANE) where the corrective action was implemented. Numerator:

Number of substantiated complaint allegations of ANE where the corrective action was implemented. Denominator: Total number of substantiated complaint allegations of ANE requiring corrective action.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Other Specify: QA/QI Contractor	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

G.2 Number and percent of sampled individuals who reported that paid staff are respectful. Numerator: Number of sampled individuals who reported paid staff are respectful. **Denominator:** Total number of sampled individuals who responded.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

National Core Indicators Aging and Disabilities (NCI-AD)

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

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

Data Aggregation and Analysis:

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

Performance Measure:

G.3 Number and percent of sampled individuals who reported they feel safe around their paid support staff. Numerator: Number of sampled individuals who reported they feel safe around their paid support staff. **Denominator:** Total number of sampled individuals who responded.

Data Source (Select one):

Other

If 'Other' is selected, specify:

National Core Indicators Aging and Disabilities (NCI-AD)

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

Data Aggregation and Analysis:

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

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

Performance Measure:

G.4 Number and percent of reported incidents of alleged abuse, neglect, or exploitation (ANE) that are monitored to appropriate resolution. Numerator: Number of reported incidents of alleged ANE that are monitored to appropriate resolution. **Denominator:** Total number of reported incidents of alleged ANE.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

G.5 Number and percent of unexpected deaths reviewed by the mortality review triage team according to policy. Numerator: Number of unexpected deaths reviewed by the mortality review triage team according to policy. Denominator: Total number of unexpected deaths.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Mortality Review Triage Team

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

Data Aggregation and Analysis:

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

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

- b. Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

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

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

Performance Measure:

G.6 Number and percent of incidents that were reported within the required time period. Numerator: Number of incidents that were reported within the required time period. **Denominator:** Total number of incident reports submitted.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

QA/QI Contractor		
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

G.7. Number and percent of individuals enrolled in the waiver with 3 or less critical incidents within the last 365 days. Numerator: Number of individuals enrolled in the waiver with 3 or less critical incidents within the last 365 days. Denominator: Total number of individuals enrolled in the waiver.

Data Source (Select one):**Critical events and incident reports**

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ QA/QI Contractor	
	Continuously and Ongoing
	Other Specify:

Performance Measure:

G.8 Number and percent of reported incidents that were resolved within the stipulated time period. Numerator: Number of reported incidents resolved within the stipulated time period. Denominator: Total number of incidents reported.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

	Other Specify: 	
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Data Aggregation and Analysis:

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

- c. **Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

Performance Measures

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

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

Performance Measure:

G.9 Number and percent of reported incidents by staff that were not coded as a prohibitive intervention (i.e. seclusion, aversive technique, restraint, etc.).

Numerator: Number of reported incidents by staff not coded as a prohibitive intervention. Denominator: Total number of reported incidents by staff.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Specify: QA/QI Contractor	
	Continuously and Ongoing
	Other Specify:

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

Performance Measures

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

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

Performance Measure:

G.10 Number and percent of medication errors by staff that did not result in medical treatment. Numerator: Number of medication errors by staff that did not result in medical treatment. Denominator: Total number of medication errors by staff.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

Other Specify: QA/QI Contractor	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

G.11 Number and percent of sampled individuals who report the ability to get an appointment to see their primary care doctor when they need to. Numerator:
Number of sampled individuals who report the ability to get an appointment to see their primary care doctor when they need to. Denominator: Total number of sampled

individuals.

Data Source (Select one):

Other

If 'Other' is selected, specify:

National Core Indicators Aging and Disabilities (NCI-AD)

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

Data Aggregation and Analysis:

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

Performance Measure:

G.12 Number and percent of sampled individuals having a complete physical exam or wellness visit in the past year. Numerator: Number of sampled individuals who report having a complete physical exam or wellness visit in the past year.

Denominator: Total number of sampled individuals who responded.

Data Source (Select one):

Other

If 'Other' is selected, specify:

National Core Indicators Aging and Disabilities (NCI-AD)

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

NCI-AD Survey Contractor		
	Continuously and Ongoing	Other Specify: Representative Sample; Confidence Interval = 95%; Proportional and stratified across state districts
	Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

G.13 Number and percent of sampled individuals indicating their health care needs are being addressed. Numerator: Number of sampled individuals indicating their current health care needs are being addressed. **Denominator:** Total number of sampled individuals.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic case management database

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 95%
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

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

Performance Measure:

G.14 Number and percent of individuals enrolled in the waiver whose acute health needs are addressed in a timely manner. Numerator: Number of individuals enrolled in the waivers whose acute health needs are addressed in a timely manner.

Denominator: Total number of individuals enrolled in the waiver.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic case management database

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

	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

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

In addition to incident reporting, filed complaints are reviewed to determine if trends exist involving specific providers. Reported provider complaints and provider related incidents are compared to APS databases to determine systemic issues affecting participants and/or community in general.

b. Methods for Remediation/Fixing Individual Problems

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

HCBS waiver providers are responsible for taking appropriate and effective measures to secure the individual's immediate safety, implementing preventative measures, and investigating reported incidents. Additionally, HCBS waiver providers are responsible for following up on all reported incidents, regardless of incident type or severity.

Bureau of Disabilities Services (BDS) is responsible for the oversight of the incident reporting system, which includes receiving and evaluating all incident reports. Incident reviewers use the web-based complaint and incident reporting systems to evaluate each of the incident reports to determine whether or not the provider has taken appropriate and sufficient actions to remedy the situation, prevent chances for reoccurrence, and to assure the individual's immediate safety.

Case managers enter follow-up reports into the state's web-based incident management system at minimum every seven calendar days until the incident is closed. The BDS QA/QI contractor's incident management staff review these follow-up reports to determine: 1) whether the individual's immediate safety has been secured, and 2) that plans are in place to prevent reoccurrences. Only when both of these criteria are satisfied will the BDS QA/QI contractor's incident management staff close the incident report.

The BDS QA/QI contractor submits a weekly report of unresolved critical events to BDS and BDS executive staff. All incident information is uploaded to the case management system and cases with open incidents display a message to facilitate follow-up.

In emergency situations, Indiana Administrative Code allows the State the authority to remove an individual from the provider's services, issue a moratorium on the provider taking new waiver participants, and/or to terminate the provider's agreement to provide waiver services. The State also has the authority to issue civil sanctions. The DDRS sanctions committee (consisting of BDS, and members of DDRS executive leadership) recommends to the DDRS director specific sanctions to be issued against providers. The DDRS director then communicates this decision to the provider.

Systemic incident reporting data is routinely analyzed for quality improvement purposes in QIEC meetings. Remediation resulting from these meetings has included issuing new and revising current policies.

FSSA uses a centralized IT system to aggregate data and to identify systemic deficiencies. The Quality Improvement Executive Committee (QIEC) meets on a quarterly basis to review data collected from the performance measures for the waivers and identify systemic improvements needed (if any). The QIEC then follows up on the status of recommended systemic improvements at the next QIEC meeting until implementation is completed.

ii. Remediation Data Aggregation

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

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

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
	Continuously and Ongoing
	Other Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of health and welfare that are currently non-operational.

No

Yes

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 1915(c) of the Social Security Act and 42 CFR § 441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver quality improvement strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a quality improvement strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the quality improvement strategy.

Quality Improvement Strategy: Minimum Components

The quality improvement strategy (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities*

of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the QIS spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The foundation of an effective quality improvement strategy is the capability to compile and analyze meaningful data across the program so that issues can be identified and addressed. The Division of Disability and Rehabilitative Services (DDRS) uses a centralized IT system to administer the day-to-day operations of the waiver program. DDRS has made, and continues to make, many efforts to ensure that the information it collects from each of its monitoring activities can be aggregated so that provider-specific and systemic data can be reviewed. DDRS uses a multi-tier strategy for collecting and addressing person-specific, provider-specific, and systemic trends.

Tier I

This tier focuses on ensuring that concerns by or on behalf of an individual, are identified and addressed timely and appropriately. Case managers are responsible for monitoring services, advocating with the individual, and following-up on issues identified through their routine contacts with the individual. Case managers also take a lead role in facilitating individualized circle of support meetings while supporting the individual to lead their meeting to the best of their ability. The case manager and individual meet at least every 90 calendar days, and the support team meet at least semiannually and annually. The support team is responsible for reviewing documentation and discussing if an individuals' outcomes are being met, whether the service plan is effective or if it should be revised, whether any needed behavior plan/risk plan is being implemented accurately, and if further staff training is necessary.

Information gathered by the support team which may be used to make decisions include:

- Data from the case manager's required support meetings where a full assessment of the individual's service implementation is conducted;
- Service providers' quarterly summaries;
- Incident reports;
- Complaint investigations; and
- Quality On-site Provider Reviews.

Tier II

In this tier, data is aggregated systemically and reviewed at the State level. The Quality Improvement Executive Committee (QIEC) meets on a quarterly basis to review data collected from the performance measures for the waivers. Each meeting is dedicated to a defined set of performance measures. At each QIEC meeting, the data team develops and presents a report with the data obtained in the time period being covered (typically in the form of charts and graphs), along with analysis, and remedial steps taken thus far to address areas with issues. The group then discusses the data and systemic remediation that DDRS should take to improve the quality of services being delivered and individuals' health outcomes. Following QIEC meetings the report presented to the committee is updated with any further systemic remediation plans that were discussed. The state team ensures that these remediation plans are implemented and then follows up with those performance measure reports at the next QIEC meeting.

Examples of systemic improvements QIEC has made include: revising DDRS provider policies, educating

providers, individuals with intellectual disabilities, and their families on key health and safety issues impacting , revising the information required to report an incident, and collaborating with provider groups to obtain better training for direct care staff. In collaboration with the Office of Medicaid Policy and Planning (OMPP), DDRS shares the data reviewed and remediation actions taken with CMS in the annual CMS-372 reports and in periodic evidence-based reports.

QIEC membership from entities within Family and Social Services Administration (FSSA) consists of:

- Bureau of Disabilities Services (BDS) leadership
- BDS provider services representative
- BDS Home and community-based services (HCBS) program representative
- OMPP representative
- BDS Home and community-based services (HCBS) policy team representative
- BDS QA/QI contractor
- BDS data analysts

DDRS participates in the National Core Indicators (NCI) project and the National Core Indicators Aging and Disabilities (NCI-AD) project to obtain individuals with disabilities perspectives on how the waiver service delivery system is operating overall. The data gathered expand DDRS's quality assurance system. Ongoing, as we collect and analyze Indiana's interview results and make comparisons to other states' performance, we will also be able to identify gaps between NCI data and information gathered through DDRS's other monitoring activities. NCI project data will help DDRS establish priorities and make recommendations for improvement.

While DDRS's routine system to collect and analyze data and make changes is functioning, changes in monitoring activities may be driven by outside forces such as organizational redesigns, legislative demands, and different amounts of funding available. An example of this is the legislature's approval of a bill to add accreditation to the provider qualifications for day program providers. As a result, when a provider shows evidence of an accredited service, BDS adjusts the reverification timelines based on the accreditation term.

DDRS Mortality Review System

An important part of DDRS's quality improvement strategy is the mortality review process. BDS conducts mortality reviews for all deaths of individuals receiving services through the waivers. As described in Indiana Administrative Code (460 IAC 6-9-5) on incident reporting, all deaths of individuals receiving DDRS-funded services are required to be reported to the State through the BDS Incident Reporting system. Upon receipt of the death report, BDS's mortality review triage team (MRTT) assesses whether a individual's housemates may be at risk for similar circumstances.

An Others at Risk (OAR) questionnaire is generated and emailed to the provider within twenty-four (24) hours of receipt of death report. A score is generated and if red, the MRTT will determine if an expedited death review or complaint review should be completed. If it is determined that a home site visit is needed, the BDS QA/QI

contractor will complete an information sheet that includes demographics, documents needed and reason for the visit. The BDS District Office will visit the home in which the individual resided to gather the requested information. If a complaint investigation is warranted the BDS QA/QI contractor may conduct the site visit. For example, if someone died due to choking, a BDS representative would go to the individual's home to assess staff performance in adhering to risk plans related to choking. If an issue was identified, the provider would be directed to complete a corrective action plan (CAP), which would include immediate staff training related to risk plans. BDS validates implementation of all CAPs, and noncompliant providers may be referred to the DDRS sanctions committee.

Per 460 IAC 6-25-10 Investigation of Death, the provider identified in an individual's service plan as responsible for the health care of the individual is required to conduct internal investigations of individual deaths. The DDRS mortality review policy describes all the specific documentation that providers need to review as part of their internal investigation process. Providers send completed internal mortality investigations, along with the individual's medical history and other related documentation to the BDS's MRTT. The MRTT reviews all deaths. Discussions include the events prior to the death, supports/services in place at the time of death, and whether additional documentation is needed for review. The MRTT also determines whether each death meets criteria to be brought before the mortality review committee (MRC). The BDS director or any other DDRS staff with a concern can also refer deaths to the MRC.

The MRC is facilitated by the BDS QA/QI contractor. Committee members include representatives from BDS Central Office, Adult Protective Services (APS), the Department of Health, OMPP, Indiana coroner's association, Statewide waiver ombudsman, BDS field service staff, and community advocates.

Based on its discussion, the MRC makes recommendations for systemic improvements such as developing new policy, revising policy, training, or sharing key information. The MRC also makes provider-specific recommendations for BDS to review key areas of a provider's system that appear to have not been in place or to have been ineffective at the time of an individual's death. Providers may be required to develop CAPs to address identified issues and to prevent other individuals from experiencing negative outcomes. To date, the communication topics have included Coumadin monitoring, malfunctioning feeding tubes, choking versus aspiration, pain management, medication administration, healthcare coordination, staff training on risk plans, and the fatal four in individuals with developmental and intellectual disabilities.

ii. System Improvement Activities

Responsible Party (check each that applies):	Frequency of Monitoring and Analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify: 	Other Specify:

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

DDRS uses a centralized IT system to monitor its HCBS waiver programs and to identify systemic changes necessary for improving the quality of individuals' services and supports. DDRS management and OMPP representatives participate in the routine QIEC DDRS leadership meetings to review data collected from monitoring systems and to assess monitoring activities' effectiveness in producing positive changes for individuals receiving waiver services.

Different positions play a role and have a responsibility in the processes for monitoring and assessing effectiveness of system design changes. These include:

- Case managers have the front-line responsibility for overseeing the delivery of waiver services. They are responsible for conducting a minimum of four visits with the individual each year, coordinating and facilitating IST meetings as necessary, and identifying and resolving issues with service delivery. Case managers have the potential to identify the effectiveness of system design changes by how the individuals they work with are impacted.
- BDS-contracted complaint investigators are continually in the field following up on allegations that individuals' health and welfare may be in jeopardy. Aggregated information and analysis compared from one quarter to the next is shared in BDS's quarterly reports and is discussed in DDRS leadership meetings.
- BDS-contracted incident management staff are responsible for reviewing and coding all incident reports as they are submitted into the State's web-based system. Similar to information on complaint investigations, incident data is aggregated and analyzed in BDS's quarterly reports and discussed in QIEC and DDRS leadership meetings.

Data is aggregated and routinely discussed in QIEC meetings.

- ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

Quality improvement strategies are living documents that result from an ongoing process of review and refinement. Necessary changes to DDRS's monitoring systems are identified through the continual review and analysis of data in QIEC and DDRS leadership meetings. Over the past few years DDRS has focused its resources on ensuring that we have the processes in place to collect data on our most basic assurances and that these processes are working effectively.

As needed, DDRS will submit modifications to the quality improvement strategy annually with the 372 report.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

- a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

b. Specify the type of survey tool the state uses:**HCBS CAHPS Survey :****NCI Survey :****NCI AD Survey :****Other** (Please provide a description of the survey tool used):

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Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

FSSA's Audit Unit is responsible for the annual review of services and billing performed by the AAA with full reporting to the OMPP and the DDRS. PI has an agreement with the FSSA Audit Unit to audit allegations of HCBS waiver provider fraud, waste, and abuse. PI and FSSA Audit maintain a level of collaboration and cooperation between the two Services. FSSA Audit's staff are knowledgeable of the different HCBS definitions, documentation standards, provider qualifications, and any required staffing ratios so it makes sense for them to audit allegations of wrongdoing in the waiver programs.

Process for Conducting Audits

PI receives allegations of provider fraud, waste, and abuse and tracks these in its Case Management system. When it receives an allegation regarding a waiver provider, PI forwards it to FSSA Audit to begin their research and audit process. FSSA Audit works with PI to vet the providers with the Indiana Medicaid Fraud Control Unit (MFCU). Once MFCU's clearance is determined, FSSA Audit determines means to validate the accuracy of the allegation. FSSA Audit may conduct statistically valid random sample of consumers and then the PI Fraud Abuse and Detection (FADS) vendor will pull a sample for their audit. The size of a random sample audit is dependent upon the universe(s) size, claim/claim line payments, and other statistical criteria. The random sample size is determined utilizing a tool developed by FADS contractors as well as their statistical consultants. The tool generates a statistically valid random sample size. Based on the concerns identified during the risk assessment FADS will suggest an approach and/or scope for the audit:

- Targeted Probe Audit Sample** - A sample of sufficiently small size designed to focus on specific services, members, timeframes or other scenarios that have been identified as higher risk for fraud, waste, and/or abuse to determine potential outcomes of audit findings or payment error issues.
- Random Sample Audit** - The goal of the random sample is to identify potential payment errors and extrapolate the errors to the entire universe of claims.

FSSA Audit conducts its audit activities and develops a findings report for the provider that may include a corrective action plan and request for overpayment. FSSA Audit shares copies of its findings reports with PI. Audits are performed onsite utilizing a probe test that includes a review of:

- Providers' source documents.** This includes documents that support paid claims, e.g. employee signed service notes, logs, evidence of supervisory approvals.
- Payroll records.** Dates/times/locations of service per claims are compared to related time cards and payroll registers.
- Employee background and qualifications.** Supporting documents, found in in HR files, are reviewed. This includes documentation for background checks, licenses (if applicable), and search of the HHS/OIG exclusions list. If the probe identifies material issues, statistical sampling is used to expand the testing and quantify overpayments. Valid statistical samples and sample results projections are provided by Program Integrity's FADS contractor. FADS audits are initiated based on referrals received from different sources/agencies. The Surveillance and Utilization Review (SUR) Unit receives information from the following sources which could potentially lead to additional action including audit action:
 1. IHCP Provider and Member Concerns Line;
 2. Other agencies (MFCU);
 3. Analyses/Analytics performed by the SUR Unit's Investigations team
 4. Analytics performed by FADS contractors.

Depending on the allegations/information received regarding the provider(s), the SUR Unit may conduct a Preliminary Investigation, utilizing the Credible Allegation of Fraud (CAF) tool developed by FADS contractors to determine next steps. In certain instances, the SUR Unit refers the provider(s) in question to FADS contractors for additional analysis which may include performing a Risk Assessment. The Risk Assessment tool, developed by FADS contractors, is utilized to gather information on a specific provider's background as well as billing patterns utilizing claims data and other research databases with a special focus on any items identified as potential issues during the referral process. FADS contractors utilize this tool to assist in the decision-making process when recommending the next appropriate action to be taken for the provider(s) in question. Depending on multiple factors, risk assessments typically result in one of the following recommended actions dependent upon the severity of the allegations and other information uncovered during the risk assessment:

- No further action** – No issues uncovered warranting further action.
- Provider education** – No major issues identified that would result in patient harm or recoveries to the program; yet, it may be apparent that the provider as well as the Medicaid Program would benefit from the provider receiving additional education on proper/best billing practices.
- Provider self-audit** – Specific concern(s) were identified resulting in a recommended limited-scope audit; yet, the concern(s) are in an area which the State is comfortable with the provider conducting the audit to ensure compliance. FADS contractors subsequently perform validation review of the provider self-audit results. If FADS contractors determine they are not in agreement with a high percentage of the provider's self-audit results during the validation review, they will recommend the audit be escalated to a desk review and all records within the provider self-audit sample are evaluated by the contractor.
- Provider desk audit** – Concern(s) were identified resulting in the need for medical record review (could be full or limited

scope). Yet, the severity of the concerns do not currently warrant an on-site review. Certain provider records, including medical records, are requested for selected claims and clinical staff (if necessary) conduct a review of the services billed to ensure compliance with IHCP guidelines. Providers are allowed thirty (30) days to submit the requested information.

- Provider on-site audit (announced or unannounced)** – Severity of the concern(s) has resulted in a recommendation of an on-site audit. Providers are generally given shorter notice (or no notice if warranted) of the pending on-site audit. If notice is provided, it can range from a few days to a few weeks depending on several factors (i.e., type of facility, audit concerns, etc.). Requested information is collected on-site. A facility tour as well as provider/staff interviews are also conducted during on-site reviews. FADS contractors, including clinical staff, are included in on-site reviews and assist with conducting interviews. State program integrity personnel often also participate in on-site reviews.

- Referral to MFCU** – Payment suspension recommended as the potential intent of fraudulent behavior was identified. Depending on the allegations/information received regarding the provider(s), the SUR Unit may conduct a Preliminary Investigation, utilizing the Credible Allegation of Fraud (CAF) tool developed by FADS contractors to determine the appropriate next steps, if any.

Audit reports containing accuracy-related issues, missing documentation, internal control deficiencies, and training issues are prepared. Providers submit corrective action plans. Any overpayments are set up for recoupment. Audit reports are distributed to provider leadership and appropriate FSSA executives. Periodically, Program Integrity is advised of any systemic issues identified. FSSA Audit Services seeks Program Integrity's advice on audit reporting and direction on technical questions.

For audits performed based on referrals such as incorrect billing, the reporting varies. If the audit finds the provider made unintentional errors, the typical audit reporting process is followed. Yet, if the referred audit identifies potential, intentional errors that may be credible allegations of fraud, the provider is referred to Program Integrity for further action. Analytics focusing on specific areas of concern are periodically rerun in an attempt to identify if provider billing patterns have changed/improved based on previous audit and/or provider education. Additional audit action may be taken for providers who continue to be identified as potential issues in these algorithms. If providers are again selected for audit. A similar audit process as previously described would occur.

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

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

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

The FSSA's oversight of the contractor's aggregate data is used to identify common problems to be audited, determine benchmarks, and offer data to peer providers for educational purposes, when appropriate. On a more proactive level, FSSA Audit also routinely meets with DDRS to identify and conduct audits on providers that have been identified as potentially not billing correctly. Detailed information on this policy can be found in the IHCP Provider and Member Utilization Review module posted at: www.indianamedicaid.com.

Under the provisions of the Single Audit Act as amended by the Single Audit Act Amendments of 1996, the State of Indiana utilizes the Indiana State Board of Accounts to conduct the independent audit of state agencies, including the Indiana FSSA Compliance office. FSSA Compliance routinely monitors audit resolution and provides annual status updates to SBOA.

Fee-for-service (FFS) providers do not fall under the Single Audit Requirement. FSSA Audit does receive service of the independent audits, but do not track them for the waiver services. FSSA Audit can pull the 990's for any agency within the State of Indiana if needed. Providers are not required to obtain an independent financial statement audit.

The State implemented an Electronic Visit Verification (EVV) system, known as the Sandata EVV System, that complies with the requirements of the federal 21st Century Cures Act. The IHCP CoreMMIS claim-processing system has been configured

to integrate with the Sandata EVV system. IHCP requires that providers use the EVV system to document the following: Date of the service; Location of service delivery; Individual providing the service; Type of service performed; Individual receiving the service; Time the service begins and ends. Providers may choose to use an EVV system other than Sandata. Yet, those providers will be required to export data from their alternate system to the Sandata "Aggregator" for integration with CoreMMIS.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

i. Sub-Assurances:

a. Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measures

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

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

Performance Measure:

I.1 Number and percent of claims paid for individuals enrolled in the waiver on the date the service was delivered. Numerator: Number of claims paid for individuals enrolled in the waiver on the date the service was delivered. Denominator: Total number of claims submitted.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Medicaid Management Information System claims data

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

Other Specify: Fiscal Agent	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

I.2 Number and percent of claims paid for services that are specified in the individual's approved service plan. Numerator: Number of claims paid during review period due to service having been identified on the approved service plan. Denominator: Total number of claims submitted during the review period.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Medicaid Management Information System claims data

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

Data Aggregation and Analysis:

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

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

- b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

Performance Measures

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

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

Performance Measure:

I.3 Number and percent of rates for waiver services adhering to reimbursement methodology in the approved waiver. Numerator: Number of waiver rates that follow the approved methodology. Denominator: Total number of waiver rates

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

Other Specify: Fiscal Agent	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

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

The State assures financial accountability through a systematic approach to the review and approval of services that are specifically coded as waiver services within the waiver case management system and the MMIS. The MMIS links to the waiver case management system in order to ensure that only properly coded services, that are approved in an individual's

plan of care, are processed for reimbursement to providers who are enrolled Medicaid Traumatic Brain Injury providers.

b. Methods for Remediation/Fixing Individual Problems

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

I.1 and I.2 Claims reimbursement issues may be identified by a case manager, the public, a provider, contractor, or FSSA staff.

For individual cases, FSSA's Operations division and/or the Medicaid Fiscal Agent, FSSA's Provider Relations staff, or FSSA's Office of Compliance, address the problem to resolution. This may include individual provider training, recoupment of inappropriately paid monies and if warranted, placing the provider on prepayment review monitoring for future claims submissions. If there is a billing issue involving multiple providers, FSSA will work with the Medicaid Fiscal Agent and/or FSSA's SUR unit within the Office of Compliance to produce an educational clarification bulletin and/or conduct training to resolve billing issues.

If the issue is identified as a systems issue, FSSA's Division of Healthcare Strategies and Technology will extract pertinent claims data to verify the problem and determine if correction is needed. If the problem indicates a larger systemic issue, it is referred to the Change Control Board for a systems fix.

Each party responsible for addressing individual problems maintains documentation of the issue and the individual resolution. Meeting minutes are maintained as applicable. Depending on the magnitude of the issue, it may be resolved directly with the provider or the waiver participant.

I.3 Financial records will be used to verify that reimbursement for services is paid at the approved rate, and therefore, using the approved rate methodology.

FSSA uses a centralized IT system to aggregate data and to identify systemic deficiencies. The Quality Improvement Executive Committee (QIEC) meets on a quarterly basis to review data collected from the performance measures for the waivers and identify systemic improvements needed (if any). The QIEC then follows up on the status of recommended systemic improvements at the next QIEC meeting until implementation is completed.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

No**Yes**

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

Appendix I: Financial Accountability**I-2: Rates, Billing and Claims (1 of 3)**

- a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

07/01/2024 AMENDMENT

A rate review occurs at least every five years.

The reimbursement rates for the new Structured Family Caregiving service were aligned to the reimbursement rates for Structured Family Caregiving services utilized on the H&W waiver which was calculated using the “Traditional cost model build-up approach” specified below. As with other services, wage requirements were determined using a combination of Bureau of Labor and Statistics data and provider survey data stratified by service and were additionally informed through discussion with a workgroup that included SFC providers. The wage build-up reflected team members required to provide the service – the family caregiver, with oversight and support from a registered nurse and caregiver coach. Historical wage information (from based on the H&W waiver) was inflated to July 1, 2023, and provision was added for benefits, administrative support, transportation needs, and for substitute care to allow opportunities for primary caregiver wellness and skill development, up to 15 days per year.

07/01/2023 AMENDMENT

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

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

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

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

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

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

Methodologies: For the purpose of this amendment, there is no change to the rate methodology utilized. To develop prospective payment rate methodologies for this waiver program services, FSSA selected the following approaches:

Traditional cost model build-up - This approach reflects the program-related cost per unit of providing each covered service. The foundation of this model is the labor cost per unit, which includes projected wages and benefits costs, allocated to the service unit level. Administration and program support costs are calculated as a percentage of the labor cost per unit component. Self-directed and non-agency service rates follow the cost model build up but do not include a supervisory component. Select services also include “other” cost components for unique requirements such as food for

adult day services. All services using this build-up approach have supporting rate models.

Key default rate inputs under this approach were as follows:

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

Wage inflation: based on changes in Consumer Price Index (CPI) for employment earnings of medical professionals

Training and Paid Time Off (PTO) factors: training and PTO ranges between 60 and 70 hours per employee per year

Benefits factor ("employee related expenses" or ERE): varies by wages and is based on BLS national benchmarks for insurance costs as well as federal and state taxes

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

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

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

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

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

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

Attendant Care

Home Maker

Skilled Nursing

Adult Day Service

Emergency Response

Non-Medical Transportation

Participant levels 1-3 are assigned based on an Indiana-specific Level of Service tool. Level 2 has the highest projected utilization and is the starting point of the Assisted Living tiered rates. Under tiered rate adjustments, the Level 2 Attendant Care, Home Maker and Skilled Nursing rate components are adjusted upwards by 17% for the level 3 rate and adjusted downward by 10% for the level 1 rate. These Assisted Living level differentials are informed by multiple discussions with interested parties, provider survey results, and the state's knowledge of service requirements. Assisted Living services will be paid on a monthly unit basis for all months except admit and discharge months, in which case payment will be based on a daily unit. The monthly rate is equal to the daily rate multiplied by 29.7 days, based on average monthly utilization.

Market-based approach - Based on market prices (up to an annual or lifetime limit) or commercial benchmarks for Community Transition, Home Modifications, Nutritional Supplements, Personal Emergency Response, Pest Control, Specialized Medical Equipment, and Vehicle Modifications.

This waiver's fee schedule can be found on the FSSA webpages.

Changes to rates and rate setting methodology require 60-day tribal notice and 30-day public comment period as well as a waiver amendment. Further, Indiana code requires that all providers of Medicaid funded services be made aware of changes 30 days prior to the change effective date. All other providers are notified of rate changes through public notice and public comments, IHCP published banner pages, bulletins, and newsletters as prepared by the division in collaboration with the Indiana Office of Medicaid Policy and Planning (OMPP) and distributed by FSSA's fiscal agent. Once the changes occur, manuals are regularly updated to reflect the changed rates. Information about payment rates is made available to waiver participants by their Case Manager. Information about payment rates is also available to waiver participants and providers, both verbally and in writing, from FSSA staff.

The Bureau of Disabilities Services (BDS) and the OMPP will continue to collaborate with the community on any revisions made to the waiver rates. Their valuable input into the waiver rate reviews is necessary to ensure that rates are sufficient to continue provider participation and waiver participant access to waiver services.

The Home Modification Assessment Service and the Home Modification service have been combined into one service line in the waiver filing. However, the service components are performed by different providers (the assessor is independent of the contractor who does the actual modification), and therefore payment for the service is remitted in two separate components: 1) the independent assessment continues to be paid using a flat fee developed using a traditional cost model build-up, and 2) the modification itself continues to use a market based approach. The payment for the combined service is the sum of these two components.

The Benefits Counseling Service rate of \$50 per hour aligns with the rate paid outside of the waiver for the same service by the FSSA Vocational Rehabilitation program. We have updated Appendix I-2-a to add the Benefits Counseling service.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Claims for TBI waiver services flow directly from the providers to the Indiana Medicaid Management Information System and payments are made via Medicaid's contracted fiscal agent. The State implemented an Electronic Visit Verification (EVV) system, known as the Sandata EVV System, that complies with the requirements of the federal 21st Century Cures Act. The IHCP CoreMMIS claim-processing system has been configured to integrate with the Sandata EVV system.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures** (select one):

No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b)

how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

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Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

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Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The Waiver service plan contains Medicaid reimbursable services that are available only under the Traumatic Brain Injury (TBI) Waiver.

The Bureau of Disabilities Services (BDS) approves an individual's service plan within the State's case management database ensuring that only those services which are necessary and reimbursable under the TBI Waiver. The service plan is sent to the state's fiscal agent, via systems interface with the MMIS, serving as the prior authorization for the individual's approved Waiver services. The case management system will not allow the addition of services beyond those services offered under the TBI Waiver. The case management data system has been programmed to alert BDS staff when a service plan is being reviewed for an individual whose Medicaid eligibility status is not currently open within an acceptable category as described under Appendix B-4-b. When the appropriate Medicaid eligibility status is in place, the service plan will be approved, and the system will generate the Notice of Action (NOA), which is sent to each authorized provider of services on the Plan. The NOA identifies the individual waiver participant, the service that each provider is approved to deliver, and the rate at which the provider may bill for the service.

The case management database transmits data, on a daily cycle, containing all new or modified service plans to the Indiana MMIS. The service plan data is utilized by the MMIS as the basis to create or modify Prior Authorization fields to bump against the billing of services for each individual waiver participant.

Providers submit electronic (or paper) claims directly to the MMIS. Claims are submitted with date(s) of service, service code, and billing amount. Reimbursements are only authorized and made in accordance with the Prior Authorization data on file. The MMIS also confirms that the waiver participant had the necessary Level of Care and Medicaid eligibility for all dates of service being claimed against.

Documentation and verification of service delivery consistent with paid claims is reviewed during the post payment review of the operating agency as well as by the Office of Medicaid Policy and Planning when executing Surveillance Utilization Review (SUR) activities. Additional information about these reviews can be found in the Financial Transactions and Remittance Advice provider reference module at the following link:
<http://provider.indianamedicaid.com/media/155457/financial%20transactions%20and%20remittance%20advice.pdf>

RECOUPMENT

If a payment to a provider is identified as paid in error due to error, fraud, policy, system issues, etc., the State can recoup that payment by any of the ways listed below:

- 1.Create a non-claim specific accounts receivable*
- 2.Claim adjustment*
- 3.Remit payment via check*

Non-Claim Specific Accounts Receivable (AR):

When this method is used to recoup payment, an AR is setup under the Medicaid Provider's identification number. Each AR is assigned a reason code. The reason code describes the purpose for the AR. The reason code also maps to various lines on the CMS 64.

Once the AR is setup, a provider's future Medicaid payments will be reduced until the AR is fully satisfied. Claim Adjustments:

Under this process, a claim specific AR will be created when a claim is adjusted. Either the provider or the State may adjust claims. With claim specific ARs, the AR is attached to a specific claim that was previously paid.

The process is the same; however, as non-claim specific ARs, in that a reason code will also be assign to a claim specific AR, and a provider's future Medicaid payments will be reduced until the AR is satisfied.

With claim specific ARs, the CMS 64 line on which the original payment was made, is reduced to reflect returning the federal share. For, example, if an inpatient claim is adjusted to recoup payment, once the recoupment happens, the adjustment would be reflected in line 1A of the CMS 64.9.

Remit Payment Via Check:

Providers may repay overpayments in the form of a check. If a provider remits payment via check, an AR is still necessary to process the check. Under this method, instead of reducing a provider's future Medicaid payments until the AR is satisfied, the AR is satisfied with the check.

In summary, the waiver participant's eligibility for Medicaid Waiver services is controlled through the electronic case management system which is linked to the Medicaid claims system. All services are approved within these systems by the operating agency. As part of the 90-day review, the Case Manager verifies with the individual the appropriateness of services and monitors for delivery of service as prescribed in the plan of care. Modifications to the plan of care are made as necessary.

The State is offering an Open Choice Model for Electronic Visit Verification (EVV). The State is contracting with an EVV vendor that allows providers with existing EVV vendors to continue to use those systems. Existing EVV vendors will report standardized aggregate data to the State operated EVV system. The H&W waiver services that utilize EVV are all forms of attendant care, unskilled respite care, Home and Community Assistance, and specialized medical equipment.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. Method of payments -- MMIS (select one):**

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. Direct payment.*** *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements

under the provisions of 42 CFR § 447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.

Specify the following: (a) the entities that are designated as an OHCDs and how these entities qualify for designation as an OHCDs; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDs; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDs arrangement is employed, including the selection of providers not affiliated with the OHCDs; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDs meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDs contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDs arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability**I-4: Non-Federal Matching Funds (1 of 3)**

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

Appropriation of State Tax Revenues to the State Medicaid Agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability**I-4: Non-Federal Matching Funds (2 of 3)**

- b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly

expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. Select one:

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

The State of Indiana excludes Medicaid payment for room and board for individuals receiving services under the waiver. No room and board costs are figured into allowable provider expenses. There are provider guidelines for usual and customary fee, and the provider agreement states that a provider may only provide services for which the provider is certified. Waiver service providers are paid a fee for each type of direct service provided: No room and board costs are included in these fees.

Note: The Waiver does not provide services in waiver group home settings. Waiver participants are responsible for all room and board costs.

Based on the method for establishing the fee for each waiver service, the State of Indiana assures that no room and board costs are paid through Medicaid. Indiana provider audit procedures also review provider billing and all allowable costs to further assure no room and board payments are made.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii)

through I-7-a-iv):

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

MEDWorks members with income between 150% - 350% FPL are responsible for paying a premium based on family size and income; the income standard includes a 50% earned income disregard for all MEDWorks members. Premiums vary from \$0 to \$254.

The included groups are the MEDWorks members with HCBS waivers with income over 150% FPL.

For 2023, the MEDWorks premiums are:

Family Size 1:

Income standard \$1216 - \$1822: Premium \$0

Income standard \$1823 - \$2127: Premium \$48

Income standard \$2128 - \$2430: Premium \$69

Income standard \$2431 - \$3038: Premium \$107

Income standard \$3039 - \$3645: Premium \$134

Income standard \$3646 - \$4253: Premium \$161

Income standard \$4254 and over: Premium \$187

Family size 2:

Income standard \$1644 - \$2465: Premium \$0

Income standard \$2465 - \$2876: Premium \$65

Income standard \$2877 - \$3287: Premium \$93

Income standard \$3288 - \$4109: Premium \$145

Income standard \$4110 - \$4930: Premium \$182

Income standard \$4931 - \$5752: Premium \$218

Income standard \$5753 and over: Premium \$254

**Income of the non-MEDWorks member is not budgeted in the eligibility determination but does apply to the premium calculation.*

Every month, the Premium Vendor sends a bill to MEDWorks members with a premium. The member has 60 days to pay the premium; failure to pay within 60 days can result in the closure of the MEDWorks Medicaid. This results in

a 2 year lock out for MEDWorks members. If the member pays the premium in full, the lock out is removed.

MEDWorks members between 101-149% FPL are excluded as are other Medicaid categories with HCBS waivers.

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility, ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	42065.73	31430.35	73496.08	102267.04	8519.04	110786.08	37290.00
2	48860.11	32341.83	81201.94	108088.38	8766.43	116854.81	35652.87
3	73839.92	25930.18	99770.10	111439.12	8959.59	120398.71	20628.61
4	73804.43	26500.65	100305.08	114893.73	9157.01	124050.74	23745.66
5	73880.97	27083.66	100964.63	118455.44	9358.78	127814.22	26849.59

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		Nursing Facility	ICF/IID
Year 1	200	100	100
Year 2	200	100	100
Year 3	200	100	100
Year 4	200	100	100
Year 5	200	100	100

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Projected average length of stay was developed based on slot projections. Slot projections assume one new entrant and one lapse each month, maintaining the slot count at 200 for each of the waiver years. This in turn keeps the average length of stay on the waiver at 343 or 344 throughout the waiver renewal period.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Base Year data reflects experience from Waiver Year 1 of the fifth renewal: January 1, 2023 – December 31, 2023. The base year data was projected to WY 2 through WY 5 of the fifth renewal, in the following manner:

- Number of users of each service was adjusted based on projected slots.
- Average units per user were projected to vary with average length of stay.
- Average cost per unit reflects reimbursement changes effective July 1, 2023 and then is projected to remain unchanged for the remainder of the waiver renewal period.
- The base year (WY 1) cost per unit for the Vehicle modification service was \$15,000. This is the maximum permitted under the cap, so cost per unit was projected to remain unchanged at \$15,000 each subsequent waiver year.
- The Integrated Healthcare Coordination (IHCC) projections were developed as follows:
 - o Reimbursement is the same as on the H&W and PathWays Waivers – updated to \$14.21 per quarter hour (16 hours per month limit) effective July 1, 2023.
 - o The number of users is assumed to ramp up gradually over time, reaching 8% of unduplicated users (16 users) by WY 5 of the renewal.
 - o Average units per user are estimated based on emerging experience from WY 2 (the first recipient for this service was in January 2024).
- Home modification assessment was added as a new service effective July 1, 2024. It is assumed that 55% of assessments lead to home modification, at a cost of \$628 per assessment.
- Structured Family Caregiving (SFC) was added as a new service effective July 1, 2024. Projections are estimated based on emerging experience from WY 2, including the number of recipients, distribution by tier, and unit per user.
- Attendant care:
 - o The projected number of users has been adjusted to remove members who began using SFC services as of July 2024, as these members will no longer be able to concurrently receive Attendant Care services
 - o Units per user reflect average utilization immediately after July 1, 2024
- The following changes are proposed to be effective December 31, 2025:
 - o For Adult Day Services – the number of average units per user and average cost per unit were adjusted to reflect elimination of two different categories for the level of reimbursement.
 - o For Attendant Care – the number of users and the number of average units per user were adjusted to reflect the limitation of the service to 40 hours per week when provided by a family member and the allowance of LRIs to provide care for members with extraordinary needs limited to 40 hours per week.
 - o Structured Family Caregiving – the number of users and the number of average units per user were adjusted to reflect the allowance of LRIs to provide Attendant Care services for members with extraordinary needs limited to 40 hour per week. This adjustment was only made to the Level 3 of the Structure Family Caregiving as members with extraordinary needs would be reimbursed under Level 3 of the service.
 - o Benefits Counseling – a new service being offered to members age 18-59 to provide counseling to members in order to seek vocational rehabilitation or other employment supports. It is assumed that 10% of TBI members age 18-59 will utilize the service for 5 hours per year with an average cost per unit of \$50.
 - o Residential-Based Habilitation - the number of average units per user were adjusted to reflect the limitation of the service to 40 hours per week when provided by a family member.
 - o Self-directions – proposed to be implemented and will impact Attendant Care, Home Community Assistance Service, Residential-Based Habilitation and Respite Care. It is assumed that 2% of members will participate in self-direction of the services and this will reduce their budget by 10%. The average cost per unit was adjusted to decrease by 0.2% for the services listed above.
 - o Home Modification and Home Modification Assessment lines were combined into one line now titled 'Home Modification and Assessment' on the Appendix J.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Base Year data reflects experience from Waiver Year 1 of the fifth renewal: January 1, 2023 – December 31, 2023.

Base year data was trended at 2.2% per year to reflect Medical CPI-U over the most recent 5 complete years(rounded).

- iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Base Year data reflects experience from Waiver Year 1 of the fifth renewal: January 1, 2023 – December 31, 2023.

Factor G was developed based on base year institutional claim experience, weighted by level of care as illustrated in Figure 2.

To develop Factor G for Nursing Home recipients with a TBI diagnosis, nursing facility UPL expenditures were added to nursing facility claims expenditures. During calendar year (CY) 2023, total paid nursing facility UPL expenditures were \$831.4 million in the state of Indiana.

Divided by 35,023 unique nursing facility recipients, the average nursing facility UPL expenditure per unique recipient was \$23,737. This amount has been added to the nursing home component of Factor G.

Factor G from WY 1 was inflated by 5.0% to WY 2 to reflect emerging experience, including higher reimbursement for nursing facilities and the start of modernization efforts for ICF/IID facilities. Future year cost factors were trended at 3.1% per year. The 3.1% trend was estimated using the average of Medical CPI-U and CPI-U over the most recent 5 complete years (rounded). This trend was applied to the WY 2 Factor G to estimate WY 3 through WY 5.

- iv. Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Base Year data reflects experience from Waiver Year 1 of the fifth renewal: January 1, 2023 – December 31, 2023.

Factor G' was developed based on the base year state plan claim experience, weighted by level of care as illustrated in Figure 2. Factor G' includes all state plan services received by the respective comparison populations while institutionalized.

Base year data was trended at 2.2% per year to reflect Medical CPI-U over the most recent 5 complete years (rounded).

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

Waiver Services	
Adult Day Services	
Attendant Care	
Case Management	
Home and Community Assistance	
Residential Based Habilitation	
Skilled Respite	
Structured Day Program	
Adult Family Care	
Assisted Living	
Behavior Management/ Behavior Program and Counseling	
Benefits Counseling (Beginning 12/31/2025)	

Waiver Services	
Community Transition	
Extended Employment Services	
Home Delivered Meals	
Home Modification Assessment (Ending 12/30/2025)	
Home Modifications (Ending 12/30/2025)	
Home Modifications and Assessments (Beginning 12/31/2025)	
Integrated Health Care Coordination	
Nutritional Supplements	
Personal Emergency Response System	
Pest Control	
Specialized Medical Equipment and Supplies	
Structured Family Caregiving	
Transportation	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						274187.70
Adult Day Services	1/4 hour	18	4402.50	3.46	274187.70	
Attendant Care Total:						5380475.40
Attendant Care	1/4 hour	120	6359.90	7.05	5380475.40	
Case Management Total:						328414.32
Case Management	month	195	10.40	161.94	328414.32	
Home and Community Assistance Total:						61341.14
Home and Community Assistance	1/4 hour	16	598.10	6.41	61341.14	
Residential Based Habilitation Total:						752673.10
Residential Based Habilitation	1/4 hour				752673.10	
GRAND TOTAL: 8413146.99 Total Estimated Unduplicated Participants: 200 Factor D (Divide total by number of participants): 42065.73 Average Length of Stay on the Waiver: 343						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		34	2696.40	8.21		
Skilled Respite Total:						641159.20
Skilled Respite	1/4 hour	37	1788.30	9.69	641159.20	
Structured Day Program Total:						99696.13
Structured Day Program	1/4 hour	8	2781.70	4.48	99696.13	
Adult Family Care Total:						133767.70
Adult Family Care	day	6	303.70	73.41	133767.70	
Adult Family Care - Level 1	day	0	0.00	0.01	0.00	
Adult Family Care - Level 2	day	0	0.00	0.01	0.00	
Adult Family Care - Level 3	day	0	0.00	0.01	0.00	
Assisted Living Total:						89718.96
Assisted Living	day/month	5	192.20	93.36	89718.96	
Behavior Management/ Behavior Program and Counseling Total:						180908.00
Behavior Management/ Behavior Program and Counseling	1/4 hour	40	248.50	18.20	180908.00	
Benefits Counseling (Beginning 12/31/2025) Total:						0.00
Benefits Counseling (Beginning 12/31/2025)	hour	0	0.00	0.01	0.00	
Community Transition Total:						1528.50
Community Transition	unit	1	1.00	1528.50	1528.50	
Extended Employment Services Total:						1742.26
Extended Employment Services	1/4 hour	1	165.30	10.54	1742.26	
Home Delivered Meals Total:						155061.44
Home Delivered Meals	meal	59	382.00	6.88	155061.44	
Home Modification Assessment (Ending 12/30/2025) Total:						0.00
GRAND TOTAL: 8413146.99 Total Estimated Unduplicated Participants: 200 Factor D (Divide total by number of participants): 42065.73 Average Length of Stay on the Waiver: 343						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Modification Assessment (Ending 12/30/2025)	unit	0	0.00	0.01	0.00	
Home Modifications (Ending 12/30/2025) Total:						12852.96
Home Modifications (Ending 12/30/2025)	unit	2	1.00	6426.48	12852.96	
Home Modifications and Assessments (Beginning 12/31/2025) Total:						0.00
Home Modifications and Assessments (Beginning 12/31/2025)	1/4 hour	0	0.00	0.01	0.00	
Integrated Health Care Coordination Total:						20249.25
Integrated Health Care Coordination	month	5	330.60	12.25	20249.25	
Nutritional Supplements Total:						4845.61
Nutritional Supplements	unit	5	9.80	98.89	4845.61	
Personal Emergency Response System Total:						21967.47
Personal Emergency Response System	unit	45	11.80	41.37	21967.47	
Pest Control Total:						6881.33
Pest Control	unit	9	4.80	159.29	6881.33	
Specialized Medical Equipment and Supplies Total:						10198.02
Specialized Medical Equipment and Supplies	unit	8	9.20	138.56	10198.02	
Structured Family Caregiving Total:						0.00
Structured Family Caregiving - Level 1	day	0	0.00	0.01	0.00	
Structured Family Caregiving - Level 2	day	0	0.00	0.01	0.00	
Structured Family Caregiving - Level 3	day	0	0.00	0.01	0.00	
Transportation Total:						205478.51
Transportation	trip/mile	21	3409.30	2.87	205478.51	
Vehicle Modifications Total:						30000.00
Vehicle Modifications					30000.00	
GRAND TOTAL: 8413146.99 Total Estimated Unduplicated Participants: 200 Factor D (Divide total by number of participants): 42065.73 Average Length of Stay on the Waiver: 343						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	unit	2	1.00	15000.00		
GRAND TOTAL: 8413146.99 Total Estimated Unduplicated Participants: 200 Factor D (Divide total by number of participants): 42065.73 Average Length of Stay on the Waiver: 343						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						288495.70
Adult Day Services	1/4 hour	18	4415.30	3.63	288495.70	
Attendant Care Total:						6161500.80
Attendant Care	1/4 hour	120	6112.60	8.40	6161500.80	
Case Management Total:						384427.68
Case Management	month	195	10.40	189.56	384427.68	
Home and Community Assistance Total:						75443.42
Home and Community Assistance	1/4 hour	16	599.90	7.86	75443.42	
Residential Based Habilitation Total:						867972.13
Residential Based Habilitation	1/4 hour	34	2704.30	9.44	867972.13	
Skilled Respite Total:						753843.92
Skilled Respite	1/4 hour	37	1793.50	11.36	753843.92	
Structured Day Program Total:						111368.82
Structured Day Program	1/4 hour	8	2789.80	4.99	111368.82	
GRAND TOTAL: 9772021.15 Total Estimated Unduplicated Participants: 200 Factor D (Divide total by number of participants): 48860.11 Average Length of Stay on the Waiver: 344						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Family Care Total:						137899.56
Adult Family Care	day	0	0.00	0.01	0.00	
Adult Family Care - Level 1	day	1	309.80	67.93	21044.71	
Adult Family Care - Level 2	day	4	286.00	72.26	82665.44	
Adult Family Care - Level 3	day	1	377.20	90.64	34189.41	
Assisted Living Total:						103518.44
Assisted Living	day/month	5	192.70	107.44	103518.44	
Behavior Management/ Behavior Program and Counseling Total:						181517.28
Behavior Management/ Behavior Program and Counseling	1/4 hour	40	249.20	18.21	181517.28	
Benefits Counseling (Beginning 12/31/2025) Total:						0.00
Benefits Counseling (Beginning 12/31/2025)	hour	0	0.00	0.01	0.00	
Community Transition Total:						1500.00
Community Transition	unit	1	1.00	1500.00	1500.00	
Extended Employment Services Total:						1974.68
Extended Employment Services	1/4 hour	1	165.80	11.91	1974.68	
Home Delivered Meals Total:						175398.50
Home Delivered Meals	meal	59	383.10	7.76	175398.50	
Home Modification Assessment (Ending 12/30/2025) Total:						1256.00
Home Modification Assessment (Ending 12/30/2025)	unit	2	1.00	628.00	1256.00	
Home Modifications (Ending 12/30/2025) Total:						12613.30
Home Modifications (Ending 12/30/2025)	unit	2	1.00	6306.65	12613.30	
Home Modifications and Assessments (Beginning 12/31/2025) Total:						0.00
GRAND TOTAL: 9772021.15 Total Estimated Unduplicated Participants: 200 Factor D (Divide total by number of participants): 48860.11 Average Length of Stay on the Waiver: 344						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Modifications and Assessments (Beginning 12/31/2025)	1/4 hour	0	0.00	0.01	0.00	
Integrated Health Care Coordination Total:						42408.32
Integrated Health Care Coordination	month	9	331.60	14.21	42408.32	
Nutritional Supplements Total:						4755.45
Nutritional Supplements	unit	5	9.80	97.05	4755.45	
Personal Emergency Response System Total:						21967.47
Personal Emergency Response System	unit	45	11.80	41.37	21967.47	
Pest Control Total:						6753.02
Pest Control	unit	9	4.80	156.32	6753.02	
Specialized Medical Equipment and Supplies Total:						10008.13
Specialized Medical Equipment and Supplies	unit	8	9.20	135.98	10008.13	
Structured Family Caregiving Total:						164038.12
Structured Family Caregiving - Level 1	day	5	172.00	77.54	66684.40	
Structured Family Caregiving - Level 2	day	3	172.00	99.71	51450.36	
Structured Family Caregiving - Level 3	day	2	172.00	133.44	45903.36	
Transportation Total:						233360.40
Transportation	trip/mile	21	3419.20	3.25	233360.40	
Vehicle Modifications Total:						30000.00
Vehicle Modifications	unit	2	1.00	15000.00	30000.00	
GRAND TOTAL: 9772021.15 Total Estimated Unduplicated Participants: 200 Factor D (Divide total by number of participants): 48860.11 Average Length of Stay on the Waiver: 344						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be

completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						274400.28
Adult Day Services	1/4 hour	24	2969.70	3.85	274400.28	
Attendant Care Total:						10667085.05
Attendant Care	1/4 hour	133	9536.70	8.41	10667085.05	
Case Management Total:						406094.39
Case Management	month	193	11.10	189.56	406094.39	
Home and Community Assistance Total:						57191.23
Home and Community Assistance	1/4 hour	12	607.90	7.84	57191.23	
Residential Based Habilitation Total:						921502.47
Residential Based Habilitation	1/4 hour	30	3349.70	9.17	921502.47	
Skilled Respite Total:						646872.93
Skilled Respite	1/4 hour	26	2436.80	10.21	646872.93	
Structured Day Program Total:						184031.60
Structured Day Program	1/4 hour	12	3048.90	5.03	184031.60	
Adult Family Care Total:						126125.16
Adult Family Care	day	0	0.00	0.01	0.00	
Adult Family Care - Level 1	day	1	1.00	67.93	67.93	
Adult Family Care - Level 2	day	1	376.20	72.34	27214.31	
Adult Family Care - Level 3	day	3	363.50	90.64	98842.92	
Assisted Living Total:						143834.37
Assisted Living	day/month	4	169.60	212.02	143834.37	
Behavior Management/ Behavior Program and Counseling Total:						216480.92
GRAND TOTAL: 14767984.61 Total Estimated Unduplicated Participants: 200 Factor D (Divide total by number of participants): 73839.92 Average Length of Stay on the Waiver: 343						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavior Management/ Behavior Program and Counseling	1/4 hour	40	292.70	18.49	216480.92	
Benefits Counseling (Beginning 12/31/2025) Total:						0.00
Benefits Counseling (Beginning 12/31/2025)	hour	0	0.00	0.01	0.00	
Community Transition Total:						2488.10
Community Transition	unit	1	1.00	2488.10	2488.10	
Extended Employment Services Total:						6443.31
Extended Employment Services	1/4 hour	2	270.50	11.91	6443.31	
Home Delivered Meals Total:						213825.15
Home Delivered Meals	meal	70	399.30	7.65	213825.15	
Home Modification Assessment (Ending 12/30/2025) Total:						10048.00
Home Modification Assessment (Ending 12/30/2025)	unit	16	1.00	628.00	10048.00	
Home Modifications (Ending 12/30/2025) Total:						88849.01
Home Modifications (Ending 12/30/2025)	unit	9	1.20	8226.76	88849.01	
Home Modifications and Assessments (Beginning 12/31/2025) Total:						0.00
Home Modifications and Assessments (Beginning 12/31/2025)	1/4 unit	0	0.00	0.01	0.00	
Integrated Health Care Coordination Total:						25100.54
Integrated Health Care Coordination	month	8	220.80	14.21	25100.54	
Nutritional Supplements Total:						2080.00
Nutritional Supplements	unit	4	5.20	100.00	2080.00	
GRAND TOTAL: 14767984.61 Total Estimated Unduplicated Participants: 200 Factor D (Divide total by number of participants): 73839.92 Average Length of Stay on the Waiver: 343						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response System Total:						28076.22
Personal Emergency Response System	unit	53	10.90	48.60	28076.22	
Pest Control Total:						6507.16
Pest Control	unit	11	4.60	128.60	6507.16	
Specialized Medical Equipment and Supplies Total:						11928.80
Specialized Medical Equipment and Supplies	unit	16	7.40	100.75	11928.80	
Structured Family Caregiving Total:						430413.55
Structured Family Caregiving - Level 1	day	2	343.00	77.54	53192.44	
Structured Family Caregiving - Level 2	day	3	343.00	99.71	102601.59	
Structured Family Caregiving - Level 3	day	6	343.00	133.44	274619.52	
Transportation Total:						283606.37
Transportation	trip/mile	29	3114.50	3.14	283606.37	
Vehicle Modifications Total:						15000.00
Vehicle Modifications	unit	1	1.00	15000.00	15000.00	
GRAND TOTAL: 14767984.61 Total Estimated Unduplicated Participants: 200 Factor D (Divide total by number of participants): 73839.92 Average Length of Stay on the Waiver: 343						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						280196.86
Adult Day Services	1/4 hour	24	2985.90	3.91	280196.86	
Attendant Care Total:						10614713.38
Attendant Care	1/4 hour	133	9512.50	8.39	10614713.38	
Case Management Total:						406094.39
Case Management	month	193	11.10	189.56	406094.39	
Home and Community Assistance Total:						57045.34
Home and Community Assistance	1/4 hour	12	607.90	7.82	57045.34	
Residential Based Habilitation Total:						996297.75
Residential Based Habilitation	1/4 hour	30	3629.50	9.15	996297.75	
Skilled Respite Total:						645605.79
Skilled Respite	1/4 hour	26	2436.80	10.19	645605.79	
Structured Day Program Total:						184031.60
Structured Day Program	1/4 hour	12	3048.90	5.03	184031.60	
Adult Family Care Total:						126125.16
Adult Family Care	day	0	0.00	0.01	0.00	
Adult Family Care - Level 1	day	1	1.00	67.93	67.93	
Adult Family Care - Level 2	day	1	376.20	72.34	27214.31	
Adult Family Care - Level 3	day	3	363.50	90.64	98842.92	
Assisted Living Total:						143834.37
Assisted Living	day/month	4	169.60	212.02	143834.37	
Behavior Management/ Behavior Program and Counseling Total:						216480.92
Behavior Management/ Behavior Program and Counseling	1/4 hour	40	292.70	18.49	216480.92	
GRAND TOTAL: 14760886.06 Total Estimated Unduplicated Participants: 200 Factor D (Divide total by number of participants): 73804.43 Average Length of Stay on the Waiver: 343						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Benefits Counseling (Beginning 12/31/2025) Total:						4250.00
Benefits Counseling (Beginning 12/31/2025)	hour	17	5.00	50.00	4250.00	
Community Transition Total:						2488.10
Community Transition	unit	1	1.00	2488.10	2488.10	
Extended Employment Services Total:						6443.31
Extended Employment Services	1/4 hour	2	270.50	11.91	6443.31	
Home Delivered Meals Total:						213825.15
Home Delivered Meals	meal	70	399.30	7.65	213825.15	
Home Modification Assessment (Ending 12/30/2025) Total:						5024.00
Home Modification Assessment (Ending 12/30/2025)	unit	8	1.00	628.00	5024.00	
Home Modifications (Ending 12/30/2025) Total:						39488.45
Home Modifications (Ending 12/30/2025)	unit	4	1.20	8226.76	39488.45	
Home Modifications and Assessments (Beginning 12/31/2025) Total:						49448.51
Home Modifications and Assessments (Beginning 12/31/2025)	1/4 hour	8	1.70	3635.92	49448.51	
Integrated Health Care Coordination Total:						37650.82
Integrated Health Care Coordination	month	12	220.80	14.21	37650.82	
Nutritional Supplements Total:						2080.00
Nutritional Supplements	unit	4	5.20	100.00	2080.00	
Personal Emergency Response System Total:						28076.22
Personal					28076.22	
GRAND TOTAL: 14760886.06 Total Estimated Unduplicated Participants: 200 Factor D (Divide total by number of participants): 73804.43 Average Length of Stay on the Waiver: 343						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Emergency Response System	unit	53	10.90	48.60		
Pest Control Total:						6507.16
Pest Control	unit	11	4.60	128.60	6507.16	
Specialized Medical Equipment and Supplies Total:						11928.80
Specialized Medical Equipment and Supplies	unit	16	7.40	100.75	11928.80	
Structured Family Caregiving Total:						384643.63
Structured Family Caregiving - Level 1	day	2	343.00	77.54	53192.44	
Structured Family Caregiving - Level 2	day	3	343.00	99.71	102601.59	
Structured Family Caregiving - Level 3	day	5	343.00	133.44	228849.60	
Transportation Total:						283606.37
Transportation	trip/mile	29	3114.50	3.14	283606.37	
Vehicle Modifications Total:						15000.00
Vehicle Modifications	unit	1	1.00	15000.00	15000.00	
GRAND TOTAL: 14760886.06 Total Estimated Unduplicated Participants: 200 Factor D (Divide total by number of participants): 73804.43 Average Length of Stay on the Waiver: 343						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						280196.86
GRAND TOTAL: 14776194.70 Total Estimated Unduplicated Participants: 200 Factor D (Divide total by number of participants): 73880.97 Average Length of Stay on the Waiver: 343						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services	1/4 hour	24	2985.90	3.91	280196.86	
Attendant Care Total:						10614713.38
Attendant Care	1/4 hour	133	9512.50	8.39	10614713.38	
Case Management Total:						406094.39
Case Management	month	193	11.10	189.56	406094.39	
Home and Community Assistance Total:						57045.34
Home and Community Assistance	1/4 hour	12	607.90	7.82	57045.34	
Residential Based Habilitation Total:						994120.05
Residential Based Habilitation	1/4 hour	30	3629.50	9.13	994120.05	
Skilled Respite Total:						645605.79
Skilled Respite	1/4 hour	26	2436.80	10.19	645605.79	
Structured Day Program Total:						184031.60
Structured Day Program	1/4 hour	12	3048.90	5.03	184031.60	
Adult Family Care Total:						126125.16
Adult Family Care	day	0	0.00	0.10	0.00	
Adult Family Care - Level 1	day	1	1.00	67.93	67.93	
Adult Family Care - Level 2	day	1	376.20	72.34	27214.31	
Adult Family Care - Level 3	day	3	363.50	90.64	98842.92	
Assisted Living Total:						143834.37
Assisted Living	day/month	4	169.60	212.02	143834.37	
Behavior Management/ Behavior Program and Counseling Total:						216480.92
Behavior Management/ Behavior Program and Counseling	1/4 hour	40	292.70	18.49	216480.92	
Benefits Counseling (Beginning 12/31/2025) Total:						4250.00
GRAND TOTAL: 14776194.70 Total Estimated Unduplicated Participants: 200 Factor D (Divide total by number of participants): 73880.97 Average Length of Stay on the Waiver: 343						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Benefits Counseling (Beginning 12/31/2025)	hour	17	5.00	50.00	4250.00	
Community Transition Total:						2488.10
Community Transition	unit	1	1.00	2488.10	2488.10	
Extended Employment Services Total:						6443.31
Extended Employment Services	1/4 hour	2	270.50	11.91	6443.31	
Home Delivered Meals Total:						213825.15
Home Delivered Meals	unit	70	399.30	7.65	213825.15	
Home Modification Assessment (Ending 12/30/2025) Total:						0.00
Home Modification Assessment (Ending 12/30/2025)	unit	0	0.00	0.01	0.00	
Home Modifications (Ending 12/30/2025) Total:						0.00
Home Modifications (Ending 12/30/2025)	unit	0	0.00	0.01	0.00	
Home Modifications and Assessments (Beginning 12/31/2025) Total:						98897.02
Home Modifications and Assessments (Beginning 12/31/2025)	1/4 hour	16	1.70	3635.92	98897.02	
Integrated Health Care Coordination Total:						50201.09
Integrated Health Care Coordination	month	16	220.80	14.21	50201.09	
Nutritional Supplements Total:						2080.00
Nutritional Supplements	unit	4	5.20	100.00	2080.00	
Personal Emergency Response System Total:						28076.22
Personal Emergency Response System	unit	53	10.90	48.60	28076.22	
Pest Control Total:						6507.16
GRAND TOTAL: 14776194.70 Total Estimated Unduplicated Participants: 200 Factor D (Divide total by number of participants): 73880.97 Average Length of Stay on the Waiver: 343						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Pest Control	unit	11	4.60	128.60	6507.16	
Specialized Medical Equipment and Supplies Total:						11928.80
Specialized Medical Equipment and Supplies	unit	16	7.40	100.75	11928.80	
Structured Family Caregiving Total:						384643.63
Structured Family Caregiving - Level 1	day	2	343.00	77.54	53192.44	
Structured Family Caregiving - Level 2	day	3	343.00	99.71	102601.59	
Structured Family Caregiving - Level 3	day	5	343.00	133.44	228849.60	
Transportation Total:						283606.37
Transportation	trip/mile	29	3114.50	3.14	283606.37	
Vehicle Modifications Total:						15000.00
Vehicle Modifications	unit	1	1.00	15000.00	15000.00	
GRAND TOTAL: 14776194.70 Total Estimated Unduplicated Participants: 200 Factor D (Divide total by number of participants): 73880.97 Average Length of Stay on the Waiver: 343						