Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Indiana** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Traumatic Brain Injury Waiver

C. Waiver Number:IN.4197
Original Base Waiver Number: IN.40197.90

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
07/01/25
Approved Effective Date of Waiver being Amended: 01/01/23

2. Purpose(s) of Amendment

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

The purpose of this amendment is to effectuate the following changes:

• Reflect the engagement, responsibilities, and oversight of the Level of Care Assessment Representative (LCAR) contractor

• Modify the nursing facility level of care evaluation /re-evaluation language to remove references to the e-screen and reflect the use of the InterRAI suite of instruments

• Revise cost neutrality demonstration information

• Make technical changes to revise or delete obsolete language/provisions/web references throughout.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☒ Waiver Application	2, 6-I, Attachment #1, Optional
☒ Appendix A Waiver Administration and Operation	A-2, A-3, A-4, A-5, A-6, A-7
☒ Appendix B Participant Access and Eligibility	B-6-c, B-6-d, B-6-f, B-6-i, B-6-j, B-QIS, B-8
☒ Appendix C Participant Services	C-1/C-3
☒ Appendix D Participant Centered Service Planning and Delivery	D-1-e, D-1-g
☐ Appendix E Participant Direction of Services	
☒ Appendix F Participant Rights	F-1, F-2-b, F-3-c
☒ Appendix G Participant Safeguards	G-1-b, G-1-d, G-1-e, G-2-a, G-2-b, G-2-c, G-QIS
☒ Appendix H	H-1-a
☒ Appendix I Financial Accountability	I-2-a, I-2-d
☒ Appendix J Cost-Neutrality Demonstration	J-1, J-2-a, J-2-c, J-2-d

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☐ **Add/delete services**

☐ **Revise service specifications**

☐ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☐ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☒ **Other**

Specify:

Update waiver to reflect engagement, responsibilities, and oversight of the Level of Care Assessment Representative (LCAR) contractor, modify the level of care evaluation /re-evaluation language to remove references to the e-screen and reflect the use of the InterRAI suite of instruments, and revise cost neutrality demonstration information.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Indiana** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Traumatic Brain Injury Waiver

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: IN.40197
Draft ID: IN.002.05.04

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

Regular Waiver

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

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

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

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

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

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

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

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

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

☐ **Waiver(s) authorized under §1915(b) of the Act.**

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

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

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

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

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**
Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

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

☐ **A program authorized under §1115 of the Act.**
Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

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

2. Brief Waiver Description

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

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

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

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

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

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

Agency. The Indiana Division of Disability and Rehabilitative Services (DDRS), a division under FSSA, has been given the authority to administer the TBI Waiver. The Office of Medicaid Policy and Planning (OMPP) also a division under FSSA has been given the administrative authority for the TBI waiver by FSSA. The Indiana Division of Aging, a division under FSSA, maintains contractual authority over the Area Agencies on Aging in their role as Indiana’s designated Aging and Disability Resource Centers (AAAs), Level of Care Assessment Representative (LCAR) contractor, and the NCI-AD Survey contractor. The Indiana Bureau of Disabilities Services (BDS), a bureau under DDRS, performs the daily operational tasks of the waiver.

Person Centered Support Planning: The service plan will contain all funded services, including medical and other services (regardless of funding sources) to be furnished, their frequency, expected activity to address the person’s clinical needs, as well as the type of provider who will furnish each service. Additionally, the service plan will include all information necessary to meet the Final Settings Rule: information that reflects the person’s preference for where they live, identification of the person’s strengths, and life preferences, individually identified goals and desired outcomes, and all un-paid (natural) supports. The plan will identify any important cultural considerations desired by the person, and will be written in plain language, and in a manner that is accessible to anyone with limited English proficiency. The care manager is responsible to monitor and evaluate the effectiveness for all service plans. The service plan will be subject to the approval of the BDS.

In accordance with Section 1902(h)(1) of the Act, the state assures that HCBS will only be provided to an individual in an acute care hospital when such services are:

-Provided to meet needs of the individual that are not met through the provision of acute care hospital services;
-Not a substitute for the services the acute care hospital is obligated to provide;
-Identified in the individual’s person-centered service plan; and
-Used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual’s functional abilities.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid

eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ◉ **Not Applicable**
- ○ **No**
- ○ **Yes**

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

- ◉ **No**
- ○ **Yes**

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

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

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect

to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

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

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

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

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery

processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

Public comments will be requested on this draft Traumatic Brain Injury (TBI) waiver amendment with a proposed effective date July 1, 2025.

This draft TBI amendment will be open for public comment for 31 days from December 25, 2024 through January 24, 2025 allowing all HCBS participants, providers and stakeholders an opportunity to provide input on the amendment.

Public notice and this draft TBI amendment will be made available via the following methods:

1. Electronic copy posted on the FSSA webpage at http://www.in.gov/fssa/ddrs/4205.htm

2. Electronic copy posted in the Indiana Register at http://iac.iga.in.gov/iac/irtoc.htm

3. Paper copy available upon request at local Division of Family Resources offices and local Bureau of Disabilities Services (BDS).

Comments on this draft TBI amendment will be accepted until 4:30 PM Eastern Time January 24, 2025, via email to DDRSwaivernoticecomment@fssa.IN.gov or via mail to the address below.

TBI Waiver Amendment Public Comment

c/o Division of Disability and Rehabilitative Services

402 W. Washington St., #W453 P.O. Box 7083, MS26

Indianapolis, IN 46207-7083

All public comments and dates of public notice for this TBI amendment will be retained on record and available for review. Once the comment period has closed, a summary of the public comments that DDRS received during the public input process, reasons why any comments are not adopted, and any modifications to the waiver that are made as a result of the public input process will be included in the Main, B. Optional field of this TBI amendment.

Federally-recognized Tribal Governments will receive written notice of this draft TBI amendment at least 60 days before the anticipated submission date of this TBI amendment to CMS. The applicable tribal consultation notice and this draft TBI amendment will be sent to the Tribal Governments on December 11, 2024, to begin the 60-day tribal consultation period that will be conducted through February 9, 2025.

DDRS routinely obtains public input and collaborates with key stakeholders in the state through the following methods:

• DDRS' Executive Management Team accepts public input from nationally recognized organizations, professional trade associations, and leaders among the service providers, in addressing concerns and suggestions on behalf of the group and the participants each represents in regard to DDRS program policy and operations. This input is considered as policies are developed. With FSSA’s approval, policies and updates are posted to DDRS' Website. DDRS hosts monthly provider webinars for statewide service providers announcing any waiver-related policy releases or updates authorized by FSSA, and meets with individual providers as needed or requested. DDRS also meets with small groups of parents and providers and intermittently attends other organized meetings of advocacy groups.

• DDRS hosts Building Bridges events which are opportunities for families and self-advocates to meet and speak with

the Bureau of Disabilities Services (BDS) state staff. These sessions are an important part of the Bureau's efforts to create direct avenues for individuals and families to share their feedback on waiver services and supervised group living.

• The monthly Advisory Council meeting (established within IC 12-9-4) consisting of the Director of DDRS and ten other participants with knowledge of or interest in the programs administered by the Division. All ten are appointed by the Secretary of the Indiana Family and Social Services Administration, the State Medicaid Agency, and represent a wide and diverse membership including providers, parents, self-advocates, the Department of Education, and other Bureaus within the Division; including First Steps and Vocational Rehabilitation. The Council's mission is to recommend strategies and actions that will ensure DDRS empowers people with disabilities to be independent and self-sufficient.

• DDRS maintains an electronic helpline available 24 hours daily, serving as a source of answering general questions surrounding programs, policies and procedures and as a receptor of suggestions and ideas from any interested party.

• Public forums and Webinars are held as needed toward the dissemination of program or operational changes.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Gilbert

First Name: Brian

Title: Program Administration Manager

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

Address: 402 W. Washington Street, Room W374 (MS 07)

Address 2:

City: Indianapolis

State: **Indiana**

Zip: 46204

Phone:

(317) 233-3340 **Ext:** ☐ **TTY**

Fax:
(317) 232-7382

E-mail:
brian.gilbert@fssa.in.gov

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

Last Name:
Mitchell

First Name:
Kelly

Title:
Director of the Division of Disability and Rehabilitative Services

Agency:
Indiana Family & Social Services Administration, Division of Disability and Rehabilitative

Address:
402 West Washington Street, Room W451 (MS26), PO Box 7083

Address 2:

City:
Indianapolis

State: **Indiana**

Zip:
46207-7083

Phone:
(317) 619-1943 **Ext:** ☐ **TTY**

Fax:
(317) 232-1240

E-mail:
kelly.mitchell@fssa.IN.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Indiana**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

As part of this amendment, the state is modifying the nursing facility level of care evaluation / re-evaluation language to remove references to the e-screen as this tool is being retired and reflect the continued use of the InterRAI suite of instruments. This change is intended to streamline nursing facility level of care determination and is not reflective of a narrowing of the nursing facility level of care criteria specified in Indiana Administrative Code 405 IAC 1-3-1 through 405 IAC 1-3-3. This change could, but is not intended to, result in some participants not meeting nursing facility level of care requirements and losing eligibility for this waiver. Further, if individuals who were previously eligible and receiving services under this waiver are found to be no longer eligible for this waiver, then this change could thereby result in reduced services to those affected individuals.

Upon approval, the state will take the following steps to mitigate potential adverse effects and facilitate the transition of impacted individuals (if any) to alternate services and supports that will enable the individual to remain in the community:

• Ensure all nursing facility level of care denials recommended by the Level of Care Assessment Representative (LCAR) contractor using the modified language are reviewed and denial is confirmed by FSSA staff prior to taking effect.

• Provide (or ensure FSSA contractors provide) options counseling to impacted individuals to identify other Medicaid services or state-funded supports they may be eligible to receive. Support during the application process is available if they choose to apply for such services.

• Collect and track the number of active participants who have been determined not to meet nursing facility level of care and identify if there are unintended impacts from this change. The state will modify processes as needed.

Additionally, all impacted individuals, their legal representatives (if any), and their care manager will be provided written notice of the changes to their eligibility and informed of the opportunity to request a Fair Hearing in accordance with the provisions set forth Appendix F-1 of this waiver.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Completed.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (*select one*):

◉ **The waiver is operated by the state Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

◉ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

Division of Disability and Rehabilitative Services

(Complete item A-2-a).

○ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

The Family and Social Services Administration (FSSA) is the single state Medicaid agency authorized to administer the waiver. The waiver is operated by the Division of Disability and Rehabilitative Services (DDRS), a division under the single State Medicaid agency. The Office of Medicaid Policy and Planning (OMPP), a division under the single state Medicaid Agency, is responsible for monitoring DDRS's operation of the waiver through:

• A Quality Management Plan that outlines in detail the quality assurance responsibilities and activities. This Plan is derived from the performance measures included in this waiver. As part of FSSA's oversight authority for assuring participants' service plans (which include risk plans for identified health issues) are appropriate and effective, OMPP has selected several administrative authority and key health issues to monitor for individuals with disabilities. Monitoring is conducted to ensure issues are identified timely and addressed appropriately.
• Ongoing and periodic reporting and analysis of data, including service utilization data, claims data, and reportable events. OMPP receives management reports from DDRS, Bureau of Disabilities Services (BDS), and the fiscal agent. These reports include:
  o From BDS, the QA/QI contractor's quarterly management report, which contains aggregate data from complaints, incident reports, mortality reviews, and trend analysis; and
  o From the fiscal agent, monthly and quarterly management reports.
• Periodic inter-division meetings to discuss activities, issues, outcomes, and needs, and to jointly plan ongoing system improvements and remediation, when indicated. FSSA Management teams meet bi-weekly to review programs, recommend changes, and address programming concerns. The performance of contracting entities is reviewed, discussed, and addressed as needed during these meetings. Termination of a vendor contract is possible should the contractor be unable or unwilling to meet the expectations of the state.

OMPP exercises oversight of operation of the waiver through the following activities:
• Annually, OMPP and the Division of Finance, a division under the single State Medicaid agency, supervises the development of the CMS annual waiver expenditure reports, reviews the final report with DDRS, and identifies problem areas that may need to be discussed and resolved with DDRS prior to submission by FSSA.
• Monthly, OMPP and Division of Finance reviews Medicaid waiver expenditure reports, after which any identified problems will be discussed and resolved with DDRS.
• Daily, FSSA (or FSSA's fiscal agent) reviews, approves, and assures payment of Medicaid claims for waiver services consistent with FSSA established policy.
• On an ongoing basis, FSSA is responsible for oversight of all waiver activities (including level of care (LOC) determinations, plan of care reviews, identification of trends and outcomes, and initiating action to achieve desired outcomes), retaining final authority for approval of level of care and plans of care.
• OMPP develops Medicaid policy for the State of Indiana and on an ongoing and as needed basis, works collaboratively with DDRS to formulate policies specific to the waiver or that have a substantial impact on waiver participants.
• OMPP seeks and reviews comments from DDRS before the adoption of rules or standards that may affect the services, programs, or providers of medical assistance services for participants with intellectual disabilities who receive Medicaid services.
• FSSA, and FSSA's fiscal agent, approves and enrolls all providers of waiver services.
• OMPP and DDRS collaborate to revise and develop the waiver application to reflect current FSSA goals and policy programs.
• OMPP reviews and approves all waiver manuals, bulletins, communications regarding waiver policy, and quality assurance/improvement plans prior to implementation or release to providers, participants, families, or any other entity.
• FSSA retains final authority for rate-setting of provider rates and any activities reimbursed through administrative funds, and coverage and criteria for all Medicaid services including state plan services.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

A contract exists between the FFSA, the single State Medicaid Agency (or FSSA division or bureau and each contracted entity listed below that sets forth the responsibilities and performance requirements of the contracted entity. The contract(s) under which these entities conduct waiver operational functions are available to CMS upon request through FSSA (as applicable).

Specific to the operational and administrative functions of this waiver, the following activities are conducted by contracted entities.

FISCAL AGENT is responsible for:
•Reimbursement of claims for authorized waiver services submitted by authorized waiver providers;
•Enrollment of qualified providers for waiver services;
•Conducting periodic training and providing technical assistance to waiver providers on waiver requirements;
•Timely submission of monthly and quarterly reporting for all contracted activities;
•Collecting and analyzing waiver paid claims data; and
•Compiling and analyzing waiver claims data to meet the CMS annual waiver reporting requirements.

UTILIZATION MANAGEMENT CONTRACTOR(S):

The waiver auditing function is incorporated into the Program Integrity (PI) functions of the contract between the Medicaid agency and Fraud and Abuse Detection System (FADS) contractor. FSSA has expanded its Program Integrity activities by using a multipronged approach to PI activity that includes provider self-audits, contractor desk audits, and full on-site audits. The FADS contractor sifts and analyzes claims data and identifies providers and claims that indicate aberrant billing patterns or other risk factors, such as correcting claims.

FSSA or any other legally authorized governmental entity (or its agents) may at any time during the term of the provider agreement and in accordance with Indiana Administrative Code conduct audits for the purposes of assuring the appropriate administration and expenditure of the monies provided to the provider through this provider agreement. Additionally, FSSA may at any time conduct audits to assure appropriate administration and delivery of services under the provider agreement.

The Program Integrity activities describe post-payment financial audits to ensure the integrity of IHCP payments. Detailed information on PI policy and procedures is available in the Indiana Health Coverage Programs (IHCP) Provider and Member Utilization Review provider reference module.

Program Integrity receives allegations of Medicaid provider fraud, waste, and abuse and tracks these in its case management system. To begin investigating these allegations, Program Integrity to vets the providers with the Medicaid Fraud Control Unit (MFCU). Once it receives MFCU’s clearance PI determines how to best validate the accuracy of the allegation.

PI conducts its audit activities and develops a findings report for the provider which may include a corrective action plan and request for overpayment.

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

QUALITY ASSURANCE/QUALITY IMPROVEMENT CONTRACTOR is responsible for:
• Complaint investigation;
• Incident review;
• Mortality review;
• Quality on-site provider reviews; and
• Provider training and technical assistance.

ACTUARIAL CONTRACTOR is responsible for
• Completing cost neutrality calculations for the waiver

• Budget planning and forecasting,
• Waiver development
• Developing and assessing rate methodology for home and community based services
• Cost surveys and calculates rate adjustments

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

NCI-AD SURVEY CONTRACTOR is responsible for:
• National Core Indicators Aging and Disabilities (NCI-AD) surveys

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

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

○ **Not applicable**

◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

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

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

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

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

Area Agencies on Aging (AAA) in their role as Indiana's designated Aging and Disability Resource Centers (ADRCs) are responsible for preparing a written service plan for each individual waiver participant. The service plan will contain all funded services, including medical and other services (regardless of funding source) to be furnished. The service plans will display the service frequency, and the type of provider/community resource who will furnish each service, with person centered goals and preferences from the individual. The service plan will be subject to the approval of the Bureau of Disability Services (BDS) and/or the Office of Medicaid Policy and Planning (OMPP). Federal Financial Participation (FFP) will not be claimed for waiver services furnished prior to the development of the service plan. FFP will not be claimed for waiver services which are not included in the individual written service plan.

Each of the AAAs are responsible for disseminating information regarding the waiver to potential enrollees, assisting individuals in the waiver enrollment application process, referring individuals to the Level of Care Assessment Representative (LCAR) contractor for nursing facility level of care evaluation activities, assisting in the recruitment of providers to perform waiver services, and conducting training and technical assistance concerning waiver requirements

Independent care managers are also responsible for preparing a written service plan for each individual waiver participant. The service plan will contain all funded services, including medical and other services (regardless of funding source) to be furnished. The service plans will display the service frequency, and the type of provider/community resources who will furnish each service, with the person centered goals and preferences from the individual. The service plan will be subject to the approval of the BDS and/or OMPP. Federal Financial Participation (FFP) will not be claimed for waiver services furnished prior to the development of the service plan. FFP will not be claimed for waiver services which are not included in the individual written service plan.

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

Assessment of Performance of AREA AGENCIES ON AGING/AGING AND DISABILITY RESOURCE CENTERS
The Division of Aging, in collaboration with the Bureau of Disabilities Services (BDS) monitors the AAAs and non-AAA care management entities through the electronic care management system, monthly communication with AAAs to verify compliance with performance and on site follow up through quality assurance surveys using the Provider Compliance Tool and the Person-Centered Monitoring Tool (PCMT).

Assessment of Performance of FISCAL AGENT
OMPP is responsible for assessing the performance of the Medicaid Fiscal Agent.

Assessment of Performance of UTILIZATION MANAGEMENT CONTRACTOR
The oversight of the performance of the Fraud and Abuse Detection System (FADS) contract is performed by Program Integrity.

Assessment of Performance of QUALITY ASSURANCE/QUALITY IMPROVEMENT CONTRACTOR
The BDS conducts monitoring and oversight of the Quality Assurance/Quality Improvement contractor.

Assessment of Performance of ACTUARIAL CONTRACTOR
The OMPP has oversight responsibility of the Actuarial contractor.

Assessment and Performance of LEVEL OF CARE ASSESSMENT REPRESENTATIVE (LCAR) CONTRACTOR

The FSSA Division of Aging in collaboration with DDRS/BDS has oversight responsibility of the LCAR Contractor.

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

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Assessment Methods and Frequency for AREA AGENCIES ON AGING/AGING AND DISABILITY RESOURCE CENTERS

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

Assessment Methods and Frequency for FISCAL AGENT

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

Assessment Methods and Frequency for UTILIZATION MANAGEMENT CONTRACTOR

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

During 2011, the State of Indiana formed the Benefit Integrity Team comprised of both state and contract staff. This team meets biweekly to review and approve audit plans, provider communications and make policy recommendations to affected program areas. FSSA Compliances oversees the contractor's aggregate data to identify common problems, determine benchmarks, and offer data to providers to compare against aggregate data.

Final review and approval of all audits and audit-related functions falls to FSSA Program Integrity. The direction of the FADS process is a fluid process, allowing for modification and adjustment in an on-going basis to ensure appropriate focus.

Assessment Methods and Frequency for QUALITY ASSURANCE/QUALITY IMPROVEMENT CONTRACTOR

The majority of primary functions of BDS are completed by a Quality Assurance/Quality Improvement (QA/QI) contractor. Specifically, the QA/QI contractor is responsible for incident review, mortality review, complaint investigation, quality on-site provider reviews, and provider training and technical assistance.

A BDS executive staff position monitors this contract using a combination of compliance and quality assurance methods to ensure that contractors perform waiver operational and administrative functions in accordance with waiver requirements:

• A BDS executive staff member meets with the QA/QI contractor’s leadership on a bi-weekly basis to review and follow up on outstanding issues.
• BDS staff has weekly phone conferences with the QA/QI contractor’s mortality review staff and complaint staff to review and follow-up on specific cases and issues.
• On a quarterly basis the QA/QI contractor submits a report that includes data, data analysis, identification of trends, and recommendations for improvement on each of the contract activities. The report also contains performance indicators regarding the contract activities. BDS executive staff reviews these reports and follows up with the contractor when concerns are identified.

Ultimately, the goal of the BDS is to assure that the state is aware of and has taken appropriate actions to ensure the participant’s health, safety, and welfare. BDS executive staff oversees the QA/QI contractor’s interactions with others, as well as monitors that the contractor implements assigned tasks.

Assessment Methods and Frequency for ACTUARIAL CONTRACTOR

OMPP is responsible for monitoring the performance of the Actuarial Contractor. The contractor performs Medicaid enrollment and expenditure forecasts, by program, which aids in monitoring expenses and supports state budgeting. Forecasting is done on both a paid basis and service incurred basis. Trends are determined and vary by population as appropriate. Trends are developed taking into account historical Indiana Medicaid trends, State and National trends, trends used by the CMS Office of the Actuary, and future program changes. Final documentation from the actuarial contractor includes an executive summary, detailed results, and sources of data, methodologies, and assumptions. On an ongoing basis, OMPP ensures the contractor complies with all requirements, deliverables, and timelines as outlined in its contract. In the event of contract non-compliance or performance deficiency, corrective action is pursued in accordance with contract terms.

The actuarial contractor is also under contract to develop and assess rate methodology for HCBS. Rate methodology for TBI services is assessed and reviewed every five years at renewal. The actuarial contractor completes the cost surveys and calculates rate adjustments. The OMPP reviews and approves the fee schedule to ensure consistency, efficiency, economy, quality of care, and sufficient access to providers for TBI services.

The Actuarial Contract is not a performance based contract.

Assessment Methods and Frequency for LEVEL OF CARE ASSESSMENT REPRESENTATIVE (LCAR) CONTRACTOR

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

Assessment Methods and Frequency for NCI-AD SURVEY CONTRACTOR

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

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☒	☐	☒

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Waiver enrollment managed against approved limits	☒	☐	☐
Waiver expenditures managed against approved levels	☒	☐	☐
Level of care evaluation	☒	☒	☐
Review of Participant service plans	☒	☐	☒
Prior authorization of waiver services	☒	☐	☐
Utilization management	☒	☒	☐
Qualified provider enrollment	☒	☒	☐
Execution of Medicaid provider agreements	☒	☐	☐
Establishment of a statewide rate methodology	☒	☐	☐
Rules, policies, procedures and information development governing the waiver program	☒	☐	☐
Quality assurance and quality improvement activities	☒	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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

Performance Measure:
A.1 Number and percent of waiver policies developed by DDRS that were approved by OMPP prior to implementation. Numerator: Number of waiver policies developed by DDRS that were approved by OMPP prior to implementation. Denominator: Total number of waiver policies implemented.

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
A.2 Number and percent of quarterly waiver performance measure data reports submitted to the OMPP by DDRS within the required time period. Numerator: Number of quarterly waiver performance measure data reports submitted within the required time period. Denominator: Total number of quarterly waiver performance measure data reports due.

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
A.3 Number and percent of providers assigned a Medicaid provider number according to the required timeframe specified in the contract with the fiscal agent. Numerator: Number of providers assigned a Medicaid provider number by the fiscal agent according to the required timeframe specified in the contract. Denominator: Total number of providers assigned a Medicaid provider number.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(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: Fiscal Agent	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

FSSA meets at least monthly to review and aggregate data, respond to questions, identify areas of concern, and resolve issues to ensure the successful implementation of the waiver program. FSSA divisions also participate in all conference calls with CMS pertaining to the waiver.

FSSA's divisions work to ensure that problems are addressed and corrected. FSSA's divisions participate in the data aggregation and analysis of individual performance measures throughout the waiver application. Between scheduled meetings, problems are regularly addressed through written and/or verbal communications to ensure timely remediation. FSSA discusses the circumstances surrounding an issue or event and what remediation actions should be taken.

In some cases, informal actions, such as obtaining an explanation of the circumstances surrounding the event, or verification that remediation actions have been taken, may be sufficient to deem the problem resolved. In other situations, more formal actions may be taken. This may consist of elevating the issue for a cross-division executive level discussion and remediation.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR Â§441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☒ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☒	**Brain Injury**	0		☒
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

b. Additional Criteria. The state further specifies its target group(s) as follows:

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

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

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to

individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

    Specify the percentage: [ ]

  - ( ) **Other**

    Specify:

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ( ) **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	200
Year 2	200
Year 3	200
Year 4	200
Year 5	200

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Applicants will enter the waiver on the following basis:

1. Eligible individuals transitioning off 100% state funded budgets to the waiver, transitioning from nursing facilities to the waiver, or discharging from in-patient hospital settings to the waiver, by date of application; followed by

2. Other eligible individuals applying to the waiver on a first-come-first serve basis by date of application.

Individuals being served under any other 1915(c) home and community-based services waiver shall not be concurrently served under the Traumatic Brain Injury Waiver.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

- (●) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

- ( ) **No**
- (●) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional state supplement recipients**
- [x] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

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

Specify percentage: [ ]

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

42 CFR 435.110 - Parents and Other Caretaker Relatives
42 CFR 435.118 - Infants and children under age 19
42 CFR 435.145 - Children for whom Adoption Assistance or foster care maintenance payments are made (under Title IV-E of the Act)
42 CFR 435.150 Former Foster Care children
42 CFR 435.226 Independent Foster Care Adolescents
42 CFR 435.227 Individuals under age 21 who are under State adoption assistance agreements
Sec 1925 of the Act --Transitional Medical Assistance

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

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

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

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

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility

applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

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

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

◉ **The following standard included under the state plan**

Select one:

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
◉ **The special income level for institutionalized persons**

(*select one*):

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

Specify the percentage:

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the state Plan**

Specify:

○ **The following dollar amount**

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

○ **The following formula is used to determine the needs allowance:**

Specify:

○ **Other**

Specify:

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

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

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

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

○ **The amount is determined using the following formula:**

Specify:

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

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

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

- ○ **The amount is determined using the following formula:**

  Specify:

- ○ **Other**

  Specify:

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

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

Select one:

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

  Specify:

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ◉ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:
- ○ **The following dollar amount:**

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

  Specify formula:
- ○ **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

- ( ) **Other**

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

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

a. A registered nurse with one year’s experience in human services; or

b. A bachelor’s degree in health, social work, or related field; or

c. An associate’s degree in nursing; or

d. A master’s degree in any field; and

e. Cleared by background checks to ensure the individual applicant does not have a criminal background.

Individuals performing intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care must be a Qualified Intellectual Disabilities Professionals (QIDP) as specified by the standard within 42 CFR 483.430(a).

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

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

A person is functionally eligible for the TBI waiver if the need for medical or nursing supervision and attention is determined by any of the following findings from the functional screening:

- Need for direct assistance at least 5 days per week due to unstable, complex medical conditions.
- Need for direct assistance for 3 or more substantial medical conditions including activities of daily living.

All applicants to the TBI Waiver are first screened for nursing facility (NF) level of care to evaluate and reevaluate whether an individual needs services through the waiver. Any individuals identified to have suffered the brain injury prior to age 22 may meet intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care. Screening for ICF/IID level of care will then be completed for these individuals using the LOC Screening Instrument.

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

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

Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID) Level of Care (LOC)
Any individuals identified to have suffered the brain injury prior to age 22 may meet ICF/IID level of care, which is assessed using the Level of Care Screening Instrument. To complete an ICF/IID waiver level of care determination, a BDS service coordinator (initial evaluations and re-evaluations) or the provider of Care Management (re-evaluations) must obtain and review the following:
1)Psychological records including I.Q. score;
2)Social assessment records;
3)Medical records;
4)Additional records necessary to have a current and valid reflection of the individual; and
5)A completed 450B Confirmation of Diagnosis form, signed and dated by a physician within the past year.

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

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

The basic conditions are:
1) an impairment/confirmed diagnosis of intellectual disability*, cerebral palsy, epilepsy, autism, or condition similar to intellectual disability*,
2) the impairment/basic condition identified in #1 is expected to continue without a foreseeable end,
3) the impairment/basic condition identified in #1 had an age of onset prior to age 22, and
4) the impairment/basic condition results in at least three of six substantial functional limitations.

The substantial functional limitation categories, as defined in 42 CFR 435.1010, are:
1) self-care,
2) learning,

3) self-direction,
4) capacity for independent living,
5) receptive and expressive language, and
6) mobility.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

All applicants to the TBI Waiver are first screened for nursing facility (NF) level of care. Any individuals identified to have suffered the brain injury prior to age 22 may meet intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care. Screening for ICF/IID level of care will then be completed for these individuals. Waiver participants must meet the minimal level of care (LOC) requirements for that of a nursing facility (NF) or Intermediate care facility for individuals with intellectual disability (ICF/IID) and have a diagnosis of Traumatic Brain Injury.

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

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

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

Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID) Level of Care (LOC)
Any individuals identified to have suffered the brain injury prior to age 22 may meet ICF/IID level of care, which is assessed using the Level of Care Screening Tool. All initial ICF/IID LOC evaluations and subsequent re-evaluations under this waiver are performed by a BDS service coordinator.

The final functional Level of Care determination is documented in the appropriate web-based platform.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ( ) **Every three months**
- ( ) **Every six months**

○ **Every twelve months**

◉ **Other schedule**

Specify the other schedule:

Every twelve months or more often as needed.

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**

○ **The qualifications are different.**

Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

Nursing Facility Level of Care (NFLOC)

The web-based assessment platform maintained by the Level of Care Assessment Representative (LCAR) contractor generates a report at least ninety (90) calendar days prior to the annual level of care (LOC) reevaluation to advise the LCAR assessor that reviews are due.

Notifying the LCAR assessors at least ninety (90) days prior to the annual LOC reevaluation due date will assist the LCAR assessors in returning the annual LOC reevaluation within the required timeframe. If the reevaluation is not completed in a timely manner, the DA will remediate the issue as outlined within the LCAR contract.

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

The web-based platform maintained by BDS generates a report at least ninety (90) calendar days prior to the annual ICF/IID level of care (LOC) reevaluation to advise the BDS service coordinator that reviews are due.

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

The evaluation and reevaluation documentation is maintained for a minimum of three years within the electronic database maintained by the LCAR contractor (for NF LOC) or DDRS/BDS (for ICF/IID LOC).

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a

hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

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

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

Performance Measure:
B.1 Number and percent of all applicants who received a Level of Care (LOC) evaluation prior to waiver enrollment. Numerator: Number of all applicants who received an LOC evaluation prior to waiver enrollment. Denominator: Total number of all applicants.

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

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

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Case Management Database System

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to

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

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Case Management Database System

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

Data Aggregation and Analysis:

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

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

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

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

LCAR Contractor		
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Case Management Database System

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

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

If the FSSA, or any other entity, identifies any instance of a new applicant not having received a level of care evaluation prior to enrollment the FSSA will ascertain any related claims had been made and deny these. The LCAR contractor or BDS service coordinator will be required to immediately conduct a proper evaluation and enter this into the electronic system. If it is identified that the applicant does not meet the LOC criteria the care manager is required to explore other community or public funded services that may be available to the individual. All LOC decisions are subject to the applicant's rights to appeal and have a Medicaid Fair Hearing.

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

If redetermination reveals that the individual does not meet one of the approved LOC categories, any claims submitted will be denied back to the date of expiration of the prior LOC period. The care manager will be advised to refer the individual for any other services which may be available, and the individual will be informed in writing that they have the right to request a formal Appeal and are entitled to a Medicaid Fair Hearing to dispute any LOC determination decision.

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

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The care manager is responsible for explaining the waiver services available to the individual requesting services. If the individual is eligible for the waiver, the care manager will work with the individual to complete a service plan. On the service plan there is a section regarding freedom of choice. The freedom of choice language is as follows and is required to be signed by the individual.

"A Medicaid Waiver Services care manager has explained the array of services available to meet my needs through the Medicaid Home and Community-Based Services Waiver. I have been fully informed of the services to choose between waiver services in a home and community-based setting or institutional care. As long as I remain eligible for waiver services, I will continue to have the opportunity to choose between waiver services in a home and community-based setting or institutional care."

A service plan is used for participants who choose waiver services. Once a qualifying individual is offered a waiver slot, is Medicaid eligible, and has met level of care approval, a service plan is developed. The service plan is used for waiver participants at the time of initial determinations, updates, and annual re-determinations. Although a signature page form documenting freedom of choice is obtained with each service plan update, a statement regarding freedom of choice is also contained in the service plan. The waiver participant/guardian signs and dates this section of the service plan indicating his/her choice of waiver services or institutional services. The care manager is responsible for explaining the array of services available in an institutional setting.

If a current waiver participant wants to transfer to the Hoosier Care Connect program (the state’s Risk-Based Managed Care program) (if eligible), the care manager is responsible for explaining eligibility under 42 CFR 435.217 (Medicaid eligible if receiving home and community-based waiver services) and the impact the selection of the Hoosier Care Connect program could have on the individual’s eligibility. The care manager may also explain the array of services available under the HCBS waiver program and under the Hoosier Care Connect program.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Forms will be maintained by the care management entity and within the electronic case management database maintained by the Division of Aging.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

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

The Bureau of Disabilities Services (BDS), a bureau within DDRS, can assist with referrals for sign language interpreters toward the effective communication with applicants or participants, when interpreter services are not already included on the service plan of the individual. BDS staff members utilize locally available interpreters associated with community or neighborhood organizations and church groups for interpretation of non-English languages. Some metropolitan communities within Indiana offer access to interpreters of varying languages through local colleges, universities or libraries.

The State of Indiana offers a variety of links for potential translation opportunities at https://www.in.gov/health/minority-health/minority-health-resources/language-translation-and-migrant-programs/, a webpage titled Language, Translation, & Migrant Programs.

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

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

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	**Adult Day Services**		
Statutory Service	**Attendant Care**		
Statutory Service	**Care Management**		
Statutory Service	**Home and Community Assistance**		
Statutory Service	**Residential Based Habilitation**		
Statutory Service	**Skilled Respite**		
Statutory Service	**Structured Day Program**		
Statutory Service	**Supported Employment**		
Other Service	**Adult Family Care**		
Other Service	**Assisted Living**		
Other Service	**Behavior Management/ Behavior Program and Counseling**		
Other Service	**Community Transition**		
Other Service	**Home Delivered Meals**		
Other Service	**Home Modification Assessment**		
Other Service	**Home Modifications**		
Other Service	**Integrated Health Care Coordination**		
Other Service	**Nutritional Supplements**		
Other Service	**Personal Emergency Response System**		
Other Service	**Pest Control**		
Other Service	**Specialized Medical Equipment and Supplies**		

Service Type	Service		
Other Service	Structured Family Caregiving		
Other Service	Transportation		
Other Service	Vehicle Modifications		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04050 adult day health
Category 2:	**Sub-Category 2:**
04 Day Services	04060 adult day services (social model)
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Adult Day Service (ADS) are community-based group programs designed to meet the needs of individuals who need structured, social integration through a comprehensive and non-residential program. The service plan will identify the need through the person-centered planning process and evident through the assessment tool. The purpose for ADS is to provide health, social, recreational, supervision, support services, and personal care. Meals, specifically, and as appropriate, breakfast, lunch, and nutritious snacks are required.

Participants attend Adult Day Services on a planned basis. The three levels of Adult Day Services are Basic, Enhanced, and Intensive.

ALLOWABLE ACTIVITIES
BASIC ADULT DAY SERVICES (Level 1) includes:
•Monitor all activities of daily living (ADLs) defined as dressing, bathing, grooming, eating, walking, and toileting with hands-on assistance provided as needed
•Comprehensive, therapeutic activities for those with cognitive impairment in a safe environment
•Initial Health assessment conducted by RN consultant prior to beginning services at the adult day, and intermittent monitoring of health status
•Monitor medication or medication administration
•Minimum staff ratio: One staff for each eight individuals
•RN Consultant available

ENHANCED ADULT DAY SERVICES (Level 2) includes: Level 1 service requirements must be met. Additional services include:
•Hands-on assistance with two or more ADLs or hands-on assistance with bathing or other personal care
•Initial health assessment conducted by RN consultant prior to beginning services as well as regular monitoring or intervention with health status
•Medication assistance
•Psychosocial needs assessed and addressed, including counseling as needed for individuals and caregivers
•Therapeutic structure and intervention for participants with mild to moderate cognitive impairments in a safe environment
•Minimum staff ratio: One staff for each six individuals
•RN Consultant available
•Minimum of one full-time LPN staff person with monthly RN supervision

INTENSIVE ADULT DAY SERVICES (Level 3) includes: Level 1 and Level 2 service requirements must be met. Additional services include:
•Hands-on assistance or monitoring with all ADLs and personal care
•One or more direct health intervention(s) required
•Rehabilitation and restorative services, including physical therapy, speech therapy, and occupational therapy coordinated or available
•Therapeutic intervention to address dynamic psychosocial needs such as depression or family issues affecting care
•Therapeutic interventions for those with moderate to severe cognitive impairments
•Minimum staff ratio: One staff for each four individuals
•RN Consultant available
•Minimum of one full-time LPN staff person with monthly RN supervision
•Minimum of one qualified full-time staff person to address participants' psycho-social needs

DOCUMENTATION STANDARDS Care Managers:
•Justification for the service is documented
The documented need for the service is to describe, but not limited to the following: Describe the structure needed for the participant (medical, social, recreational) Types of ADL care the participant may require and level of assistance needed
•Level of service is determined in the person-centered planning process, which is given to provider

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

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

Adult Day Services are allowed for a maximum of ten (10) hours per day.

ACTIVITIES NOT ALLOWED:

Services to participants receiving Assisted Living waiver service.

This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual) as outlined in C-2-d and C-2-e of this waiver.

NOTE: Therapies provided through this service will not duplicate therapies provided under any other service.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/ OMPP approved Adult Day Service Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Services

Provider Category:

Agency

Provider Type:

FSSA/ OMPP approved Adult Day Service Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must comply with the Adult Day Services Provision and Certification Standards, as follows:

OMPP approved
455 IAC 2 Provider Qualifications: Becoming an approved provider; maintaining approval
455 IAC 2 Provider Qualifications: General requirements
455 IAC 2 Provider Qualifications: General requirements for direct care staff
455 IAC 2 Procedures for Protecting Individuals
455 IAC 2 Unusual occurrence; reporting
455 IAC 2 Transfer of individual's record upon change of provider
455 IAC 2 Notice of termination of services
455 IAC 2 Provider organizational chart
455 IAC 2 Collaboration and quality control
455 IAC 2 Data collection and reporting standards
455 IAC 2 Quality assurance and quality improvement system
455 IAC 2 Financial information
455 IAC 2 Liability insurance
455 IAC 2 Maintenance of personnel records
455 IAC 2 Adoption of personnel policies
455 IAC 2 Operations manual
455 IAC 2 Maintenance of records of services provided
455 IAC 2 Individual's personal file; site of service delivery

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Attendant Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Attendant Care services (ATTC) are provided to participants with nursing facility level of care needs. ATTC provides direct, hands-on care to participants for the functional needs with Activities of Daily Living (ADLs). ATTC is provided to participants with either nursing facility or ICF/IID level of care needs.

ALLOWABLE ACTIVITIES
All non-skilled ADL care as identified in the person-centered service plan that includes the following:

Provides assistance with personal care, which includes:
•Bathing, partial bathing
•Oral hygiene
•Hair care including clipping of hair
•Shaving
•Hand and foot care
•Intact skin care
•Application of cosmetics
•Dressing

Provides assistance with mobility, which includes:
•Proper body mechanics
•Transfers (including lifting with mechanical assistance with appropriate training)
•Ambulation
•Use of assistive devices

Provides assistance with elimination, which includes:
•Assists with bedpan, bedside commode, toilet
•Incontinent or involuntary care
•Emptying urine collection and colostomy bags

Provides assistance with nutrition, which includes:
•Meal planning, preparation, clean-up

Provides assistance with safety, which includes:
•Use of the principles of health and safety in relation to self and individual
•Identify and eliminate safety hazards
•Practice health protection and cleanliness by appropriate techniques of hand washing
•Waste disposal, and household tasks
•Reminds individual to self-administer medications
•Provides assistance with correspondence and bill paying
•Transportation of individuals to community activities. Out of State transportation is limited to 50 miles of State geographic limits. Escorting does not include costs that are not associated with the provision of personal care, for example mileage.

SERVICE STANDARDS
ATTC may be provided from the following:
*Agency—an agency enrolled in the program is responsible to hire and render services

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

a) add Home and Community Assistance and eliminate Attendant Care Services or
b) reduce attendant care hours and replace with the appropriate number of hours of Home and Community Assistance services

DOCUMENTATION STANDARDS
Care Managers:

*Responsible to document the need for ATTC and types of ADL support the participant may require.
*Responsible to document the type of ATTC determined to meet the needs of the individual or caregiver through the person-centered planning process
*Document the ATTC activity that will meet the participant's needs and assure it is accurately documented in the level of care assessment tool
*If the participant has a skilled LOC, the care manager must document how the skilled need is being met and by whom. If ATTC is being requested for an individual with skilled care, the documentation must describe who will be providing ATTC, the frequency of care and activities being performed.

•ATTC Providers:
In addition to Electronic Visit Verification, providers will record services provided, including:
-complete date and time of service (in and out)
-specific services/tasks provided
-signature of participant verifying the service was provided by agency
-signature of employee providing the service (minimally the last name and first initial) If the person providing the service is required to be a professional, the title must also be included
•Each staff member providing direct care or supervision of care to the participant must make at least one entry on each day of service.
•Documentation of service delivery is to be signed by the participant or designated participant representative.

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

When provided by a Legal Guardian, Attendant Care Services are limited to a maximum of forty (40) hours per week.

ACTIVITIES NOT ALLOWED

Services provided for a participant regarding specialized feeding, (such as difficulty swallowing, refuses to eat, or does not eat enough), unless permitted under law and not duplication of State Plan services.

•ATTC services will not be reimbursed to a provider for a participant requiring management of uncontrolled seizures, infusion therapy; venipuncture; injection; wound care for, decubitus, incision; ostomy care; and tube feedings must be considered for skilled respite services unless permitted under law and not duplication of State Plan services.

The ATTC will not be a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician, or other health professional.

ATTC will not set up and administer medications. ATTC may not assist with catheter and ostomy care,
•Attendant Care services will not be provided to household members other than to the participant.
•This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual) as outlined in C-2-d and C-2-e of this waiver.
•Attendant Care services to participants receiving Adult Family Care waiver service, Assisted Living waiver service, or Structured Family Caregiving waiver service.

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

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☒ **Relative**
☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	FSSA/OMPP approved Attendant Care Individual
Agency	Licensed Personal Services Agency
Agency	Licensed Home Health Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Attendant Care

Provider Category:

Individual

Provider Type:

FSSA/OMPP approved Attendant Care Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved
455 IAC 2 Provider Qualifications; General requirements
455 IAC 2 General requirements for direct care staff
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements
455 IAC 2 Personnel Records

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Attendant Care

Provider Category:

Agency

Provider Type:

Licensed Personal Services Agency

Provider Qualifications

License *(specify):*

IC 16-27-4

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Attendant Care

Provider Category:

Agency

Provider Type:

Licensed Home Health Agency

Provider Qualifications

License *(specify):*

IC 16-27-1
IC 16-27-4

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Care Management

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

ALLOWABLE ACTIVITIES
• The care manager is responsible for referring individuals to the Level of Care Assessment Representative (LCAR) contractor for nursing facility level of care evaluation activities.

• Person Centered Planning. This activity includes but is not limited to discovering the individual's strengths, needs, goals, and preferences. The care manager will appropriately facilitate use of person-centered discovery tools and practice to engage the individual and their circle of support. The planning phase can include but is not limited to, brokering community resources, and action and/or service planning.

• Development and implementation of a Person-Centered Support Plan, including action and/or service plans. Action Planning is a process to determine community resources to meet the individual's functional and social needs. Service Planning is a process to determine funded services to appropriately meet the individual's needs.

Additionally, care managers 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 participant, guardian and/or family, a paper/hard copy of the IHCP DDRS HCBS Module will be provided by the care manager.

• Monitoring and evaluating all action and/or service plans.
Care managers are responsible to monitor progress for all services displayed on the action and/or service plans.

The care manager will provide and coordinate high quality services to the individual, while promoting seamless, integrated, coordinated care.

Monitoring person centered support plans will be completed by the care manager in a face to face contact every 90 days from the initial service plan activation. When the initial care plan is activated, the care manager will either call or visit the individual within 30 days and no more than 40 days from initial service plan activation to ensure implementation of services.

When incidents are reported, the care 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.

Care managers are responsible for notifying families/guardians of incidents reported and sharing results of the provider's investigation.

The care manager is responsible to complete annual service planning.

The care manager is responsible to coordinate changes in the service plan that include but are not limited to notifying all providers about the change and when they are to begin or end services, notifying all providers when a care plan is in a terminated or re-start status.

The care manager will be responsible to evaluate the effectiveness of all services. Evaluation is demonstrated through but not limited to:
• Monitoring the progress from identifying need to meeting goals/preferences identified by the individual.
• Direct collaboration and coordination with providers to ensure services are within the individual's preferences
• Adjusting action and service plans appropriately to identify changing needs that meet the participant's needs

•Termination of plans
The care manager will follow the Medicaid Nursing Facility level of Care Home and Community-Based Services Waivers termination procedures when an individual is no longer to receive services under the waiver program. This includes providing a thirty (30) day notice to any individual the care manager is terminating.

SERVICE STANDARDS

• Care Management Services must be reflected in the service plan of the individual.
• Care managers enhance the individual's functional and social well-being.
• Care managers broker community resources that align with the individual's unique needs.
• Care managers will engage the individual and their circle of support in all aspects of the care management process and tailor the person-centered support plan to the individual's needs, preferences, goals, and strengths.
• Care manager is expected to coordinate and collaborate with other care managers, other organizations, community partners, and BDS staff to ensure quality care management is being delivered and options are being discovered and presented to the individual to optimize their overall functioning capability.
• Care manager maximum Medicaid Waiver caseload is not to exceed 65 individuals at any time.
• Care managers are responsible for identifying when a participant is residing in a provider owned or controlled setting, monitoring HCBS characteristics, monitoring person centered modifications to HCBS characteristics, and documenting in the PCMT as such.

DOCUMENTATION STANDARDS

Person Centered Planning. This activity includes but is not limited to discovering the individual's strengths, needs, goals, and preferences. The care manager will appropriately facilitate the planning process to engage the individual and his/her circle of support. The planning phase can include but is not limited to, brokering community resources, action and/or service planning, and eligibility for funded services. To meet the HCBS Settings Rule, Care Managers must support the person to lead and direct their planning process as much as possible, and to the extent the person wants. The circle of support must include people the participant wishes to include.

Development and implementation of a Person-Centered Support Plan, including action and/or service plans. Action Planning is a process to determine community resources to meet the individual's functional and social needs. Service Planning is a process to determine funded services to appropriately meet the individual's needs.

Monitoring and evaluating all action and/or service plans.

Care managers are responsible to monitor progress for all services displayed on the action and/or service plans.

The care manager will provide and coordinate high quality services to the individual, while promoting seamless, integrated, coordinated care.

Monitoring person centered support plans will be completed by the care manager in a face to face contact every 90 days from the initial service plan activation. When the initial care plan is activated, the care manager will either call or visit the individual within 30 days and no more than 40 days from initial service plan activation to ensure implementation of services.

The care manager is responsible to complete annual service planning.

The care manager is responsible to complete all assessment tools including but not limited to incident reports timely.

The care manager will be responsible to evaluate the effectiveness of all services. Evaluation is demonstrated through but is not limited to:
1.Monitoring the progress from identified need to meeting goals/preferences identified by the individual.
2.Direct collaboration and coordination with providers to ensure services are within the individual's preferences
3.Adjusting action and service plans appropriately to identify changing needs that meet the individual's needs

Termination of plans:
The care manager will follow the Medicaid Nursing Facility level of Care Home and Community-Based Services Waivers termination Procedures when an individual is no longer to receive services under the waiver program.

Assistance with Transition to New Care Manager
It is the responsibility of the care manager to assure the individual fully understands their ability to make choices concerning all services they receive. This includes care management services. In the event the individual chooses another care manager agency the current care management agency is to fully assist the individual in their transition,

to the new agency or individual care manager of choice. The goal is to assure a seamless transition for the individual.

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

ACTIVITIES NOT ALLOWED
•Care management may not be conducted by any organization, entity, or participant that also delivers other in-home and community-based services, or by any organization, entity, or participant related by common ownership or control to any other organization, entity, or participant who also delivers other in-home and Community-based services, unless the organization is an AAA that has been granted permission by BDS (or formerly the FSSA's DA) to provide direct services to participants.

Prior to billing, a care manager must have completed the care management curriculum to become a Medicaid certified care manager.

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

•Independent care managers and independent care management companies may not provide initial applications for Medicaid Waiver services.

•Reimbursement of care management under Medicaid Waivers may not be made unless and until the participant becomes eligible for Medicaid Waiver services. Care management provided to participants who are not eligible for Medicaid Waiver services will not be reimbursed as a Medicaid Waiver service.

•This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual) as outlined in C-2-d and C-2-e of this waiver.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/OMPP approved Care Management Agency
Individual	FSSA/ OMPP approved Care Management Individual

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Care Management

Provider Category:

Agency

Provider Type:

FSSA/OMPP approved Care Management Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OMPP, or its designee, approved
455 IAC 2 Provider Qualifications General requirements
455 IAC 2 Procedures for protecting individuals
455 IAC 2 Unusual occurrence; reporting
455 IAC 2 Transfer of individual's record upon change of provider
455 IAC 2 Notice of termination of services
455 IAC 2 Provider organizational chart
455 IAC 2 Collaboration and quality control
455 IAC 2 Data collection and reporting standards
455 IAC 2 Quality assurance and quality improvement system
455 IAC 2 Financial information
455 IAC 2 Liability insurance
455 IAC 2 Documentation of qualifications
455 IAC 2 Maintenance of personnel records
455 IAC 2 Adoption of personnel policies
455 IAC 2 Operations manual
455 IAC 2 Maintenance of records of services provided
455 IAC 2 Individual's personal file; site of service delivery
455 IAC 2 Care Management

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Care Management

Provider Category:

Individual

Provider Type:

FSSA/ OMPP approved Care Management Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OMPP, or its designee, approved

455 IAC 2 Documentation of qualifications
455 IAC 2 Case Management Liability Insurance

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

Home and Community Assistance

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08050 homemaker
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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

ALLOWABLE ACTIVITIES:
Provides IADL care that may include to the following:
*dusting and straightening furniture
•cleaning floors and rugs by wet or dry mop and vacuum sweeping
•cleaning the kitchen, including washing dishes, pots, and pans; cleaning the outside of appliances and counters and cupboards; cleaning ovens and defrosting and cleaning refrigerators
•maintaining a clean bathroom, including cleaning the tub, shower, sink, toilet bowl, and medicine cabinet; emptying and cleaning commode chair or urinal
•laundering clothes in the home or laundromat, including washing, drying, folding, putting away, ironing, and basic mending and repair
•changing linen and making beds
•washing insides of windows
•removing trash from the home
•assistance with outdoor tasks including raking leaves, snow removal, lawn mowing, weeding,
*Provides assistance with meal planning and preparation, including special diets under the supervision of a registered dietitian or health professional
*Completing essential errands and/or unassisted transportation for non-medical, community activities,
*Provides assistance with correspondence and bill paying
*Minor pet care may be allowed at the discretion of the agency

SERVICE STANDARDS
•Care Manager Standards:
•Care manager will document through the person-centered planning process the need for Home and Community Assistance, the frequency of need, the required type of Home and Community Assistance activities.

DOCUMENTATION STANDARDS
Care Manager Documentation Standards:
•Care manager will document through the person-centered planning process the need for Home and Community Assistance, the frequency of need, the required type of Home and Community and Assistance activities.

Home and Community Assistance Providers:
•Data record of services provided, including:
-complete date and time of service (in and out)
-specific services/tasks provided
-For errands such as utilizing a laundromat due to there not being a washer or dryer in the participant' home, then the time spent traveling and completing the errand shall be recorded as well as the specific tasks and necessity of the task being completed.
-If Home and Community Assistance services take place outside the participant's home (such as errands being required due to no washer/dryer in home, or travel for other allowable tasks) travel expenses beyond the time spent on the errand are the responsibility of the agency providing Home and Community Assistance services
-signature of employee providing the service (minimally the last name and first initial). If the person providing the service is required to be a professional, then that title must also be included.
•Each staff member providing direct care or supervision of care to the participant must make at least one entry on each day of service. All entries should describe an issue or circumstance concerning the participant.
•Documentation of service delivery is to be signed by the participant or designated participant representative.

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

ACTIVITIES NOT ALLOWED
•Assistance with ADL hands on care. Specifically, Home and Community Assistance may not provide any ADL assistance such as eating, bathing, dressing, personal hygiene, medication set up and administration. Hands on and/or assisted transportation of participants to community activities or errands
•Home and Community Assistance services provided to household members other than to the participant.
•This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual) as outlined in C-2-d and C-2-e of this waiver.
•Services to participants receiving Adult Family Care waiver service, Assisted Living waiver service, or Structured Family Caregiving waiver service.

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

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☒ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Home Health Agency
Agency	Licensed Personal Services Agency
Individual	FSSA/OMPP approved Home and Community Assistance Individual

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Home and Community Assistance

Provider Category:

Agency

Provider Type:

Licensed Home Health Agency

Provider Qualifications

License *(specify):*

IC 16-27-1
IC 16-27-4

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Home and Community Assistance

Provider Category:

Agency

Provider Type:

Licensed Personal Services Agency

Provider Qualifications

License *(specify):*

IC 16-27-4

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Home and Community Assistance

Provider Category:

Individual

Provider Type:

FSSA/OMPP approved Home and Community Assistance Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved
455 IAC 2 Provider qualifications: becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: general requirements
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements
455 IAC 2 Personnel Records

Compliance with IC 16-27-4, if applicable.

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Residential Based Habilitation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02031 in-home residential habilitation
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

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

ALLOWABLE ACTIVITIES
Goal oriented training and demonstration with:
1.Skills related to activities of daily living:
•personal grooming;
•bed making and household chores; and
•planning meals, the preparation of food.
2.Skills related to living in the community:
•using the telephone
•learning to prepare lists and maintaining calendars of essential activities and dates, and other organizational activities to improve memory;
•handling money and paying bills;
•shopping and errands;
•accessing public transportation;

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

DOCUMENTATION STANDARDS
•Identified need in the service plan
•Services outlined in the service plan
•Data record of services provided, including:
-complete date and time of service (in and out)
-specific services/tasks provided -monthly documentation of progress toward identified goals
-signature of employee providing the service (minimally the last name and first initial) If the person providing the service is required to be a professional, the title of the individual must also be included.
•Each staff member providing direct care or supervision of care to the individual must make at least one entry on each day of service. All entries should describe an issue or circumstance concerning the individual.
•Documentation of service delivery is to be signed by the participant or designated participant representative.

As authorized under §3715 of the CARES Act, RHS services may be provided to an individual in an acute care hospital when such services are:

- Identified in an individual’s person-centered service plan (or comparable plan of care);
- Provided to meet needs of the individual that are not met through the provision of hospital services;
- Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and
- Designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual’s functional abilities.

The HCBS provided in an acute care hospital must not be duplicative of services available in the acute care hospital setting.

HCBS provided during an acute care hospitalization assists the individual to maintain current levels of functioning and support, provides ongoing coordination of care, assurance that new or additional needs are identified and addressed by the person-centered planning team as the individual prepares to return to the community.

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

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

ACTIVITIES NOT ALLOWED
•Payments for residential based habilitation are not made for room and board.
•This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual) as outlined in C-2-d and C-2-e of this waiver.
•Payments will not be made for the routine care and supervision.
•Residential Based Habilitation services to participants receiving Adult Family Care waiver service, or Structured Family Caregiving waiver service.

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

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/OMPP approved Residential Based Habilitation Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Based Habilitation

Provider Category:
Agency
Provider Type:

FSSA/OMPP approved Residential Based Habilitation Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved
455 IAC 2 Provider Qualifications; General requirements
455 IAC 2 General requirements for direct care staff
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements
455 IAC 2 Personnel Records

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Skilled Respite

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**
05 Nursing	05020 skilled nursing
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Skilled Respite services are those services that are provided temporarily or periodically in the place of the usual caregiver. Skilled Respite occurs in home and community based settings. Under this waiver service two forms of skilled respite are allowable:

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

SERVICE STANDARDS

The level of professional care provided under skilled respite services depends on the needs of the participant and caregiver determined in the person-centered planning process.

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

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

RNUR authorized hours will roll over month to month through the duration of the Annual Service Plan. If a request for an increase in RHHA during the annual care plan is needed the Care Manager must coordinate with the agency to verify unused hours before requesting the additional hours. If there are unused hours they must first be used before requesting additional hours.

DOCUMENTATION STANDARDS

Care Manager Documentation Standards:
*The care manager must identify the primary caregiver being relieved. The care manager needs to identify the primary caregiver is not being paid by the agency to skilled respite themselves during this time.
The care manager must document needs and activities that require skilled respite.

Provider Documentation Standards
•Data Record of staff to participant service documenting the complete date and time in and time out, and the number of units of service delivered that day.
•Each staff member providing direct care or supervision of care to the participant makes at least one entry on each day of service describing an issue or circumstance concerning the participant.
•Documentation should include date and time, and at least the last name and first initial of the staff person making the entry. If the person providing the service is required to be a professional, that title must also be included (example: if a nurse is required to perform the service, then the RN title would be included with the name).
•Any significant issues involving the participant requiring intervention by a health care professional, or care manager that involved the participant also needs to be documented. Specify applicable (if any) limits on the amount, frequency, or duration of this service.
•Documentation must include the following elements: the reason for the skilled respite and the type of skilled respite rendered.

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

ACTIVITIES NOT ALLOWED
•Skilled Respite may not be used to replace services that should be provided under the Medicaid State Plan.
•This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual) as outlined in C-2-d and C-2-e of this waiver.
•Skilled Respite must not duplicate any other service being provided under the participant's service plan.
•Skilled Respite service to participants receiving Adult Family Care waiver service, or Assisted Living waiver service.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Home Health Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Skilled Respite

Provider Category:

Agency

Provider Type:

Licensed Home Health Agency

Provider Qualifications

License *(specify):*

IC 16-27-1

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Structured Day Program

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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

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

DOCUMENTATION STANDARDS
•Identified need in the service plan
•Services outlined in the service plan
•Data record of services provided, including:
-complete date and time of service (in and out)
-specific services/tasks provided
-signature of employee providing the service (minimally the last name and first initial) If the person providing the service is required to be a professional, the title of the individual must also be included.
•Each staff member providing direct care or supervision of care to the individual must make at least one entry on each day of service. All entries should describe an issue or circumstance concerning the individual.

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

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

This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual) as outlined in C-2-d and C-2-e of this waiver.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/OMPP approved Structured Day Program Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Structured Day Program

Provider Category:

Agency

Provider Type:

FSSA/OMPP approved Structured Day Program Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved
455 IAC 2 Provider Qualifications; General requirements
455 IAC 2 General requirements for direct care staff
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements
455 IAC 2 Personnel Records

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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

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

DOCUMENTATION STANDARDS
•Identified need in the service plan
•Services outlined in the service plan
•Data record of services provided, including:
-complete date and time of service (in and out)
-specific services/tasks provided
-signature of employee providing the service (minimally the last name and first initial) If the person providing the service is required to be a professional, the title of the individual must also be included.
•Each staff member providing direct care or supervision of care to the individual must make at least one entry on each day of service. All entries should describe an issue or circumstance concerning the individual.

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

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

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

•This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual) as outlined in C-2-d and C-2-e of this waiver.

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

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☒ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Mental Health Center
Agency	FSSA/OMPP approved Supported Employment Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Community Mental Health Center

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved
455 IAC 2 Provider Qualifications; General requirements
455 IAC 2 General requirements for direct care staff
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements
455 IAC 2 Personnel Records
IC 12-7-2-38(1) Community Mental Health Center

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

FSSA/OMPP approved Supported Employment Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

CARF

Other Standard *(specify):*

OMPP approved
455 IAC 2 Provider Qualifications; General requirements
455 IAC 2 General requirements for direct care staff
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements
455 IAC 2 Personnel Records

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Family Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02023 shared living, other
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Adult Family Care (AFC) is a comprehensive service in which a participant resides with an unrelated caregiver. The participant and up to three (3) other participants who have physical and/or cognitive disabilities, and who are not members of the provider's or primary caregiver's family, and/or reside in a home that is owned, rented, or managed by the AFC provider.

SERVICE LEVELS

There are three service levels of adult family care each with a unique rate. The applicable rate is determined through completion of the Adult Family Care/Structured Family Care Level of Service Assessment (AFC/SFC LOS Assessment). Care Managers complete this assessment at least annually to accurately reflect the relative support need of the individual. The AFC/SFC LOS Score determines the reimbursement rate to be utilized in the participant's next service plan.

The breakdown is as follows:

• Level 1 – AFC/SFC LOS Assessment Score of 0 - 35.
• Level 2 – AFC/SFC LOS Assessment Score of 36 - 60.
• Level 3 – AFC/SFC LOS Assessment Score of 61+.

ALLOWABLE ACTIVITIES:
The following are included in the daily per diem for Adult Family Care:
•Attendant care related to ADL's
•Home and Community Assistance care related to IADL's
•Medication oversight (to the extent permitted under State law)

SERVICE STANDARDS
•Adult Family Care services must follow a written service plan addressing specific needs determined in the person-centered planning process.
•Services must address the participant's level of service needs
•Provider must live in the AFC home, unless another provider-contracted primary caregiver, who meets all provider qualifications, lives in the provider's home
•Backup services must be provided by a qualified participant familiar with the participant's needs for those times when the primary caregiver is absent from the home or otherwise cannot provide the necessary level of care.
•AFC provides an environment that has the qualities of a home, including privacy, safe place that is free of environmental hazards such as pests, habitable environment, comfortable surroundings, and the opportunity to modify one's living area to suit one's participant preferences.
•Rules managing or organizing the home activities in the AFC home that are developed by the provider or provider-contracted primary caregiver, or both and approved by the Medicaid waiver program must be provided to the participant prior to the start of AFC services and may not be so restrictive as to interfere with a participant's rights under state and federal law.
•Participant-focused activity plans are developed by the provider with the participant or his/her representative
•Providers or provider's employees who provide medication oversight as addressed under allowed activities must receive necessary instruction from a doctor, nurse, or pharmacist on the administration of controlled substances prescribed to the participant.

DOCUMENTATION STANDARDS:
Level of service is determined by person-centered planning process and documented in the individual's person-centered service plan.

Care Manager Documentation Standards:
•Responsible to document the need for AFC and types of ADL and IADL care the participant may require.
*Document the staff activity to meet the individual's needs and is accurately shown in the level of care assessment tool.
*If the participant requires skilled care, the care manager must explain how the skilled need will be met and by whom. The documentation must describe the ADL and IADL assistance provided, who will be providing the assistance, and the activities and frequency to be performed.
•Care manager must give the completed person-centered service plan to the provider.

Provider Documentation Standards:
•Daily documentation to support services rendered by AFC staff to address needs identified in the person-centered service plan:
-participant's status, including health, mental health, medication, diet, sleep patterns, social activity /community engagement
-updates, including health, mental health, medication, diet, sleep patterns, social activity /community engagement
-participation in consumer-focused activities
-medication management records, if applicable

Monthly updated service plans provided to the participant's care manager from the AFC caregiver.
•Maintenance of participant's personal records to include:
1. social security number
2. medical insurance number
3. birth date
4. emergency contact(s)
5. all medical information available including all prescription and non-prescription drug medication currently in use
6. most recent prior residence
7. hospital preference
8. primary care physician
9. mortuary (if known)
10. religious affiliation and place of worship, if applicable
11. strengths
12. risks
13. any goals identified by the participant and support provided by AFC staff to help participant achieve goals

•Participant's personal records must include copies of all applicable documents, which the AFC caregiver will also provide to the participant's care manager on an ongoing basis if there are changes to these documents:
1.advance directive
2.living will
3.power of attorney (POA)
4.health care representative
5.do not resuscitate (DNR) order
6.letters of guardianship

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

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

ACTIVITIES NOT ALLOWED:
Services provided in the home of a caregiver who is related by blood or related legally to the participant.
•This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual) as outlined in C-2-d and C-2-e of this waiver.
•Payments for room and board or the costs of facility maintenance, upkeep or improvement.

The Adult Family Care service per diem does not include room and board.

Separate payment will not be made for Home and Community Assistance, Skilled Respite, Environmental Modifications, Attendant Care, Home Delivered Meals, Pest Control, Community Transition, or Structured Family Caregiving furnished to a participant selecting Adult Family Care services as these activities are integral to and inherent in the provision of Adult Family Care Services.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	FSSA/OMPP approved Adult Family Care Individual
Agency	FSSA/OMPP approved Adult Family Care Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Family Care

Provider Category:

Individual

Provider Type:

FSSA/OMPP approved Adult Family Care Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Provider and home must meet the requirements of the Indiana Adult Foster Care Service Provision and Certification Standards.

OMPP approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider Qualifications; General requirements
455 IAC 2 General requirements for direct care staff
455 IAC 2 Procedures for protecting individuals
455 IAC 2 Unusual occurrence; reporting
455 IAC 2 Transfer of individual's record upon change of provider
455 IAC 2 Notice of termination of services
455 IAC 2 Provider organizational chart
455 IAC 2 Collaboration and quality control
455 IAC 2 Data collection and reporting standards
455 IAC 2 Quality assurance and quality improvement system
455 IAC 2 Financial information
455 IAC 2 Liability insurance
455 IAC 2 Transportation of an individual
455 IAC 2 Documentation of qualifications
455 IAC 2 Maintenance of personnel records
455 IAC 2 Adoption of personnel policies
455 IAC 2 Operations manual
455 IAC 2 Maintenance of records of services provided
455 IAC 2 Individual's personal file; site of service delivery

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Family Care

Provider Category:

Agency

Provider Type:

FSSA/OMPP approved Adult Family Care Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Provider and home must meet the requirements of the Indiana Adult Foster Care Service Provision and Certification Standards.

OMPP approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider Qualifications: General Requirements
455 IAC 2 General requirements for direct care staff
455 IAC 2 Procedures for protecting individuals
455 IAC 2 Unusual occurrence; reporting
455 IAC 2 Transfer of individual's record upon change of provider
455 IAC 2 Notice of termination of services
455 IAC 2 Provider organizational chart
455 IAC 2 Collaboration and quality control
455 IAC 2 Data collection and reporting standards
455 IAC 2 Quality assurance and quality improvement system
455 IAC 2 Financial information
455 IAC 2 Liability insurance
455 IAC 2 Transportation of an individual
455 IAC 2 Documentation of qualifications
455 IAC 2 Maintenance of personnel records
455 IAC 2 Adoption of personnel policies
455 IAC 2 Operations manual
455 IAC 2 Maintenance of records of services provided
455 IAC 2 Individual's personal file; site of service delivery

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assisted Living

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

02 Round-the-Clock Services	02013 group living, other

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Assisted living service is defined as personal care and services, home and community assistance, chore, attendant care and companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a congregate residential setting in conjunction with the provision of participant paid room and board. This service includes 24 hour24-hour on-site response staff to meet scheduled and unpredictable needs. The participant retains the right to assume risk.

ALLOWABLE ACTIVITIES

The following are included in the daily per diem and monthly rate for Assisted Living Services:
Attendant care related to ADL's
Home and Community Assistance care related to IADL's
Medication oversight (to the extent permitted under State law).
Non-emergency non-medical transportation
Therapeutic social and recreational programming

SERVICE STANDARDS
•Assisted Living (AL) services must follow a written service plan addressing specific needs determined in the person-centered planning process.
If the participant requires skilled care, the care manager must explain how the skilled need will be met and by whom.

The documentation must describe the entity providing this service, the activities that are expected to be performed and frequency.

DOCUMENTATION STANDARDS
Care Manager Documentation Standards:

*Responsible to document the need, types, and frequency of ADL and/or IADL care the participant may require, which is identified in the person-centered service plan.

If the participant requires skilled care, the CM must explain how the skilled need will be met and by whom. The documentation must describe the entity providing this service, the activities that are expected to be performed and frequency.

Care manager must give the completed person-centered service plan to the Assisted Living provider.

Provider Documentation Standards:
A. Complete and accurate documentation to support daily services rendered by the AL to address needs identified in the Person Centered Care Plan:
• Participant's strengths, goals, support needed to assist the participant in achieving goals, risk and interventions to reduce risk.
• Community engagement activities performed by the participant
•participant's status, including health, mental health, medication, diet, sleep patterns, social activity
•updates, including health, mental health, medication, diet, sleep patterns, social activity
•participation in consumer focused activities
•medication management records, if applicable
•quarterly updated service plans provided to the participant's care manager from the AL.

B. Maintenance of participant's personal records to include:
•social security number
•medical insurance number
•birth date
•emergency contact(s)
•available medical information including all known prescription and non-prescription drug medication currently in use
•hospital preference
•primary care physician
•mortuary (if known)

C. Participant's personal records must include copies of below documents, if available, which the assisted living caregiver will also provide to the participant's care manager on an ongoing basis if there are changes to these documents:
•advance directive
•living will
•power of attorney (POA)
•health care representative
•do not resuscitate (DNR) order
•letters of guardianship
•Fully executed lease agreement with the AL

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

Services outlined in the service plan

Documentation to support service rendered

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

ACTIVITIES NOT ALLOWED
The Assisted Living service per diem does not include room and board.

Personal care services provided to medically unstable or medically complex participants as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician or other health professional.

This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual) as outlined in C-2-d and C-2-e of this waiver.

Separate payment will not be made for Home and Community Assistance, Skilled Respite, Environmental Modifications, Transportation, Personal Emergency Response System, Attendant Care, Adult Family Care, Adult Day Services, Home Delivered Meals, Pest Control, or Structured Family Caregiving furnished to a participant selecting Assisted Living Services as these activities are integral to and inherent in the provision of the Assisted Living Service.

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

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

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☒ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Assisted Living Agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assisted Living

Provider Category:

Agency

Provider Type:

Licensed Assisted Living Agencies

Provider Qualifications

License *(specify):*

IC 16-28-2

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved
410 IAC 16.2-5

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavior Management/ Behavior Program and Counseling

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10090 other mental health and behavioral services

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

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

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

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

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

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

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

ACTIVITIES NOT ALLOWED
•Aversive techniques
•Any techniques not approved by the individual's person-centered planning team and the Bureau of Disabilities Services (BDS)
•This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual) as outlined in C-2-d and C-2-e of this waiver.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	FSSA/OMPP approved Behavior Management/ Behavior Program and Counseling Individual
Agency	FSSA/OMPP approved Behavior Management/ Behavioral Program and Counseling Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Management/ Behavior Program and Counseling

Provider Category:

Individual

Provider Type:

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved
455 IAC 2 Provider Qualifications; General requirements
455 IAC 2 General requirements for direct care staff
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements
455 IAC 2 Personnel Records

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Management/ Behavior Program and Counseling

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved
455 IAC 2 Provider Qualifications; General requirements
455 IAC 2 General requirements for direct care staff
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements
455 IAC 2 Personnel Records

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Community Transition

HCBS Taxonomy:

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

Service Definition *(Scope):*

Community Transition Services (CTS) supports reasonable, set-up expenses for participants who make the transition from an institution to their own home where the person is directly responsible for his or her own living expenses in the community and will not be reimbursable on any subsequent move.

Note: Own Home is defined as any dwelling, including a house, an apartment, a condominium, a trailer, or other lodging that is owned, leased, or rented by the participant and/ or the participant's guardian or family, or a home that is owned and/ or operated by the agency providing supports.

Items purchased through Community Transition are the property of the participant receiving the service, and the participant takes the property with him or her in the event of a move to another residence, even if the residence from which he or she is moving is owned by a provider agency. Nursing Facilities are not reimbursed for Community Transition because those services are part of the per diem. For those receiving this service under the waiver, reimbursement for approved Community Transition expenditures are reimbursed through the local AAA or OMPP approved provider who maintains all applicable receipts and verifies the delivery of services.
Providers can directly relate to the State Medicaid Agency at their election.
ALLOWABLE ACTIVITIES
1.Security deposits and application fees that are required to obtain a lease on an apartment or a home
2.Furnishings and moving expenses required to occupy and use a community domicile. Approved items have been a bed, table or chairs, assembly of flat-packed furniture, window coverings, (1) land line telephone, eating utensils, housekeeping supplies, food preparation items, hygiene products, microwave, bed or bath linens.
3.Set-up fees or deposits for utility or service access including telephone, electricity, heating, internet and water
4.Health and safety assurances including pest eradication, allergen control, or one-time cleaning prior to occupancy.
*Cover related costs with Government issued identification items, birth certificate, Social Security Card, State ID, State Driver's license.

SERVICE STANDARDS
Community Transition services must follow a written service plan addressing specific needs determined by the person-centered planning process.

DOCUMENTATION STANDARDS

Care Managers Documentation Standards:
•Responsible to document the need for CTS and furnishings or set up expenses being requested by the participant. Determined through the person-centered planning process.
•Documentation requirements include maintaining receipts for all expenditures, showing the amount and what item or deposit was covered
*If care manager requests full $1,500 and not all funds are used, then the CM is responsible to complete a service plan update to reduce the amount to ensure Medicaid is not over-reimbursing for these services.

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

Reimbursement for Community Transition is limited to a lifetime cap for set up expenses, up to $1,500.

•This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual) as outlined in C-2-d and C-2-e of this waiver.

ACTIVITIES NOT ALLOWED
Apartment or housing rental or mortgage expenses
Large Appliances
Diversional or recreational items such as hobby supplies
Cable TV access
VCRs
Regular utility charges
*When participant discharges from facility the CTS must be identified, ordered, and delivered within 3 months.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/OMPP approved Community Transition Service Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition

Provider Category:

Agency

Provider Type:

FSSA/OMPP approved Community Transition Service Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: General requirements
455 IAC 2 Transfer of individual's record upon change of provider
455 IAC 2 Financial information
455 IAC 2 Liability insurance
455 IAC 2 Transportation of an individual
455 IAC 2 Professional qualifications and requirements; documentation of qualifications
455 IAC 2 Maintenance of personnel records
455 IAC 2 Adoption of personnel policies
455 IAC 2 Operations manual
455 IAC 2 Maintenance of records of services provided
455 IAC 2 Individual's personal file; site of service delivery

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1:	Sub-Category 1:
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A Home Delivered Meal is a nutritionally balanced meal.

ALLOWABLE ACTIVITIES
Approved Home delivered meals have included the following items:
•No more than two meals per day will be reimbursed under the waiver
•Diet/ nutrition counseling provided by a registered dietician
•Nutritional education based on needs of each participant
•Diet modification according to a physician's order as required meeting the individual's medical and nutritional needs

SERVICE STANDARDS
A participant's ability to receive home delivered meals is based on the needs of the participant, as determined by a level of care assessment in accordance with Department requirements and as outlined in the participant's service plan. A participant's, social, psychosocial and health should be considered when determining the participant's ability to prepare his/her own meals.

All meals must meet state, local, and federal laws and regulations regarding the safe handling of food. The provider must also hold adequate and current servsafe certification.

All home delivered meals provided must contain at least 1/3 of the current recommended dietary allowance (RDA) as established by the Food and Nutrition Board of the National Academy of Sciences, National Research council, including but not limited to:
A variety of vegetables; dark green, red and orange, legumes (beans and peas), starchy and other vegetables
Fruits, especially whole fruit,
Grains, at least half of which are whole grain
Fat-free or low-fat dairy, including milk, yogurt, cheese, and/or fortified soy beverages
A variety of protein foods, including seafood, lean meats and poultry, eggs, legumes (beans and peas), soy products, and nuts and seeds
Oils, including those from plants: canola, corn, olive, peanut, safflower, soybean, and sunflower. Oils also are naturally present in nuts, seeds, seafood, olives, and avocados.

Meals shall contain less than 10% daily calories from added sugars unless prior BDS or Registered Dietitian approval.

Meals shall contain less than 10% of daily calories from saturated fats unless prior BDS or Registered Dietitian approval.

Meals shall contain less than 2,300 mg of sodium per day unless prior BDS or Registered Dietitian approval.

DOCUMENTATION STANDARDS
Care Manager Documentation Standards:
*Responsible to document the need for Home Delivered Meals and amount being requested

Provider Standards:
*date of delivery, how many meals included in care professional, or care manager that involved the participant also needs to be documented
Document any food allergies, food preferences, gluten sensitivity for waiver participants.
Date of expiration included on all meals
Written or oral instruction for appropriate storage of meal
Written or oral instruction for preparing meal

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

ACTIVITIES NOT ALLOWED

This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual) as outlined in C-2-d and C-2-e of this waiver.

No more than two meals per day will be reimbursed under the waiver
Services to participants receiving Adult Family Care waiver service
Services to participants receiving Assisted Living waiver service

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/OMPP approved Home Delivered Meals Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

FSSA/OMPP approved Home Delivered Meals Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: General requirements
455 IAC 2 Maintenance of Records of services provided
455 IAC 2 Liability insurance
455 IAC 2 Maintenance of records of services provided

Must comply with all State and local health laws and ordinances concerning preparation, handling, and serving of food.

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Modification Assessment

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17030 housing consultation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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

The home modification assessment will assess the home for physical adaptations to the home, which as indicated by individual's service plan, are necessary to ensure the health, welfare and safety of the individual and enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

The assessor will be responsible for writing the specifications, review of feasibility and the post-project inspection. Upon completion of the specifications, and review of feasibility, the Assessor will prepare and submit the project specifications to the care manager and individual for the bidding process and be paid first installment for completion of home specifications. Once the project is complete, the assessor, consumer and care manager will each be present on an agreed upon date and time to inspect the work and sign- off indicating that it was completed per the agreed upon bid and be paid the final installment of the home modification work. In the event the participant, provider, assessor and/or care manager become aware of discrepancies for complaints about the work being completed, the provider shall stop work immediately, and contact the care manager and Bureau of Disabilities Services (BDS) for further instruction.

The BDS also has the ability to request additional assessment visits to help resolve a disagreement between the home modification provider and the participant. This payment is not included in the actual home modification cost category and shall not be subtracted from the participant's lifetime cap for home modifications. The care management provider entity will be responsible for maintaining related records that can be accessed by the state.

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

SERVICE STANDARDS
• Need for home modification must be indicated in the participant's plan of care
• Modification must address the participant's level of service needs
• Proposed specifications for modification must conform to the requirements and limitations of the current approved service definition for home modification services
Assessment should be conducted by an approved, qualified individual who is independent of the entity providing the home modifications.
Contact appropriate authority regarding potential code violations.
An annual cap of $628 is available for home modification assessment services, unless the BDS requests an additional assessment in order to help mediate disagreements between the home modification provider and the participant.

DOCUMENTATION STANDARDS

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

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

An annual cap of $628 is available for home modification assessment services, unless the BDS requests an additional assessment in order to help mediate disagreements between the home modification provider and the participant.

ACTIVITIES NOT ALLOWED
Home Modification Assessment services shall not be performed by the same provider that performs the subsequent Home Modification.

Payment will not be made for home modifications under this service.

This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual) as outlined in C-2-d and C-2-e of this waiver.

This service must not be used for living arrangements that are owned or leased by providers of waiver services.

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

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Architect
Individual	FSSA/OMPP approved Home Modification Assessment Individual

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modification Assessment

Provider Category:
Individual
Provider Type:

Architect
Provider Qualifications
License *(specify):*

IC 25-4
Certificate *(specify):*

Other Standard *(specify):*

OMPP Approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: General requirements
455 IAC 2 Financial information
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements; documentation of qualifications
455 IAC 2 Warranty required
Compliance with applicable building codes and perm

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modification Assessment

Provider Category:

Individual

Provider Type:

FSSA/OMPP approved Home Modification Assessment Individual

Provider Qualifications

License *(specify):*

IC 25-20.2 Home Inspector

Certificate *(specify):*

In addition to the licensure standard, either a Certified Aging-In-Place Specialist (CAPS Certification – National Association of Home Builders) OR
a Executive Certificate in Home Modifications (University of Southern California)

Other Standard *(specify):*

OMPP Approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: General requirements
455 IAC 2 Financial information
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements; documentation of qualifications
455 IAC 2 Warranty required
Compliance with applicable building codes and permits

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Modifications

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

Home Ownership
Home modifications will be for when the participant owns a home. Rented homes or apartments or family-owned homes are allowed to be modified only when a signed agreement from the property owner is obtained. The signed agreement must be submitted along with all other required documentation. Disputes between different parties may not be within the scope of, the Bureau of Disabilities Services (BDS) to be able to intervene in a resolution.

Choice of Provider
The participant chooses the certified providers to submit bids for the home modifications. If the participant chooses to continue with the home modification after receiving the bids, then the lowest bid that meets the minimum requirements shall be chosen, such as, timeframe to start service. There is a minimum requirement to gather 2 bids for any expected amount over $5,000.00.

ALLOWABLE ACTIVITIES

Approved Home modifications may include the following:
A. Adaptive door openers and locks –

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

C. Home Control Units - Adaptive switches and buttons to operate medical equipment, communication devices, heat and air conditioning, and lights for an individual living alone or who is alone without a caregiver for a substantial portion of the day.

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

E. Home safety devices such as:
1.door alarms;
2.anti-scald devices;
3.hand held shower head;
4.grab bars for the bathroom.

F. Ramp – including:
Portable - considered for rental property only; Permanent;
Vertical lift.

G. Stair lift –

H. Single room air or portable conditioner (s) / single room air purifier (s) –

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

J. Windows - replacement of glass with Plexi-glass or other shatterproof material when there is a documented

medical/behavioral reason (s);

K. Upon the completion of the modification, the room being modified will be matched to the degree possible with the same paint, wall texture, wall coverings, doors, trim, flooring etc. to the previous color/style/design;

L. Home Modification Maintenance (HOMM) - limited to $1,000.00 annually for the repair and service of environmental modifications that have been provided through a HCBS waiver:
1.Requests for service must detail parts cost and labor cost;
2.If the need for maintenance exceeds $1000.00, the care manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor funded through a non-waiver funding source.

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

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

O. Requests for modifications may be denied if the State BDS director or State agency designee determines the documentation does not support residential stability and/or the service requested.

SERVICE STANDARDS
• Participants are allotted $20,000 lifetime cap to receive home modification services.
• The cap represents a cost for basic modification of a participant's home for accessibility and accommodates the participant's needs for housing modifications. The cost of a home modification includes all materials, equipment, labor, and permits to complete the project. No parts of a home modification may be billed separately as part of any other service category (e.g. Specialized Medical Equipment). In addition to the $20,000 lifetime cap, $1,000.00 is allowable annually for the repair, replacement, or an adjustment to an existing home modification that was funded by a Home and Community Based Services (HCBS) waiver.
• Home Modification Maintenance is limited to $1,000.00 annually for the repair and service of home modifications that have been provided through a HCBS waiver. Requests for maintenance must detail cost of part(s) and cost of labor. If the need for maintenance exceeds $1000.00, the care manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor funded through a non-waiver funding source.

Care Manager Standards:
*Responsible to document the need for home modification
*Share expected modification requests identified by the participant determined through the person-centered planning process to the assessor

All home modifications must be approved by the waiver program prior to services being rendered.
Collect 2 bids if over $5,000.00. If 1 bid is obtained the CM must document the date of contact, the provider name, and why the bid was not obtained from that provider.
Notification to the Bureau of Disabilities Services (BDS) of any discrepancies or complaints about the work while it is being completed.
Notice provided to the Bureau of Disabilities Services (BDS) within forty-eight hours upon learning of the issues.
Before and after drawings are required for bathroom, kitchen and ramps.
Bid must contain warranty information.
If a home assessor is available in the county where the participant lives, then all participants must receive a home modification assessment if a provider is available in that county, with a certified waiver provider selected by the participant prior to any subsequent home modifications as well as a home modification inspection upon completion of the work.

Provider Standards:
*Need for home modification must be indicated in the participant's service plan

Proposed specifications for modification must conform to the requirements and limitations of the current approved service definition for home Modification Services.

Providers are required to provide a written warranty for a new product or service in the form of a binding document stating that, for a period of not less than one (1) year, the service provider shall replace or repair any product or installation.

If the State agency determines the provider is at fault for poor and/or incorrect work during the home modification, then the provider is responsible for correcting work at the cost of the provider.

Bid must contain warranty information.

Before and after drawings are required for bathroom, kitchen and ramps.

Bid must be itemized with cost for each major component of the modification.

Prohibited from placing residential liens.

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

Home modification requests must be provided in accordance with applicable State and/or local building codes. Home Modifications must be compliant with applicable building codes.

Land survey may be required when exterior modification(s) approach property line. Provider of services must maintain receipts for all incurred expenses related to the modification; Must be in compliance with FSSA and Division specific guidelines and/or policies.

Notification to the participant’s care manager and Bureau of Disabilities Services (BDS) of any discrepancies or complaints about the work while it is being completed. Notice provided to the Bureau of Disabilities Services (BDS) within forty-eight hours upon learning of the issues.

DOCUMENTATION STANDARDS

Documentation/explanation of the service within the Request for Approval to Authorize Services (RFA) including the following:
1.Property owner of the residence where the requested modification is proposed;
2.Property owner's relationship to the participant;
3.What, if any, relationship the property owner has to the participant;
4.Written agreement of landlord or homeowner for modification including agreement about items purchased during the modification, such as a bathtub, upon participant moving from the property or eviction.

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

A lifetime cap of $20,000 is available for home modifications. The cap represents a cost for basic modification of a participant's home for accessibility and accommodates the participant's needs for housing modifications. The cost of a home modification includes all materials, equipment, labor, and permits to complete the project. No parts of a home modification may be billed separately as part of any other service category (e.g. Specialized Medical Equipment). In addition to the $20,000 lifetime cap, $1000.00 is allowable annually for the repair, replacement, or an adjustment to an existing home modification that was funded by a Home and Community Based Services (HCBS) waiver.

ACTIVITIES NOT ALLOWED
Examples/descriptions of activities not allowed include following:
A. Adaptations or improvements which do not address participant accessibility or are not of direct medical or remedial benefit to the participant:
1. central heating and air conditioning;
2. roof repair;
3. structural repair that is not incidental to the original modification ;
4. driveways, decks, patios, publicly owned sidewalks, household furnishings;
5. swimming pools, spas or hot tubs;
6. outside storage spaces;
7. home security systems.

B. Modifications that create living space or facilities where they did not previously exist (e.g. installation of a bathroom in a garage/basement, etc.);

C. Adaptations which add to the total square footage of the home;

D. Participants living in foster homes, group homes, assisted living facilities, or homes for special services (any licensed residential facility) are not eligible to receive this service. (Note: The responsibility for home modifications rests with the facility owner or operator);

E. Participants living in a provider owned or controlled residence are not eligible to receive this service. (Note: The responsibility for home modifications rests with the facility owner or operator);

F. Completion of, or modifications to, new construction or significant remodeling/reconstruction are excluded unless there is documented evidence of a significant change in the participant's medical or remedial needs that now require the requested modification.

G. This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual) as outlined in C-2-d and C-2-e of this waiver.

H. The services under home modification are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

I. This service must not be used for living arrangements that are owned or leased by providers of waiver services.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Plumber
Agency	FSSA/ OMPP approved Home Modification Agency/ Contractor
Individual	FSSA/OMPP approved Home Modification Individual
Individual	Architect

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modifications

Provider Category:

Individual

Provider Type:

Plumber

Provider Qualifications

License *(specify):*

IC 25-28.5

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: General requirements
455 IAC 2 Financial information
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements; documentation of qualifications
455 IAC 2 Warranty required
Compliance with applicable building codes and permits

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modifications

Provider Category:

Agency

Provider Type:

FSSA/ OMPP approved Home Modification Agency/ Contractor

Provider Qualifications

License *(specify):*

Any applicable licensure
IC 25-20.2 Home inspector
IC 25-28.5 Plumber

Certificate *(specify):*

IC 25-4 Architect

Other Standard *(specify):*

OMPP approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: General requirements
455 IAC 2 Maintenance of Records of services provided
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements; documentation of qualifications
455 IAC 2 Warranty required
Compliance with applicable building codes and permits

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modifications

Provider Category:

Individual

Provider Type:

FSSA/OMPP approved Home Modification Individual

Provider Qualifications

License *(specify):*

Any applicable licensure must be in place

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: General requirements
455 IAC 2 Maintenance of Records of services provided
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements; documentation of qualifications
455 IAC 2 Warranty required
Compliance with applicable building codes/ permits.

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modifications

Provider Category:

Individual

Provider Type:

Architect

Provider Qualifications

License *(specify):*

Certificate *(specify):*

IC 25-4

Other Standard *(specify):*

OMPP approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: General requirements
455 IAC 2 Financial information
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements; documentation of qualifications
455 IAC 2 Warranty required
Compliance with applicable building codes and permits

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Integrated Health Care Coordination

HCBS Taxonomy:

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

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Integrated Health Care Coordination (IHCC) is to promote improved health status and quality of life, delay/prevent deterioration of health status, manage chronic conditions in collaboration with the participant's provider and circle of support, and integrate medical and social services.

ALLOWABLE ACTIVITIES

•Development and oversight of a healthcare support plan which includes coordination of medical care and proactive care management of both chronic diseases and complex conditions such as falls, depression and dementia.
•Skilled nursing services are provided within the scope of the Indiana State Nurse Practice Act.
• Collaboration across all service providers: waiver, state plan, mental health, dental, medical.
• Collaboration across social supports: housing, food, Medicare/Medicaid system navigation, finances, transportation
•Medication review
•Transitional support from hospital or nursing facility to home/assisted living.
•Advance care planning

PROVIDER SERVICE STANDARDS
•Current Indiana RN license for each nurse.
•Current Indiana license for each LPN
•Indiana license for social worker (LSW) with master's degree in social work with additional documentation of at least two years of experience providing health care coordination.
•Weekly consultations or reviews
•Face-to-face visits with the participant; including a minimum of one (1) face to face visit per month.
•Not to exceed sixteen (16) hours of Health Care Coordination per month, including travel time.

CARE MANAGEMENT STANDARDS Care manager is expected to coordinate and collaborate with the participant's integrated health care coordination provider; review any and all updates about the participant from the health care coordination provider including interventions and follow up with the participant about changes in medical and social services as well as interventions implemented by the health care coordinator provider to ensure the member's needs are being met. The care manager shall communicate information learned in these follow-up meetings with the integrated health care coordination provider and shall work together to resolve any un-met needs identified.

DOCUMENTATION STANDARDS
Evidence of a consultation including complete date and signature; consultation can be with the participant, informal caregivers, other staff, other professionals, as well as health care professionals.

Weekly consultations or reviews.
Minimum of one (1) face to face visit/month. IHCC is not to exceed sixteen (16) hours per month.
Services must address needs identified in the plan of care as determined by the person-centered planning process.
The provider of will provide a written report to pertinent parties at least quarterly. Pertinent parties include the participant, guardian, waiver care manager, all waiver service providers including mental health providers, State Plan services, and physicians.

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

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

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

This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual) as outlined in C-2-d and C-2-e of this waiver.

ACTIVITIES NOT ALLOWED

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

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Home Health Agencies

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Licensed Home Health Agencies

Provider Qualifications

License *(specify):*

IC 16-27-1 Home Health Agency
IC 25-23-1 RN
IC 2-23-1 LPN
IC 25.23.6 LSW

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Nutritional Supplements

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

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

Reimbursement for approved Nutritional Supplement expenditures are reimbursed through the local AAA or an approved OMPP provider, who maintains all applicable receipts and verifies the delivery of services. Providers can directly relate to the State Medicaid Agency at their election.

ALLOWABLE ACTIVITIES

Enteral Formulae, category 1 such as "Boost" or “Ensure”

SERVICE STANDARDS
Nutritional Supplement services must follow a written service plan addressing specific needs determined in the person-centered planning process.

DOCUMENTATION STANDARDS
Care Manager Documentation Standards:
*Responsible to document the need for nutritional supplements and amount being requested
*Identify the amount requesting from the Annual Cap of $1200 for nutritional supplemental services.

Provider Standards:
*Date of delivery, how many meals included in care professional, or care manager that involved the participant also needs to be documented

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

Services available through the Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before this service may be requested by waiver.

An annual cap of $1200 is available for nutritional supplement services.

This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual) as outlined in C-2-d and C-2-e of this waiver.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/OMPP approved Nutritional Supplements Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Nutritional Supplements

Provider Category:

Agency

Provider Type:

FSSA/OMPP approved Nutritional Supplements Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: General requirements
455 IAC 2 Transfer of individual's record upon change of provider
455 IAC 2 Maintenance of Records of services provided
455 IAC 2 Liability insurance
455 IAC 2 Individual's personal file; site of service delivery

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14010 personal emergency response system (PERS)

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Personal Emergency Response System (PERS) is an electronic device which enables certain participants at high risk of institutionalization to secure help in an emergency. The participant may also wear a portable help button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a button is activated. The response center is staffed 24 hours daily/ 7 days per week by trained professionals.

ALLOWABLE ACTIVITIES
Device Installation service
Ongoing monthly maintenance of device electronic service that is usually a portal help button; however, it can also be an electronic device that includes GPS or video monitoring service. No remote monitoring will be placed in participant bedrooms or bathrooms.

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

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

The mainframe location would be determined by the provider.

The State confirms there is a back-up plan in the event of equipment failure.

Yes, the care manager is the central vehicle for the state to provide information to the participant, their family, and their entire circle of support. This is part of the person-centered planning process, which would include the provider.

SERVICE STANDARDS
Personal Emergency Response services must follow a written service plan addressing specific needs determined by the individual's assessment.
Care manager is required to contact the waiver participant if contacted by the PERS provider that waiver participant experienced a fall.

DOCUMENTATION STANDARDS
Care Manager Documentation Standards:
*The need for PERS
*The need for PERS maintenance
*Whether the person is residing alone or alone for significant parts of the day without a caregiver present
* Interventions implemented as a result of fall data from the PERS provider.
* a back-up plan in the event of equipment failure.
* The care manager is the central vehicle for the state to provide information to the participant, their family, and their entire circle of support. This is part of the person-centered planning process, which would include the provider.

Provider Documentation Standards:
*Date of installation,
*Documentation of expense for installation
Documentation of monthly rental fee
Ongoing monthly maintenance of device
Monthly written notification to care managers of any participant who experienced a fall within a one-month timeframe.

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

ACTIVITIES NOT ALLOWED

This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual) as outlined in C-2-d and C-2-e of this waiver.

Services to participants receiving Assisted Living waiver service
Services to participants receiving Adult Family Care Services

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/OMPP approved Personal Emergency Response System Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:

Agency

Provider Type:

FSSA/OMPP approved Personal Emergency Response System Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: General requirements
455 IAC 2 Maintenance of Records of services provided
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements; documentation of qualifications
455 IAC 2 Warranty required
Compliance with applicable building codes and permits

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Pest Control

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Pest Control services are designed to prevent, suppress, or eradicate anything that competes with humans for food and water, injures humans, spreads disease to humans and/ or annoys humans and is causing or is expected to cause more harm than is reasonable to accept. Pests include but are not limited to, insects such as roaches, mosquitoes, fleas; bed bugs insect-like organisms, such as mites and ticks; and vertebrates, such as rats and mice.

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

Reimbursement for approved Pest Control expenditures is reimbursed through the local AAA or other approved OMPP provider, who maintain all applicable receipts and verifies the delivery of services. Providers can directly relate to the State Medicaid Agency at their election.

ALLOWABLE ACTIVITIES

Pest Control services are added to the service plan when the care manager determines, either through direct observation or by participant report, that a pest is present that is causing or is expected to cause more harm than is reasonable to accept.
Services to control pests are services that prevent, suppress, or eradicate pest infestation.

SERVICE STANDARDS
Pest control services must follow a written service plan addressing specific needs determined in the person-centered planning process.

DOCUMENTATION STANDARDS

CM Standards:
Responsible to document the need for Pest Control and the types of pests to eradicate through the person-centered planning process.

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

Pest Control services may not be used solely as a preventative measure. There must be documentation of a need for this service either through care manager direct observation or participant report that a pest is causing or is expected to cause more harm than is reasonable to accept.

Services to participants receiving Adult Family Care waiver service or Assisted Living waiver service Preventive measures or on-going need for service, or Eradication or prevention of mold or mold like substances.

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

This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual) as outlined in C-2-d and C-2-e of this waiver.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/OMPP approved Pest Control Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Pest Control

Provider Category:

Agency

Provider Type:

FSSA/OMPP approved Pest Control Agency

Provider Qualifications

License *(specify):*

IC 15-3-3.6

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: General requirements
455 IAC 2 Maintenance of Records of services provided
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements; documentation of qualifications
455 IAC 2 Warranty required

Pesticide applicators must be certified or licensed through the Purdue University Extension Service and the Office of the Indiana State Chemist.

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)
Area Agencies on Aging verify license number.

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

specified in statute.

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

A. Participants requesting authorization for this service through utilization of Home and Community Based Services (HCBS) waivers must first exhaust eligibility of the desired equipment or supplies through Indiana Medicaid State Plan, which may require Prior Authorization (PA). The Bureau of Disabilities Services (BDS) will deny any provider claim that did not follow the correct Medicaid billing practices.
1.There should be no duplication of services between HCBS waiver and Medicaid State Plan;
2.The refusal of a Medicaid vendor to accept the Medicaid reimbursement through the Medicaid State Plan is not a justification for waiver purchase;
3.Preference for a specific brand name is not a medically necessary justification for waiver purchase. Medicaid State Plan often covers like equipment but may not cover the specific brand requested. When this occurs, the participant is limited to the Medicaid State Plan covered service/brand;
4.Reimbursement is limited to the Medicaid State Plan fee schedule, if the requested item is covered under Medicaid State Plan;
5.All requests for items to be purchased through a Medicaid waiver must be accompanied by documentation of Medicaid State Plan PA request and decision, if requested item is covered under State Plan.

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

ALLOWABLE ACTIVITIES

Justification and documentation is required to demonstrate that the request is necessary in order to meet the participant's identified need(s).

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

B. Medication Dispensers.

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

D. Slip resistant socks.

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

F. Strollers - when needed because participant’s primary mobility device does not fit into the participant's vehicle/mode of transportation, or when the participant does not require the full-time use of a mobility device, but a stroller is needed to meet the mobility needs of the participant outside of the home setting.

G. Interpreter service – provided in circumstances where the interpreter assists the individual in communication during specified scheduled meetings for service planning (e.g. waiver case conferences, team meetings) and is not available to facilitate communication for other service provision.

H. Voice activated smart devices

I. Maintenance - limited to $1,000.00 annually for the repair and service of items that have been provided through a HCBS waiver:
1.Requests for service must detail parts cost and labor cost;
2.If the need for maintenance exceeds $1000.00, the care manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs

funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a non-waiver funding source.

Items requested which are not listed above, will be submitted in the service plan and will be reviewed and approved by the State BDS Director, if the request meets the participant's need.

SERVICE STANDARDS

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

B. All items shall meet applicable standards of manufacture, design and service specifications

DOCUMENTATION STANDARDS
Care Manager Documentation Standards:
*Responsible to document the need for medical specialized equipment
*Describe the how the equipment is expected to improve the participants quality of ADL.
Collect 2 bids if over $1,000.00. If 1 bid is obtained the CM must document the date of contact, the provider name, and why the bid was not obtained from that provider.
Bid must contain warranty information.
Picture of the equipment.
State plan denial for the equipment and/or supplies.

Provider Standards:
*Date of installation,
*Documentation of expense for installation
*Provider of services must maintain receipts for all incurred expenses related to this service

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

Maintenance - limited to $1000.00 annually for the repair and service of items that have been provided through a HCBS waiver:
1. Requests for service must detail parts cost and labor cost;
2. If the need for maintenance exceeds $1000.00, the care manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a non-waiver funding source.

ACTIVITIES NOT ALLOWED

A. Unallowable items include the following:
1. hospital beds, air fluidized suspension mattresses/beds;
2. therapy mats;
3. parallel bars;
4. scales;
5. paraffin machines or baths;
7. therapy balls;
8. books, games, toys; electronics - such as CD players, radios, cassette players, tape recorders, television, VCR/DVDs, cameras or film, videotapes and other similar items;
9. computers and software;
10. exercise equipment such as treadmills or exercise bikes;
11. furniture;
12. appliances - such as refrigerator, stove, hot water heater;
13. indoor and outdoor play equipment such as swing sets, swings, slides, bicycles adaptive tricycles, trampolines, playhouses, merry-go-rounds;
14. swimming pools, spas, hot tubs, portable whirlpool pumps;
15. adjustable mattresses, positioning devices, pillows;
16. motorized scooters;
17. barrier creams, lotions, personal cleaning cloths;
18. essential oils
19. totally enclosed cribs and barred enclosures used for restraint purposes;
20. manual wheelchairs’
21. vehicle modifications.

B. Any equipment or items that can be authorized through Medicaid State Plan.

C. Any equipment or items purchased or obtained by the participant, his/her family members, or other non- waiver providers.

D. The services under specialized medical equipment and supplies are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

E. This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual) as outlined in C-2-d and C-2-e of this waiver.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Home Health Agency
Agency	FSSA/OMPP approved Specialized Medical Equipment and Supplies Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Licensed Home Health Agency

Provider Qualifications

License *(specify):*

IC 16-27-1

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved
455 IAC 2 Warranty required

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

FSSA/OMPP approved Specialized Medical Equipment and Supplies Agency

Provider Qualifications

License *(specify):*

IC 25-26-21

Certificate *(specify):*

IC 6-2.5-8-1

Other Standard *(specify):*

OMPP approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: General requirements
455 IAC 2 Maintenance of Records of services provided
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements; documentation of qualifications
455 IAC 2 Warranty required

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Structured Family Caregiving

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
02 Round-the-Clock Services	02023 shared living, other
Category 2:	**Sub-Category 2:**
02 Round-the-Clock Services	02033 in-home round-the-clock services, other
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Structured Family Caregiving means a caregiving arrangement in which a participant lives with a principal caregiver who provides daily care and support to the participant based on the participant's daily care needs. The person responsible for providing day-to-day support (hereafter known as principal caregiver) may be a non-family member or a family member (except as limited below) who lives with the participant in the private home of the participant or the principal caregiver. Structured Family Caregiving agencies (hereafter known as provider agencies) are the Medicaid provider of this service and are responsible for identifying principal caregivers and substitute caregivers as needed, assessing the home setting, and providing ongoing oversight and support.

Necessary support services are provided by the principal caregiver as part of Structured Family Caregiving. Principal caregivers must be qualified to meet all Federal and State regulatory guidelines, and be able to provide care and support to a participant based on the participant's assessed needs .Principal caregivers receive training based on their assessed needs and are paid a per diem stipend for the care and support they provide to participants.

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

Only agencies may be Structured Family Caregiving providers, with the home settings being assessed and accessible, and all paid caregivers (including principal caregivers) being qualified as able to meet the participant's needs. The provider agency must conduct at a minimum of two quarterly home visits. Additional home visits and ongoing communication with the principal caregiver is based on the assessed needs of the participant and the principal caregiver. Home visits are conducted by a registered nurse and/or a caregiver coach as determined by a person-centered plan of care. The Provider Agency must make a substitute caregiver available to allow opportunities for primary caregiver wellness and skill development in alignment with the needs of the primary caregiver as identified by the caregiver coach, up to 15 days per year. The provider agency must capture daily notes that are completed by the principal caregiver in an electronic format, and use the information collected to monitor participant health and principal caregiver support needs. The agency provider must make such notes available to waiver care managers and the State, upon request.

SERVICE LEVELS

There are three service levels of structured family caregiving each with a unique rate. The applicable rate is determined through completion of the Adult Family Care/Structured Family Care Level of Service Assessment (AFC/SFC LOS Assessment). Care Managers complete this assessment at least annually to accurately reflect the relative support need of the individual. The AFC/SFC LOS Score determines the reimbursement rate to be utilized in the participant's next service plan.

The breakdown is as follows:

• Level 1 – AFC/SFC LOS Assessment Score of 0 - 35.
• Level 2 – AFC/SFC LOS Assessment Score of 36 - 60.
• Level 3 – AFC/SFC LOS Assessment Score of 61+.

ALLOWABLE ACTIVITIES

Structured Family Caregiving includes (Levels 1-3)
• Services provided by a principal caregiver who is the spouse of the participant or the parent of the minor participant (Legally Responsible Persons).
• Home and Community Assistance care services related needed IADLs.
• Attendant care services related to needed ADLs.
• Medication oversight (to the extent permitted under State law).

• Escorting for necessary appointments, whenever possible, such as transporting individuals to doctor. When provided, such transportation is incidental and not duplicative of any other State Plan or waiver service.
• Appointments and community activities that are therapeutic in nature or assist with maintaining natural supports.
• Other appropriate supports as described in the individual's service plan.

SERVICE STANDARDS
• Structured Family Caregiving provider agencies must demonstrate 3 years of delivering services to older adults and adults with disabilities and their caregivers in Indiana or as a Medicaid participating provider in another State or have a national accreditation.
• Structured family caregiving must be reflected in the participant's service plan and address specific needs determined by the participant's person-centered planning process.
• Structure Family Caregiving provider agencies develop, implement and provide ongoing management and support of a person-centered service plan that addresses the participant's level of service needs.
• The supports provided within the home are managed and completed by the principal caregiver throughout the day based on the participant's daily needs.
• Structured Family Caregiving is provided in a private residence and affords all of the rights, dignity and qualities of living in a private residence including privacy, comfortable surroundings, and the opportunity to modify one's living area to suit one's individual preferences.
• Provider agencies must conduct, at a minimum, two home visits per quarter based on the participant's assessed needs and caregiver coaching needs, but the actual frequency of visits should be based on the participant's assessed needs and caregiver coaching needs.
• The Provider Agency must identify the skill development and wellness needs of the primary caregiver and provide access to a qualified substitute caregiver as needed for up to 15 days per year.
• Principal caregivers receive a minimum of 8 hours in person annual training that reflects the participant's and principal caregiver's assessed needs. Training may be delivered during quarterly home visits, or in another manner that is flexible and meaningful for the caregiver.
• Provider agencies must work with participants and principal caregivers to establish backup plans for emergencies and other times when the principal caregiver is unable to provide care.
• Structured Family Caregiving emphasizes the participant's independence in a setting that protects and encourages the participant's dignity, choice, and decision-making while preserving self-respect.
• Provider agencies who provide medication oversight, as addressed under Allowable Activities, must receive necessary instruction from a doctor, nurse, or pharmacist regarding medications prescribed to the participant.

DOCUMENTATION STANDARDS
Waiver Care Manager:
Identified need for Structured Family Caregiving in the service plan,
Services outlined in the service plan performed by the principal caregiver
Caregiver assessment findings
Care manager must give the completed person-centered service plan and Caregiver Assessment to the Structured Family Caregiving provider.

Provider Agency:
Documentation to support service rendered include:
• Training outlined in the service plan that provider agency will provide to the principal caregiver
• Electronic caregiver notes that record and track the participant's status, and updates or significant changes in the participant's health status or behaviors and participation in community based activities and other notable or reportable events,
• Medication management records, if applicable,

Regular review of caregiver notes by provider agency in order to:
• Understand and respond to changes in the participant's health status and identify potential new issues in an effort to better communicate changes with the participant's doctors or healthcare providers and avoid unnecessary hospitalizations or emergency room use.
• Document and investigate and refer reportable events to the Waiver Care manager.
• Documentation of home visits conducted by the provider agency.
•Documentation of education, skills training and coaching conducted with the principal caregiver.

• Documentation demonstrating collaboration and communication with other service providers and healthcare professionals (as appropriate), waiver care managers and other caregivers or individuals important to the participant regarding changes in the participant's health status and reportable events.
• Documentation of all qualified caregivers (including paid substitute caregivers).

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

ACTIVITIES NOT ALLOWED

1. Separate payment will not be made for Home and Community Assistance, Attendant Care, Assisted Living, or Adult Family Care.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/OMPP approved Structured Family Caregiving Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Structured Family Caregiving

Provider Category:

Agency

Provider Type:

FSSA/OMPP approved Structured Family Caregiving Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Provider and home must meet the requirements of the Adult Foster Care Service Provision and Certification Standards.

OMPP approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider Qualifications: General Requirements
455 IAC 2 General requirements for direct care staff
455 IAC 2 Procedures for protecting individuals
455 IAC 2 Unusual occurrence; reporting
455 IAC 2 Transfer of individual's record upon change of provider
455 IAC 2 Notice of termination of services
455 IAC 2 Provider organizational chart
455 IAC 2 Collaboration and quality control
455 IAC 2 Data collection and reporting standards
455 IAC 2 Quality assurance and quality improvement system
455 IAC 2 Financial information
455 IAC 2 Liability insurance
455 IAC 2 Transportation of an individual
455 IAC 2 Documentation of qualifications
455 IAC 2 Maintenance of personnel records
455 IAC 2 Adoption of personnel policies
455 IAC 2 Operations manual
455 IAC 2 Maintenance of records of services provided
455 IAC 2 Individual's personal file; site of service delivery

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transportation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
15 Non-Medical Transportation	15010 non-medical transportation

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Services offered in order to enable participants served under the waiver to gain access to waiver and other non-medical community services, activities and resources, specified by the service plan.

SERVICE STANDARDS

Transportation services must follow a written service plan addressing specific needs determined in the person-centered planning process.

This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

Transportation services are reimbursed at three (3) types of service:
1.Level 1 Transportation - the participant does not require mechanical assistance to transfer in and out of the vehicle
2.Level 2 Transportation - the participant requires mechanical assistance to transfer into and out of the vehicle
3.Adult Day Service Transportation - the participant requires round trip transportation to access adult day services

DOCUMENTATION STANDARDS

Identified need in the service plan.
Services outlined in the service plan.
A provider or its agent shall maintain documentation that the provider meets and maintains the requirements for providing services under 455 IAC 2.

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

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

ACTIVITIES NOT ALLOWED
Services available through the Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before reimbursement is available through the Medicaid waiver for this service)
Services to participants receiving Adult Family Care waiver service or Assisted Living waiver service.

This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual) as outlined in C-2-d and C-2-e of this waiver.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/OMPP approved Transportation Agency
Agency	Licensed Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

FSSA/OMPP approved Transportation Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider Qualifications: General Requirements
455 IAC 2 General requirements for direct care staff
455 IAC 2 Procedures for protecting individuals
455 IAC 2 Unusual occurrence; reporting
455 IAC 2 Transfer of individuals record upon change of provider
455 IAC 2 Notice of termination of services
455 IAC 2 Provider organizational chart
455 IAC 2 Collaboration and quality control
455 IAC 2 Data collection and reporting standards
455 IAC 2 Quality assurance and quality improvement system
455 IAC 2 Financial information
455 IAC 2 Liability insurance
455 IAC 2 Transportation of an individual
455 IAC 2 Documentation of qualifications
455 IAC 2 Maintenance of personnel records
455 IAC 2 Adoption of personnel policies
455 IAC 2 Operations manual
455 IAC 2 Maintenance of records of services provided
455 IAC 2 Individuals personal file; site of service delivery

Compliance with applicable vehicle/driver licensure for vehicle being utilized

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Licensed Home Health Agency

Provider Qualifications

License *(specify):*

IC 16-27-1

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved
Compliance with applicable vehicle/driver licensure for vehicle being utilized

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

specified in statute.

Service Title:

Vehicle Modifications

HCBS Taxonomy:

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

Service Definition *(Scope):*

Vehicle Modifications (VMOD) are the addition of adaptive equipment or structural changes to a motor vehicle that will empower a participant to safely transport in a motor vehicle.

ALLOWABLE ACTIVITIES

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

A. Wheelchair lifts;

B. Wheelchair tie-downs (if not included with lift);

C. Wheelchair/scooter hoist;

D. Wheelchair/scooter carrier for roof or back of vehicle;

E. Raised roof and raised door openings;

F. Power transfer seat base;

G. Maintenance is limited to $1,000.00 annually for repair and service of items that have been funded through a HCBS waiver:
1.Requests for service must differentiate between parts and labor costs;
2.If the need for maintenance exceeds $1000.00, the care manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a non-waiver funding source.

SERVICE STANDARDS
A. The vehicle to be modified must meet all of the following:
1. The participant or primary caregiver is the titled owner;
2. The vehicle is registered and/or licensed under state law;
3. The vehicle has appropriate insurance as required by state law;
4. The vehicle is the participant's sole or primary means of transportation;
5. The vehicle is not registered to or titled by a Family and Social Services Administration (FSSA) approved provider.
6. Only one vehicle per a participant's household may be modified;

B. Many automobile manufacturers offer a rebate of up to $1,000.00 for participants purchasing a new vehicle requiring modifications for accessibility. To obtain the rebate the participant is required to submit to the manufacturer documented expenditures of modifications. If the rebate is available, it must be applied to the cost of the modifications.

C. Requests for modifications may be denied if the BDS director or designee determines the documentation does not support the service requested.

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

DOCUMENTATION STANDARDS

Care Manager Documentation Standards:
Responsible to document the need for VMOD determined to meet the needs of the participant through the person-centered planning process.
Responsible to describe the specific modification being requested to the vehicle.
Collect 2 bids if over $1,000.00. If 1 bid is obtained the CM must document the date of contact, the provider name, and why the bid was not obtained from that provider.
Warranty information.
Picture of vehicle modification is included with the bid.

Provider Standards:
D. Provider of services must maintain receipts for all incurred expenses related to the modification;
E. All bids must be itemized.
F. Must be in compliance with FSSA and Division specific guidelines and/or policies.

Provider Standards:
D. Provider of services must maintain receipts for all incurred expenses related to the modification;
E. All bids must be itemized.
F. Must be in compliance with FSSA and Division specific guidelines and/or policies.

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

A cap of $15,000.00 is available for one (1) vehicle per every ten (10) year period for a participant's household. In addition to the applicable lifetime cap $1000.00 will be allowable annually for repair, replacement, or an adjustment to an existing modification that was funded by a Home and Community Based Services (HCBS) waiver.

This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual) as outlined in C-2-d and C-2-e of this waiver.

ACTIVITIES NOT ALLOWED

Examples/descriptions of modifications/items Not Covered include the following:

A. Repair or replacement of modified equipment damaged or destroyed in an accident;
B. Alarm systems;
C. Auto loan payments;
D. Insurance coverage;
E. Driver's license, title registration, or license plates;
F. Emergency road service;
G. Routine maintenance and repairs related to the vehicle itself.
H. Specialized Medical Equipment or Home Modification items are not allowed.
I. Leased vehicles

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

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/OMPP approved Vehicle Modification Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Agency

Provider Type:

FSSA/OMPP approved Vehicle Modification Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: General requirements
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements; documentation of qualifications
455 IAC 2 Maintenance of records of services provided
455 IAC 2 Warranty required

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Medicaid Policy and Planning (OMPP)

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf

of waiver participants:

Appendix C: Participant Services

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

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

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

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

All providers must submit a criminal background check as required by 455 IAC 2. The criminal background check must not show any evidence of acts, offenses, or crimes affecting the applicant’s character or fitness to care for waiver consumers in their homes or other locations. Additionally, licensed professionals are checked for findings through the Indiana Professional Licensing Agency. The Office of Medicaid Policy and Planning (OMPP) also requires that a current limited criminal history be obtained from the Indiana State Police central repository as prescribed in 455 IAC 2 Adoption of personnel policies, for each employee or agent involved in the direct management, administration, or provision of services in order to qualify to provide direct care to individuals receiving services at the time of provider certification. Direct care staff is also checked against the nurse aide registry at the Indiana Professional Licensing Agency verifying that each unlicensed employee or agent involved in the direct provision of services has no finding entered into the registry in order to qualify to provide direct care to individuals receiving services. The Office of Medicaid Policy and Planning (OMPP) verifies receipt of documentation as a part of provider enrollment.

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

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ○ **No. The state does not conduct abuse registry screening.**
- ◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Indiana Professional Licensing Agency is responsible for maintaining the nurse aide registry. Pursuant to Indiana Administrative Code 455 IAC 2.6.2 General Requirements: the provider must obtain and submit a current document from the nurse aide registry of the Indiana Professional Licensing Agency verifying that each unlicensed employee involved in the direct provision of services has no finding entered into the registry before providing direct care to individuals receiving services. The Office of Medicaid Policy and Planning (OMPP) verifies receipt of documentation as a part of provider enrollment. The Home- and Community-Based Services (HCBS) provider ensures the nurse aide remains current on the registry. Their certifications expire and must be renewed every 2 years, which includes verification of their status against the abuse registry.

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

Appendix C: Participant Services

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

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- ○ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ◉ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

In accordance with the federal description, Legally Responsible Individuals (LRIs) include ONLY the parent of a minor child or a spouse of a participant. LRIs DO NOT include the parent of an adult participant (including a parent who also may be a legal guardian) or other types of relatives.

LRIs may be paid by an FSSA-approved provider for the provision of ONLY Structured Family Caregiving services (SFC) and ONLY when the following conditions are met:

• the SFC services are provided as “extraordinary care.” Extraordinary care in the provision of Structured Family Caregiving means the day-to-day care or support activities provided by a legally responsible individual principal caregiver (spouse or parent who meet the established waiver provider qualifications) that exceed the daily care that a legally responsible individual ordinarily would provide or perform in the household on behalf of a person of the same age without a disability or chronic illness;

• the SFC services are provided in alignment with the SFC waiver service definition and limitations found in Appendix C of this waiver;

• the LRI is qualified to provide SFC services in alignment with the qualifications found in Appendix C of this waiver; and

• the LRI is employed by or contracts with an OMPP-approved provider agency. Payment for SFC services provided by an LRI is only made to an OMPP-approved provider agency, and payment for such SFC services is never made directly to the LRI.

The State tracks service plans that include the provision of SFC by an LRI for monitoring purposes. Additionally, provider agencies and their employed/contracted LRIs who receive payment for the provision of SFC services will be subject to service plan monitoring by the Care Manager as described in Appendix D-2-a. These practices will ensure that services delivered will continue to meet the needs and goals as well as the best interest of the participant.

As with all other waiver-funded services, SFC service delivery is authorized via the Notice of Action (NOA) issued by the state upon approval of the participant’s service plan. Provider agencies are required to ensure that waiver services are provided as authorized and to document service delivery, allowing access to that documentation at any time by the state or its agents, including the care manager. As explained in Appendix I-2-d of the waiver application, the state uses a billing validation process to ensure claims are paid only for necessary services that were properly authorized and actually provided to the participant within the authorized timeframe. Billing is subject to audit by the state in look behind efforts of BDS, OMPP, and by the FSSA’s surveillance and utilization unit.

☐ **Self-directed**

☒ **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

○ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

◉ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

In accordance with the federal description, Legally Responsible Individuals (LRIs) include ONLY the parent of a minor child or a spouse of a participant. LRI's DO NOT include the parent of an adult participant (including a parent who also may be a legal guardian) or other types of relatives. Except as specified in Appendix C-2-d above for Structured Family Caregiving, the state does not make payments to legally responsible individuals for furnishing any other waiver services.

Relatives and Legal Guardians may be paid by an FSSA-approved provider agency for the provision of selected services (as specified below in this Appendix C-2-e) ONLY when:

the services are provided in alignment with the waiver service definitions and limitations found in Appendix C of this waiver;
the individual providing such services is qualified to provide such services in alignment with the qualifications found in Appendix C of this waiver; and
the individual providing such services is employed by or contracts with a FSSA-approved agency service provider.

The state will make payment to an FSSA-approved provider agency for the provision of selected services (as specified below in this Appendix C-2-e) allowing the provider to reimburse the following types of relatives (natural, adoptive and/or step relationships, whether by blood or by marriage, inclusive of half and/or in-law status):

Parent of an Adult (natural, step, adopted, in-law)
Grandparent (natural, step, adopted)
Uncle (natural, step, adopted)
Aunt (natural, step, adopted)
Brother (natural, step, half, adopted, in-law)
Sister (natural, step, half, adopted, in-law)
Child (natural, step, adopted)
Grandchild (natural, step, adopted)
Nephew (natural, step, adopted)
Niece (natural, step, adopted)
First cousin (natural, step, adopted)

The state allows payment to be made to Relatives (as specified above in this Appendix C-2-e) for the provision of the following waiver services:

Adult Day Services
Attendant Care
Home and Community Assistance
Skilled Respite
Day Habilitation
Supported Employment
Assisted Living
Behavior Management/Behavior Program and Counseling
Structured Family Caregiving Services

The state allows payment to be made to Legal Guardians for the provision of Attendant Care Services and Structured Family Caregiving, but will not allow payment to be made to Legal Guardians for the provision of any other waiver service. Additionally, when provided by a Legal Guardian, Attendant Care Services are limited to a maximum of forty (40) hours per week per paid Legal Guardian caregiver.

Relatives and Legal Guardians who receive payment for waiver services (as specified above in this Appendix C-2-e) will be subject to post-payment review as described in Appendix D-1-g and service plan monitoring as described in Appendix D-2-a. These practices will ensure that services delivered will continue to meet the needs and goals as well as the best interest of the participant.

As with all other waiver-funded services, service delivery is authorized via the Service Authorization/Notice of Action (SA/NOA) issued by the state upon approval of the participant's person-centered service plan. Providers (including Legal Guardians and Relatives) are required to ensure that waiver services are provided as authorized and

to document service delivery, allowing access to that documentation at any time by the state or its agents, including the care manager. As explained in Appendix I-2-d of the waiver application, the state uses a billing validation process to ensure claims are paid only for necessary services that were properly authorized and actually provided to the participant within the authorized timeframe. Billing is subject to audit by the state in look behind efforts of BDS as well as by the FSSA's surveillance and utilization unit.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The Office of Medicaid Policy and Planning is dedicated to increasing home and community-based providers for the waiver. The OMPP is dedicated to focusing on recruitment, certification, timely enrollment of providers by the fiscal agent, and retention of waiver providers. Information regarding home and community-based services is posted on the Family and Social Services Administration's website. The OMPP has open enrollment meaning any provider can apply at any time.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
C/L.1 Number and percent of newly enrolled licensed/certified waiver providers that met the provider qualifications prior to providing waiver services. Numerator: Number of newly enrolled licensed/certified waiver providers that met the provider qualifications prior to providing waiver services. Denominator: Total number of newly enrolled licensed/certified waiver providers.

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

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

Data Aggregation and Analysis:

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

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:
C/L.2 Number and percent of existing enrolled licensed/certified waiver providers that continue to meet provider qualifications. Numerator: Number of existing enrolled licensed/certified waiver providers continuing to meet provider qualifications. Denominator: Total number of existing enrolled licensed/certified waiver providers.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
C/L.3 Number and percent of current licensed/certified waiver providers reviewed in a waiver year who conduct criminal background checks as required. Numerator: Number of current licensed/certified waiver providers reviewed in a waiver year who conduct criminal background checks as required. Denominator: Total number of current licensed/certified waiver providers reviewed in a waiver year.

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

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

Data Aggregation and Analysis:

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

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

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
C.1 Number and percent of newly enrolled non-licensed/non-certified (NL/NC) waiver providers that met the provider qualifications prior to providing waiver services. Numerator: Number of newly enrolled NL/NC waiver providers that met the provider qualifications prior to providing waiver services. Denominator: Total number of newly enrolled NL/NC waiver providers.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
C.2 Number and percent of existing non-licensed/non-certified (NL/NC) waiver providers that continue to meet provider qualifications. Numerator: Number of

existing NL/NC waiver providers reviewed that continue to meet provider qualifications. Denominator: Total number of existing NL/NC waiver providers reviewed.

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

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

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

Performance Measure:
C.3. Number and percent of current non-licensed/non-certified (NL/NC) waiver providers reviewed in a waiver year who conduct criminal background checks as required. Numerator: Number of current NL/NC waiver providers reviewed in a waiver year who conduct criminal background checks as required. Denominator: Total number of current NL/NC waiver providers reviewed in a waiver year.

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

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

Specify:		Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Providers will be reviewed when an allegation is received or once every four years.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
C.4 Number and percent of current waiver providers who attend state mandated provider training. Numerator: Number of current waiver providers who attend state mandated provider training. Denominator: Total number of current waiver providers.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
C.5 Number and percent of enrolled care managers who completed required care management training. Numerator: Number of enrolled care managers who completed required care management training. Denominator: Total number of enrolled care managers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Management Training Tracking Sheet

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

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

Data Aggregation and Analysis:

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

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 BDS reviews daily incident reports, complaints, and other data sources, such as Adult Protective Services records, to determine on an on-going basis if specific provider trends exist. Additionally, the BDS utilizes various electronic reports, generated on a monthly basis, which directly relate to the performance measures identified in the approved waiver. Each negative finding is individually researched by the BDS to determine if the problem or issue has been resolved.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

C.LC.1 and C.1: Indiana requires all new waiver provider-applicants to submit documentation verifying that they meet the criteria and qualifications to provide services prior to allowing them to enroll with the fiscal agent contractor. The process in place effectively prevents provider-applicants from providing waiver services prior to approval and enrollment. In the event a provider became enrolled and initiated delivery of waiver services prior to approval by the OMPP, the OMPP would instruct the fiscal agent to deny any claim relating to waiver service provision, and disenroll the provider-applicant until such time as provider-applicant fully documents they meet all qualifications. The OMPP will initiate an investigation of both internal and fiscal agent processes to identify deficiencies or vulnerabilities within the enrollment and approval processes and undertake appropriate improvements.

C.LC.2 and C.2: To assure existing providers continue to meet provider qualifications, providers undergo a formal service review at least every three (3) years. For licensed providers, this review is conducted by the Indiana Department of Health (IDOH). Non-licensed providers are reviewed by the OMPP. Both IDOH and the OMPP have formal review and remediation procedures which utilize CAPs submitted by the provider with approval or denial by the reviewing entity. If denied, the provider is required to re-submit the CAP. Once approved, the reviewing entity verifies successful implementation of the CAP. Any provider not successfully completing the remediation process to document qualifications is decertified as a provider.

Performance measures C.LC.2, C.2, C.LC3, C.3, C.4, and C.5 Providers that do not meet state requirements or standards are required to develop CAPs to address issues identified in their compliance reviews. OMPP and/or BDS reviews and approves CAPs, and validates that providers are implementing these as stated.

All non-compliant providers are referred to FSSA Administration for review and potential sanctioning, up to and including termination of the provider.

Periodic reports on remediation actions are presented to the QIEC for review.

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 Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The Indiana Family and Social Services Administration (FSSA) attests that all settings are compliant with the HCBS Settings requirements at 42 CFR 441.301(c)(4)-(5). Participants receiving HCBS under the TBI waiver may reside in the following settings:

-Privately owned or rented homes by themselves or with family members, friends, or roommates.

-Adult family care (AFC) homes: Residential services provided in a family-like setting. The AFC homes are approved to serve not more than four participants in a home-like setting in a residential community with a live-in caregiver.

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

-Residential Based Habilitation: Residential services offering training to regain skills lost secondary to a traumatic brain injury.

-Structured Family Caregiving (SFC) homes: Residential service arrangement in which a participant lives together with a related or non-related principal caregiver who provides daily care and support.

TBI 1915(c) waiver services are provided in the participant's home and community, based upon their preference. Additionally, Adult Day Services and Structured Day Program are activities provided in a group setting, outside the participant's home. Settings for service delivery are chosen by the participant during the service planning process and identified in the participant's service plan. To ensure compliance of all settings, HCBS questions are addressed and recorded in the service plan.

TBI 1915(c) waiver services are provided in the participant's home and community, based upon their preference. Additionally, Adult Day Services and Structured Day Program are activities provided in a group setting, outside the participant's home. Settings for service delivery are chosen by the participant during the service planning process and identified in the participant's service plan. To ensure compliance of all settings, HCBS questions are addressed and recorded in the service plan.

FSSA has developed and utilizes a variety of tools to establish HCBS settings criteria compliance and monitor on-going compliance for all provider-owned or controlled settings as well as any other settings where HCBS services are provided. These tools include the following:

Provider application/reverification process that is conducted at least every 4 years.
Service plan development/review process that is conducted at least annually.
Provider Compliance Review (PCR) process that is conducted at least every 3 years.
Complaint Investigation Process that is conducted on a continuously and on-going basis.

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

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

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

Complaint Investigation Process: Individuals can report any instances of non-compliance directly to their care manager or BDS field staff. BDS Quality Assurance also provides an online complaint form as well as a complaint hotline to submit reports of non-compliance. Any individual, guardian, family member, and/or community member has the right to file a complaint on the behalf of an individual receiving waiver services through the TBI waiver. A complaint can be filed if it is felt the provider has not followed state and/or federal rules or program requirements. FSSA will then investigate the complaint and determine the best course of action to assess the situation.

FSSA applies a combination of existing guidelines to address any necessary remedial strategies including providing additional education and technical assistance. In the event a provider has gone through remediation activities and continues to demonstrate non-compliance with HCBS requirements, FSSA will apply its authority under IC 12-11-1.1-11 that allows for the issuance of citations in the form of developing corrective actions up to and including provider sanctions.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Service Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:
- ☐ **Social Worker**
  Specify qualifications:
- ☐ **Other**
  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- ◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made

available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The care manager facilitates the service plan development process with the participant, or the participant's legal guardian, and the participant's invited supports identified in their circle of support. The participant and their circle of support are educated on all HCBS program service options for consideration in developing a service plan. A "pick- list" of all approved service providers in his or her area is provided to the participant and the participant has freedom of choice to select among these providers for each service addressed in the service plan. The care manager empowers the participant to actively self-advocate by communicating needs and preferences to potential and selected providers and other plan development participants.

Appendix D: Participant-Centered Planning and Service Delivery

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

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The care manager facilitates the service plan development process with the participant, or the participant's legal guardian, and the participant's chosen supports identified in their circle of support. The participant and their circle of support are educated on all HCBS program service options for consideration in developing a service plan. The care manager, in collaboration with the participant, develops the service plan. During this development when service types have been identified to appropriately meet their service needs, then the participant with their circle of support will select providers. When providers are selected the participant or guardian will appropriately sign the pick list for all services. When the service plan is ready for review the CM will follow their internal process to submit to the BDS.

The care manager in collaboration with the participant, the participant circle of support, and providers will engage with the initial, ninety (90) day, mid-reviews, and annual re-determination assessments to evaluate the participant's holistic well-being that includes but is not limited to, strengths, capacities, needs, preferences and desired outcomes, health status, and risk factors. Assessments can be conducted more often depending on the participant's changing needs. Based on the outcomes of the assessments, a comprehensive service plan is developed.

The care manager is responsible for the coordination of all services and to assure that needs are met. The care manager is responsible for the implementation and monitoring of the service plan. In accordance with 42 CFR 431.301, the person-centered service plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation. FSSA requires that care managers furnish providers with a copy of the service plan initially, annually, and when there is a change or revision to the plan.

The participant receives a copy of the service plan, so they are aware of the services that are being provided and the frequency of the services by the service providers. The service plan development process affords a checks and balance approach regarding the assignment of responsibilities to implement and monitor the service plan by input from the participant, care manager, physician, provider of service, and the BDS.

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

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

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

The participant signs a release form that allows the care manager to contact service providers once the client has selected the providers of choice. The care manager is responsible for the coordination of all services and to assure that needs are met. The care manager is responsible for the implementation and monitoring of the service plan.

The participant and other people involved in the plan receive a copy of the service plan, so they are aware of the services that are being provided and the frequency of the services by the service providers. The service plan development process affords a checks and balance approach regarding the assignment of responsibilities to implement and monitor the service plan by input from the participant, Care Manager, physician, provider of service, and the DA. The DA's policy and processes require the person-centered plan to be finalized, agreed to, and to obtain informed consent of the individual in writing. Then the plan is to be signed by all individuals and providers responsible for its implementation. The person-centered plan includes signature lines for all individuals and providers responsible for its implementation. Care Managers are responsible for updating the plan and obtaining applicable signatures. A signed person-centered plan is made

available to other providers responsible for its implementation.

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

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

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

Formal and informal back-up supports are identified early in the service planning process to address risks which could pose a threat to the participant's health or welfare. Contingency plans may address medical emergencies, failure of a support worker to be present when scheduled, or any other potential risk which can be identified by assessment tools, the participant, or members of their support system. Informal supports including friends, family, and neighbors may be used to assist in providing services in a crisis situation. The State also requires that all participants have easy access to emergency contact information and monitors for this in provider compliance reviews.

Each person-centered service plan will identify any assessed risks and strategies for supporting the person the opportunity to still engage in activities that may pose a risk. Person centered service plans will address each person's right to dignity of risk and associated decisions, along with the specific supports necessary to engage in the identified risky activity.

The person-centered service plan will clearly identify any activities that pose a significant level of risk which require restricting the person's ability to engage in the activity. Such restrictions will have a targeted modification plan, proportional to the risk itself, including support necessary for the person to engage in the activity, and a plan to restore the person's unrestricted right to that activity. The service provider must document the assessed risk, including when and how often the risk occurs, and develop a strategic plan to attempt to restore the person's right to that activity.

The State recognizes that risk tolerance varies greatly from participant to participant and encourages care managers to recognize and respect the participant's individual desires and preferences when formulating risk mitigation strategies.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

An electronic database is maintained by DDRS that contains information regarding all qualified waiver providers for each service on the TBI waiver. Care managers are able to generate a list of all qualified providers for each service on the TBI waiver for the participants' use.

As a service is identified, participant or guardian with the circle of support are encouraged to call and interview potential service providers and make their own choice. Care managers can assist the participant with interviewing potential providers and obtaining references on potential providers, if desired by the participant.

The participant can request a change of any service provider at any time while receiving TBI services. The care manager will assist the participant with obtaining information about any and all providers available for a given service.

Care managers are not allowed to give their personal or professional opinion on any waiver service provider. The care manager is responsible for the coordination of the transition of a provider once determined by the participant.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

FSSA is the Single State Medicaid Agency. The Office of Medicaid Policy and Planning (OMPP) and the Division of Disability and Rehabilitative Services (DDRS) are divisions within FSSA. The Bureau of Disabilities Services (BDS) is a bureau within DDRS.

All service plans are subject to the approval of the state Medicaid agency. Oversight of service plans has been delegated to DDRS and its BDS. Initial service plans that require confirmation of facility discharge and service plans that include variable rate services are reviewed to verify the individual's needs and receipt of sufficient supporting documentation. Service plans are approved, denied, or returned for additional information or clarification when necessary.

A valid sample of service plans is reviewed in depth on a routine basis. The number of service plans to be reviewed is determined semi-annually. Designated staff from BDS conducts in-depth reviews of service plans, verifying that all required components of the service plans are in place. Service plans are approved, denied, or returned for additional information or clarification when necessary.

The service plan includes natural and other non-paid supports.

As the result of the Quality Improvement Executive Committee (QIEC) meetings where performance measures are monitored and discussed, OMPP receives quarterly reports from BDS that contain performance-related data pertaining to oversight of the service plans.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ○ **Every twelve months or more frequently when necessary**
- ◉ **Other schedule**

Specify the other schedule:

The service plan is reviewed and updated no less than annually. The service plan is reviewed by the care manager at least once every 90 calendar days. The participant can request a change at any time.

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

☒ **Medicaid agency**

☐ **Operating agency**

☐ **Case manager**

☒ **Other**

Specify:

Electronic documents of the service plans are maintained in the State's case management data system for a minimum of three years.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The waiver care manager is the entity responsible for monitoring implementation of the service plan as well as the general health and welfare of the participant. The care manager maintains regular contact with the participant, family/guardian, and the provider(s) of services through home and community visits or by phone to coordinate care, monitor progress, and address any immediate needs. During each of these contacts the care manager assesses implementation of the plan as well as monitors the participant's needs. Contact information is in place in the home, including the telephone numbers for Adult Protective Services or Child Protective Services and BDS.

The state requires the care manager to meet face-to-face with the participant at a minimum of every ninety (90) calendar days. At this 90 Day Review, the care manager completes the 90 Day Checklist to assure that approved services continue to meet the medical needs and goals of the participant. The 90-Day Checklist is a comprehensive assessment tool which addresses the following domains via responses from both the care manager and the participant: service plan implementation and applicability, behavior, rights, medical issues, medication issues, seizures, nutrition and dining, health and safety, critical incident reporting and resolution, staffing, and financial issues. This review tool also provides a means of assessing the potential for suspected abuse, neglect or exploitation and forms the basis for any needed revision to the service plan.

All providers rendering services to the participant are required to coordinate efforts and to share documentation regarding the participant’s well-being with the care manager. Providers of waiver services are required to have back-up plans to provide staffing for waiver participant’s needs. At the ninety (90) Day Review, the care manager verifies with the participant the appropriateness and effectiveness of back up plans and adjusts the plan accordingly.

As part of the monitoring of the participant’s health and welfare, the provider is required to send all incident reports to both the BDS and the care manager. If follow-up is required for an incident, the State requires the care manager to provide follow-up every 7 calendar days until the incident is deemed resolved. Similarly, the State may require the care manager to address any provider complaints filed by the participant, or on their behalf.

If changes to the service plan are warranted in order to meet the medical needs and goals of the participant, the care manager submits additional information and an updated service plan to the BDS. The BDS determines if the additional services are appropriate based on the assessment and documentation provided.

The care manager serves as the primary contact for the participant and family and is expected to coordinate needs with the participant’s providers.

The BDS reviews service plan delivery and the supporting documentation through the use of the Person-Centered Management Tool (PCMT).

Additional methods for systemic collection of information about monitoring results are detailed in Appendix H.

b. Monitoring Safeguards. *Select one:*

- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
D.2 Number and percent of sampled individuals whose service plan addresses their needs and abilities. Numerator: Number of sampled individuals whose service plan addresses their needs and abilities. Denominator: Total number of sampled individuals.

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

Electronic Case Management Database System

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: 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**

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

Performance Measure:
D.3 Number and percent of sampled individuals whose service plan included a risk assessment. Numerator: Number of sampled individuals whose service plan included a risk assessment. Denominator: Total number of sampled individuals.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Case Management Database System

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: 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:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.4 Number and percent of sampled individuals whose service plan addressed their assessed risks (as applicable). Numerator: Number of sampled individuals whose service plan addressed their assessed risks (as applicable). Denominator: Total

number of individuals sampled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Case Management Database System

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: 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:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

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

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

Performance Measure:
D.5 Number and percent of sampled individuals whose service plan was reviewed and

changed (as needed) when their needs changed. Numerator: Number of sampled individuals whose service plan was reviewed and changed (as needed) when their needs changed. Denominator: Total number of sampled individuals.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Care 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: 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:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.6 Number and percent of individuals whose service plans were updated/revised within 365 days of the previously approved annual service plan. Numerator: Number of individuals whose service plans were updated/revised within 365 days of the previously approved annual service plan. Denominator: Total number of individuals enrolled in the waiver who are due for an annual service plan.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Care Management Database System

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

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

Data Aggregation and Analysis:

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
D.7 Number and percent of individuals who received the waiver services/supports in their service plans in the stipulated type, scope, amount, duration, and frequency. Numerator: Number of sampled individuals who received the waiver services/supports in their service plans in the stipulated type, scope, amount, duration, and frequency. Denominator: Total number of sampled individuals.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Care Management Database System

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**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

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

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

Performance Measure:
D.8 Number and percent of individuals who were afforded a choice between/among waiver services and providers. Numerator: Number of sampled individuals who were afforded a choice between/among waiver services and providers. Denominator: Total number of sampled individuals.

Data Source (Select one):
Other

If 'Other' is selected, specify:
Electronic Care Management Database System

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: 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**

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

Performance Measure:
D.9 Number and percent of sampled individuals who responded that the care manager (CM) talked to them about services/resources that may help with their unmet needs/goals. Numerator: Number of sampled individuals who responded that the CM talked to them about services/resources that may help with their unmet needs/goals. Denominator: Total number of sampled individuals who responded.

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

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

Specify: NCI-AD Survey Contractor		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:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

For measures D.1 and D.9, a service plan is developed to support the participant in attaining a good life. Indiana utilizes the NCI-AD In-Person Survey to assess whether a participant's services and supports identified in the service plan are supporting him or her in moving towards a good life. A face-to-face survey is conducted in which the participant is asked a series of questions regarding satisfaction. One of the questions is specific to whether the participant believes the services and supports help him or her live a good life. The NCI-AD response data is collected during the survey process, but the specific participant is not identified. The data is reviewed on a quarterly basis by QIEC and when a trend is identified, guidance and education for the entire community is developed and communicated. DDRS has conducted training on the LifeCourse Framework™ and the implementation of the service plan.

For measures D.2, D.3, D.4, D.5, D.6, D.7, and D.8, BDS conducts monthly case record reviews utilizing a waiver-specific valid sampling methodology. BDS staff review waiver participant records for care manager compliance with Indiana Administrative Code rules related to the service plan. Additional aspects of the case record review include: review of the service plan, risk assessment (embedded in the service plan), identified risk plans, Medicaid services (BDS signature page/freedom of choice section), signed pick lists for each service, and an updated service plan when a participant's conditions or circumstances change.

For any item reviewed that is not in compliance, a corrective action plan is required, and an electronic notification is sent to the responsible party that includes a description of the corrective action, steps to resolve, and due date. BDS verifies implementation of the corrective action and either closes the case record review or issues a second attempt for implementation by the responsible party. Reports are provided quarterly to QIEC for trends related to case record reviews. This process allows for identification of issues that may require additional training and education.

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: NCI-AD Survey Contractor	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- (●) **No**
- ( ) **Yes**

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

Appendix E: Participant Direction of Services

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

- ( ) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- (●) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- ( ) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

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 individual's initial eligibility assessment by the Level of Care Assessment Representative (LCAR) contractor.

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

• Denying functional level of care;

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

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

Each formal notification is generated from and stored within the electronic eligibility systems. The care 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 care manager assists the participant in preparing the written request for an appeal. The care manager advises the 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**

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

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 participant's needs.

Any issues that involve a participant'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 participant 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 Individualized Support Team (IST) a description of the dispute, their positions, and their efforts to resolve the dispute. The IST will provide a decision and the parties must abide by that decision. If an IST cannot resolve the matter within 15 days after the dispute is referred to the IST, 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 IST to use, but it is not required before a participant or guardian can request an appeal. The care manager is responsible for the monitoring of services and ensuring that the participant understands that the dispute process is not a prerequisite or substitute for the 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 a participant such that an emergency exists. Under these circumstances, BDS takes actions to protect the health and welfare of the participant 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**

b. 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.

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

a) TYPES OF GRIEVANCES/COMPLAINTS 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 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 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 care 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 participant's home or day program site;
- Conducting one-on-one interviews with the 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 a participant's health and welfare are classified as "Urgent." Urgent complaints require an immediate response to ensure the health and welfare of the participant. Within one business day, a Quality Reviewer will perform an unannounced onsite visit/phone contact to ensure the participant'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 a participant'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 participant'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 care 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 a participant or death of a participant:

1) Alleged, suspected, or actual abuse, neglect, or exploitation (ANE) of a participant. 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 a participant, pending investigation by the provider. If needed, the care manager coordinates replacement services for the participant. In the event that the care manager is the alleged perpetrator the participant will be given a new pick list from which a new care manager will be selected. If APS or DCS has reason to believe that a participant 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 participant 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 a participant as indicated in the service plan.

• "Exploitation” is defined as an unauthorized use of the personal services, the property, or the identity of a participant; 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 a participant. 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 a participant while the participant 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 a participant, 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 a participant receiving services. This includes but is not limited to relocation, personal injury, or property loss.

5) Participant elopement or missing person, including elopement of a participant where a provider or service delivery site fails to provide the required support as described in the service plan as necessary for the participant’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 participants care; (b) a family member of a participant receiving services when it affects or has the potential to affect the participants care or services; or (c) the participant receiving services This may include:
☐ Police arrest of the participant or any person responsible for the care of the participant

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

7) An event with the potential for causing significant harm or injury and requiring medical or psychiatric treatments or services to or for a participant 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 a participant 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 a participant 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 a participant is restrained the injury must also be specified in incident report.

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

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 participant;

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 a participant, including inadequate supervision, with the potential for:

a) Significant harm or injury to a participant; or

b) Death of a participant.

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 a participant to a nursing facility, excluding respite stays.

17) Inadequate medical support for a participant, 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 a participant's behavior. An incident report related to the use of PRN medication related to a participant's behavior must include the following information:

a) The length of time of the participant's behavior that resulted in the use of the PRN medication related to the participant's behavior.

b) A description of what precipitated the behavior resulting in the use of PRN medication related to the participant'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 participant'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 a participant's behavior.

f) A description of the provider's PRN medication protocol related to a participant's behavior, including the provider's:

i. Notification process regarding the use of a PRN medication related to a participant’s behavior; and

ii. Approval process for the use of a PRN medication related to a participant's behavior.

g) The name and title of the staff approving the use of the PRN medication related to the participant's behavior.

h) The medication and dosage that was approved for the PRN medication related to the participant's behavior.

i) The date and time of any previous PRN medication given to the participant related to the participant'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 participant at the time of the incident; or
- Becomes aware of or receives information about an alleged incident.

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

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 participant, guardian and/or family, a paper/hard copy of the IHCP DDRS HCBS Module will be provided by the case manager.

Participants are required to sign and date that they received the grievance procedure and a link and/or copy of the above mentioned IHCP 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 participant'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 participant's care 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 participant's health and safety, the care 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 opens until there is documentation that the provider took the appropriate actions to resolve the issue.

Care managers are responsible for following-up on all incident reports while BDS oversees how timely and effectively care 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 care manager follow-up and reporting every seven (7) calendar days until the incident is determined by the incident reviewer to be resolved. Follow-up reports are also submitted via the web-based incident reporting system. 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 care managers are completing required follow-up reports until incidents are closed.

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

To further clarify the role of the care manager:
• At a minimum, care managers will meet with participants four times per year, not less than once every 90 calendar days. Care managers shall monitor the effectiveness of the service plan outcomes using documented review between the 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 participants with high risk or high health needs, care managers have monthly face-to-face interactions with the participant.
• Care managers are responsible for ensuring the participant's immediate protection from harm when participants have had critical events which includes making contact with the provider and/or waiver participant/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 care 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 participants' health or safety, and whether immediate follow-up is necessary. Providers are responsible for taking appropriate and effective measures to secure the participant's immediate safety, implementing preventative measures, and investigating reported incidents. Care managers then validate and use follow-up reports to document the provider's actions to safeguard the participant. Care 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 participant'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 a participant from the provider's services, issue a moratorium on the provider taking new 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.

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, care 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 care 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 participant of the investigation results would be dependent upon the unique range of activity required to complete each investigation and the policies of each individual care manager. Informing the participant 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 care manager to wait longer than 90 calendar days to report the results to the participant.

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, care 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 Disability 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 care manager training.

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

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

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

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

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

Appendix G: Participant Safeguards

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

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

◉ **The state does not permit or prohibits the use of seclusion**

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

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 care manager training.

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

b. Medication Management and Follow-Up

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

Medication management and follow up responsibilities resides 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 participants have medications that must be consumed during the times they are attending the ADS. These providers are responsible for the medication management and all necessary follow ups to ensure the health and welfare of the individuals within their care. 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 participant 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 participant and he/she requires assistance in the delivery of such medication. Additionally, the provider must demonstrate an understanding of the medication regimen, including the reason for the medication, medication actions, specific instructions, and common side effects. The providers must assure the security and safety of each participant's specific medications if medications are located in a common area such as kitchen or bathroom of the home.

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 care manager conducts a face-to-face visit with the participant at least every ninety (90) calendar days to assure all services, including medication management, are within the expectations of the waiver program. Additionally, non-licensed providers will be surveyed by the 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 participant's medication regime which includes the reason for the medication, medication actions, specific instructions, and common side effects. The provider must maintain a written medication record for each participant for whom they assist with medication management. Medication records will be reviewed as a part of announced and unannounced provider visits and service reviews by Care Managers, 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 participants selected for random review. Care managers review services, including medication management, during their 90-day participant service plan review. Additionally, non-licensed providers will be surveyed by 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)*

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

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 participant and he/she requires assistance in the delivery of such medication. Additionally, all providers must demonstrate an understanding of the medication regimen, including the reason for the medication, medication actions, specific instructions, and common side effects. The providers must assure the security and safety of each participant's specific medications if medications are located in a common area such as kitchen or bathroom.

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

- ◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
  Complete the following three items:

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

All approved waiver providers that are responsible for medication 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 participants record as per BDS's IR policy. This includes the following:

a) Medication given that was not prescribed or ordered for the participant;
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 participant;
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:

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

IDOH has responsibility for monitoring the licensed providers through survey and compliance review processes. Additionally, 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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
G.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	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(check each that applies):		
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: 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: QA/QI 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:

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 *(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.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	**Frequency of data**	**Sampling Approach**

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

Data Aggregation and Analysis:

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

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

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 *(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:

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

Agency		
☒ **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**
	☐ **Other** Specify:

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

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: 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: 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	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: 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: QA/QI Contractor	☐ **Annually**

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

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:	

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** 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:

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 *(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:

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 care 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 *(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.

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 States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

HCBS waiver providers are responsible for taking appropriate and effective measures to secure the participant'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 participant's immediate safety.

Care 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 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.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- (●) **No**
- ( ) **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

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

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

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

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

Quality Improvement Strategy: Minimum Components

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

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

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

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

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

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able

to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

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

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. Care managers are responsible for monitoring services, advocating with the individual, and following-up on issues identified through their routine contacts with the individual. Care managers also take a lead role in facilitating individualized support team (IST) meetings while supporting the individual to lead their meeting to the best of their ability. The care manager and individual meet at least every 90 calendar days, and the IST meet at least semiannually and annually. The IST 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 IST which may be used to make decisions include:
- Data from the care manager's required IST 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 participants' 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) chief program officer
• BDS provider services representative
• BDS field operations liaison
• BDS special projects director/vendor management
• OMPP representative
• BDS Home and community-based services (HCBS) policy analyst
• 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 participant'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 participants' 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:

• Care 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 participant each year, coordinating and facilitating IST meetings as necessary, and identifying and resolving issues with service delivery. Care managers have the potential to identify the effectiveness of system design changes by how the participants they work with are impacted.
• BDS-contracted complaint investigators are continually in the field following up on allegations that participants' 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.
• Designated staff from the BDS QA/QI contractor conduct case record reviews to assess whether service plans have been developed according to the state's standards for service plans.

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):*

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 Care Management system. When it receives an allegation regarding a waiver provider, PI forwards it to FSSA Audit to begin their research and audit process. FSSA Audit works with PI to vet the providers with the Indiana Medicaid Fraud Control Unit (MFCU). Once MFCU's clearance is determined, FSSA Audit determines means to validate the accuracy of the allegation. FSSA Audit may conduct statistically valid random sample of consumers and then 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 ultimately 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, time frames or other scenarios that have been identified as higher risk for fraud, waste, and/or abuse to determine potential outcomes of audit findings or payment error issues.
•Random Sample Audit - The goal of the random sample is to identify potential payment errors and extrapolate those errors to the entire universe of claims.

FSSA Audit conducts its audit activities and develops a findings report for the provider 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; however, it may be apparent that the provider as well as the Medicaid Program would benefit from the provider receiving additional education on proper/best billing practices.
•Provider self-audit – Specific concern(s) were identified resulting in a recommended limited-scope audit; however, the concern(s) are in an area which the State is comfortable with the provider conducting the audit to ensure compliance. FADS contractors subsequently perform validation review of the provider self-audit results. If FADS contractors determine they are not in agreement with a high percentage of the provider's self-audit results during the validation review, they will recommend the audit be escalated to a desk review and all records within the provider self-audit sample are evaluated by the contractor.
•Provider desk audit – Concern(s) were identified resulting in the need for medical record review (could be full or limited

scope). However, the severity of the concerns do not currently warrant an on-site review. Certain provider records, including medical records, are requested for selected claims and clinical staff (if necessary) conduct a review of the services billed to ensure compliance with IHCP guidelines. Providers are allowed thirty (30) days to submit the requested information.
•Provider on-site audit (announced or unannounced) – Severity of the concern(s) has resulted in a recommendation of an on-site audit. Providers are generally given shorter notice (or no notice if warranted) of the pending on-site audit. If notice is provided, it can range from a few days to a few weeks depending on several factors (i.e., type of facility, audit concerns, etc.). Requested information is collected on-site. A facility tour as well as provider/staff interviews are also conducted during on-site reviews. FADS contractors, including clinical staff, are included in on-site reviews and assist with conducting interviews. State program integrity personnel often also participate in on-site reviews.
•Referral to MFCU – Payment suspension recommended as the potential intent of fraudulent behavior was identified. Depending on the allegations/information received regarding the provider(s), the SUR Unit may conduct a Preliminary Investigation, utilizing the Credible Allegation of Fraud (CAF) tool developed by FADS contractors to determine the appropriate next steps, if any.

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

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

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

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

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

The FSSA's oversight of the contractor's aggregate data is used to identify common problems to be audited, determine benchmarks, and offer data to peer providers for educational purposes, when appropriate. On a more proactive level, FSSA Audit also routinely meets with 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. However, those providers will be required to export data from their alternate system to the Sandata "Aggregator" for integration with CoreMMIS.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
I.1 Number and percent of claims paid 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***

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

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

Performance Measures

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

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

Performance Measure:
I.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 States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

I.1 and I.2 Claims reimbursement issues may be identified by a care 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 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.

ii. Remediation Data Aggregation

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

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

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

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 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. 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 participant. The rate composite for each level includes the following components:

Attendant Care
Home Maker
Skilled Nursing
Adult Day Service
Emergency Response
Non-Medical Transportation

Participant levels 1-3 are assigned based on an Indiana-specific Level of Service tool. Level 2 has the highest projected utilization and is the starting point of the Assisted Living tiered rates. Under tiered rate adjustments, the Level 2 Attendant Care, Home Maker and Skilled Nursing rate components are adjusted upwards by 17% for the level 3 rate and adjusted downward by 10% for the level 1 rate. These Assisted Living level differentials are informed by multiple discussions with 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 participant access to waiver services.

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

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

Appendix I: Financial Accountability

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

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

- (●) ***No. state or local government agencies do not certify expenditures for waiver services.***
- ( ) ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services***

and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

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

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

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

Appendix I: Financial Accountability

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

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

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 a participant'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 participant'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 a participant whose Medicaid eligibility status is not currently open within an acceptable category as described under Appendix B-4-b. When the appropriate Medicaid eligibility status is in place, the service plan will be approved, and the system will generate the Notice of Action (NOA), which is sent to each authorized provider of services on the Plan. The NOA identifies the individual participant, the service that each provider is approved to deliver, and the rate at which the provider may bill for the service.

The 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 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 Care Manager verifies with participant the appropriateness of services and monitors for delivery of service as prescribed in the plan of care. Modifications to the plan of care are made as necessary.

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

g. Additional Payment Arrangements

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

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

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

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

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

iii. Contracts with MCOs, PIHPs or PAHPs.

- ◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

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

- ○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver***

and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

○ ***This waiver is a part of a concurrent ?1115/?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 ?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 textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

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

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

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

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

☐ ***Other State Level Source(s) of Funds.***

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

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or*

sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

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

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

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

☐ ***Other Local Government Level Source(s) of Funds.***

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

Appendix I: Financial Accountability

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

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

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

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

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

Appendix I: Financial Accountability

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

a. Services Furnished in Residential Settings. *Select one:*

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

individual.

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

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

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

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

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

Appendix I: Financial Accountability

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

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

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

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

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

Appendix I: Financial Accountability

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

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

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

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

i. Co-Pay Arrangement.

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

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

☐ ***Nominal deductible***

☐ ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

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

Appendix I: Financial Accountability

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

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

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

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

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment

fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

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	73902.67	26500.65	100403.32	114893.73	9157.01	124050.74	23647.42

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)
5	73965.43	27083.66	101049.09	118455.44	9358.78	127814.22	26765.13

Appendix J: Cost Neutrality Demonstration

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

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

Table: J-2-a: Unduplicated Participants

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

Appendix J: Cost Neutrality Demonstration

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

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

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

Estimates of Factor D for each waiver year are illustrated in the cost neutrality summary in APPENDIX J-1: COMPOSITE OVERVIEW AND DEMONSTRATION OF COST NEUTRALITY.

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).

Estimates of Factor D’ for each waiver year are illustrated in the cost neutrality summary in APPENDIX J-1: COMPOSITE OVERVIEW AND DEMONSTRATION OF COST NEUTRALITY.

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 the WEIGHTED AVERAGE CALCULATION OF FACTOR G AND FACTOR G'.

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

A WEIGHTED AVERAGE CALCULATION OF FACTOR G AND FACTOR G' table demonstrates the weighted average calculation for WY 1 for the first amendment of the fifth renewal. A similar calculation was performed for WY 2 through WY 5.

WAIVER YEAR 1
Level of Care = Level of Care 1
Factor G Estimate = $104,604.79
Factor G' Estimate = $8,868.64
# of Users = 100
Total Expenditures = $11,347,342.89

WAIVER YEAR 1
Level of Care = Level of Care 2
Factor G Estimate = $99,929.30
Factor G' Estimate = $8,169.44
# of Users = 100
Total Expenditures = $10,809,873.91

TOTAL
# of Users = 200
Total Expenditures = $22,157,216.80

WEIGHTED AVERAGE
Factor G Estimate = $102,267.04
Factor G' Estimate = $8,519.04

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.

Estimates of Factor G for each waiver year are illustrated in the cost neutrality summary in APPENDIX J-1: COMPOSITE OVERVIEW AND DEMONSTRATION OF COST NEUTRALITY.

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 the WEIGHTED AVERAGE CALCULATION OF FACTOR G AND FACTOR G'.

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

A WEIGHTED AVERAGE CALCULATION OF FACTOR G AND FACTOR G' table demonstrates the weighted average calculation for WY 1 for the first amendment of the fifth renewal. A similar calculation was performed for WY 2 through WY 5.

WAIVER YEAR 1
Level of Care = Level of Care 1
Factor G Estimate = $104,604.79
Factor G' Estimate = $8,868.64
# of Users = 100
Total Expenditures = $11,347,342.89

WAIVER YEAR 1
Level of Care = Level of Care 2
Factor G Estimate = $99,929.30
Factor G' Estimate = $8,169.44
# of Users = 100
Total Expenditures = $10,809,873.91

TOTAL
# of Users = 200
Total Expenditures = $22,157,216.80

WEIGHTED AVERAGE
Factor G Estimate = $102,267.04
Factor G' Estimate = $8,519.04

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).

Estimates of Factor G' for each waiver year are illustrated in the cost neutrality summary in APPENDIX J-1: COMPOSITE OVERVIEW AND DEMONSTRATION OF COST NEUTRALITY.

Appendix J: Cost Neutrality Demonstration

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

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

Waiver Services	
Adult Day Services	
Attendant Care	
Care Management	

Waiver Services	
Home and Community Assistance	
Residential Based Habilitation	
Skilled Respite	
Structured Day Program	
Supported Employment	
Adult Family Care	
Assisted Living	
Behavior Management/ Behavior Program and Counseling	
Community Transition	
Home Delivered Meals	
Home Modification Assessment	
Home Modifications	
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	
Care Management Total:						328414.32
Care Management	month	195	10.40	161.94	328414.32	
Home and Community						61341.14

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
Assistance Total:						
Home and Community Assistance	1/4 Hour	16	598.10	6.41	**61341.14**	
Residential Based Habilitation Total:						**752673.10**
Residential Based Habilitation	1/4 Hour	34	2696.40	8.21	**752673.10**	
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**	
Supported Employment Total:						**1742.26**
Supported Employment	1/4 Hour	1	165.30	10.54	**1742.26**	
Adult Family Care Total:						**133767.70**
Adult Family Care	day	6	303.70	73.41	**133767.70**	
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**	
Community Transition Total:						**1528.50**
Community Transition	unit	1	1.00	1528.50	**1528.50**	
Home Delivered Meals Total:						**155061.44**
Home Delivered Meals	meal	59	382.00	6.88	**155061.44**	
Home Modification Assessment 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	unit	0	0.00	0.01	0.00	
Home Modifications Total:						12852.96
Home Modifications	unit	2	1.00	6426.48	12852.96	
Integrated Health Care Coordination Total:						20249.25
Integrated Health Care Coordination	month	5	330.60	12.25	20249.25	
Nutritional Supplements Total:						4845.61
Nutritional Supplements	unit	5	9.80	98.89	4845.61	
Personal Emergency Response System Total:						21967.47
Personal Emergency Response System	unit	45	11.80	41.37	21967.47	
Pest Control Total:						6881.33
Pest Control	unit	9	4.80	159.29	6881.33	
Specialized Medical Equipment and Supplies Total:						10198.02
Specialized Medical Equipment and Supplies	unit	8	9.20	138.56	10198.02	
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	Unit	2	1.00	15000.00	30000.00	
				GRAND TOTAL:		8413146.99
				Total Estimated Unduplicated Participants:		200
				Factor D (Divide total by number of participants):		42065.73
				Average Length of Stay on the Waiver:		343

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 2

Waiver Service/ Component	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Adult Day Services Total:						***288495.70***
Adult Day Services	*1/4 Hour*	*18*	*4415.30*	*3.63*	***288495.70***	
Attendant Care Total:						***6161500.80***
Attendant Care	*1/4 Hour*	*120*	*6112.60*	*8.40*	***6161500.80***	
Care Management Total:						***384427.68***
Care Management	*month*	*195*	*10.40*	*189.56*	***384427.68***	
Home and Community Assistance Total:						***75443.42***
Home and Community Assistance	*1/4 Hour*	*16*	*599.90*	*7.86*	***75443.42***	
Residential Based Habilitation Total:						***867972.13***
Residential Based Habilitation	*1/4 Hour*	*34*	*2704.30*	*9.44*	***867972.13***	
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***	
Supported Employment Total:						***1974.68***
Supported Employment	*1/4 Hour*	*1*	*165.80*	*11.91*	***1974.68***	
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***	

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
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**	
Community Transition Total:						**1500.00**
Community Transition	unit	1	1.00	1500.00	**1500.00**	
Home Delivered Meals Total:						**175398.50**
Home Delivered Meals	meal	59	383.10	7.76	**175398.50**	
Home Modification Assessment Total:						**1256.00**
Home Modification Assessment	unit	2	1.00	628.00	**1256.00**	
Home Modifications Total:						**12613.30**
Home Modifications	unit	2	1.00	6306.65	**12613.30**	
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					**66684.40**	

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
Caregiving - Level 1	day	5	172.00	77.54		
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	
Care Management Total:						406094.39
Care 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	
				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
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**	
Supported Employment Total:						**6443.31**
Supported Employment	1/4 Hour	2	270.50	11.91	**6443.31**	
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**	
Community Transition Total:						**2488.10**
Community Transition	unit	1	1.00	2488.10	**2488.10**	
Home Delivered Meals Total:						**213825.15**
Home Delivered Meals	meal	70	399.30	7.65	**213825.15**	
Home Modification Assessment Total:						**10048.00**
Home Modification Assessment	unit	16	1.00	628.00	**10048.00**	

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
Home Modifications Total:						**88849.01**
Home Modifications	unit	9	1.20	8226.76	**88849.01**	
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**	
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:						**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**	
Care Management Total:						**406094.39**
Care 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**	
Supported Employment Total:						**6443.31**
Supported Employment	1/4 Hour	2	270.50	11.91	**6443.31**	
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**	

GRAND TOTAL:	**14780534.88**
Total Estimated Unduplicated Participants:	**200**
Factor D (Divide total by number of participants):	**73902.67**
Average Length of Stay on the Waiver:	343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
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**	
Community Transition Total:						**2488.10**
Community Transition	unit	1	1.00	2488.10	**2488.10**	
Home Delivered Meals Total:						**213825.15**
Home Delivered Meals	meal	70	399.30	7.65	**213825.15**	
Home Modification Assessment Total:						**10048.00**
Home Modification Assessment	unit	16	1.00	628.00	**10048.00**	
Home Modifications Total:						**88849.01**
Home Modifications	unit	9	1.20	8226.76	**88849.01**	
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 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**	

GRAND TOTAL:	**14780534.88**
Total Estimated Unduplicated Participants:	**200**
Factor D (Divide total by number of participants):	**73902.67**
Average Length of Stay on the Waiver:	343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
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:			**14780534.88**
			Total Estimated Unduplicated Participants:			**200**
			Factor D (Divide total by number of participants):			**73902.67**
			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:						**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**	
Care Management Total:						**406094.39**
Care Management	month	193	11.10	189.56	**406094.39**	
Home and Community Assistance Total:						**57191.23**
			GRAND TOTAL:			**14793085.15**
			Total Estimated Unduplicated Participants:			**200**
			Factor D (Divide total by number of participants):			**73965.43**
			Average Length of Stay on the Waiver:			343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
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	
Supported Employment Total:						6443.31
Supported Employment	1/4 Hour	2	270.50	11.91	6443.31	
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	
Community Transition Total:						2488.10
Community Transition	unit	1	1.00	2488.10	2488.10	
Home Delivered Meals Total:						213825.15
Home Delivered Meals	unit	70	399.30	7.65	213825.15	
Home Modification Assessment Total:						10048.00

GRAND TOTAL:	14793085.15
Total Estimated Unduplicated Participants:	200
Factor D (Divide total by number of participants):	73965.43
Average Length of Stay on the Waiver:	343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Modification Assessment	unit	16	1.00	628.00	10048.00	
Home Modifications Total:						88849.01
Home Modifications	unit	9	1.20	8226.76	88849.01	
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
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:	14793085.15
Total Estimated Unduplicated Participants:	200
Factor D (Divide total by number of participants):	73965.43
Average Length of Stay on the Waiver:	343