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.

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*):

Indiana PathWays for Aging (PathWays)

C. Type of Request: new

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

○ **3 years** ◉ **5 years**

☐ **New to replace waiver**

Replacing Waiver Number:

Base Waiver Number:

Amendment Number (if applicable):

Effective Date: (mm/dd/yy)

Waiver Number:IN.2407.R00.00

Draft ID: IN.018.00.00

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

Regular Waiver

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

07/01/24

Approved Effective Date: 07/01/24

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:

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

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

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

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs)

approved under the following authorities
Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §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:

The PathWays 1915(b) waiver has been submitted concurrently with this 1915(c) waiver application.

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.

Indiana operates this 1915(c) waiver concurrent with a 1915(b) waiver to implement Indiana PathWays for Aging (PathWays), a statewide managed long term services and supports (MLTSS) program. PathWays serves Medicaid enrollees who are 60 years of age and older and are eligible for Medicaid on the basis of age, blindness, or disability. Enrollees receive long term services and supports (including hospice, nursing facility, and home and community based services (HCBS)) as well as physical and behavioral health services through managed care entities (MCEs) selected through a competitive procurement process.

The PathWays 1915(c) waiver provides an alternative to nursing facility admission for enrollees 60 years of age and older. The waiver is designed to provide services to supplement informal supports for individuals who would require care in a nursing facility if waiver or other supports were not available. Services can be utilized to help enrollees remain in their own homes, as well as assist those living in nursing facilities return to community settings.

Through PathWays, Indiana seeks to achieve the following:
- Ensure more Hoosiers can choose to age at home and simplify access to HCBS
- Appropriately divert individuals from long-term nursing facility stays in accordance with a person-centered approach
- Coordinate care across the delivery system and care continuum, including across Medicaid and Medicare for dually eligible members and taking into account physical health, behavioral health, and social services
- Improve quality outcomes and consistency of care across the delivery system
- Provide person-centered and strengths-based care
- Ensure member choice, protections, and access
- Promote caregiver support and skill development
- Emphasize communication, training, and collaboration with network providers to ease administrative burden and help accomplish program goals
- Align incentives across the delivery system with improved health and quality of life outcomes
- Deliver cost-effective and accountable coverage
- Leverage data to make informed program and care decisions
- Understand, measure, and address health inequities in care and access
- Promote primary and preventive care
- Ensure the appropriate use of health care services
- Develop informed health care consumers by increasing health literacy and providing price and quality transparency of members and their informal caregivers
- Encourage quality, continuity, and appropriateness of medical care
- Develop innovative member and provider incentives
- Develop innovative utilization management techniques that incorporate member and provider education to facilitate the right care, at the right time, in the right location
- Engage in provider and member outreach regarding preventive care, wellness and a holistic approach
- Expand the HCBS provider network, especially in rural areas

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

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

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:

The Participant-Directed Home Care Service is limited to the 46143, 46202, 46204, and 46260 zip codes.

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:

FSSA engaged extensively with interested parties in developing PathWays. This included leveraging over 200 meetings with interested parties, including representation from diverse groups such as recipients and families, caregivers, nursing homes, assisted living facilities, home-based providers, health care providers, AAAs, AARP, advocates, experts in the needs and wellness of older adults, and health coalitions. For example, interested parties spent over 1,700 hours with FSSA in co-design and workgroup sessions. Interested parties contributed 75% of a Request for Information (RFI) released to MCEs in the summer of 2021. This RFI, along with continued stakeholder engagement and peer-state best practices informed the final program design and MCE Request for Proposals.

Ongoing engagement with interested parties regarding PathWays is assured through a variety of strategies. For example, FSSA has formed an independent Aging and LTSS Advisory Committee that convenes quarterly. The Committee includes a cross-representation of enrollees, formal and informal caregivers, enrollee advocates, aging and disability-led advocacy groups, subject matter experts, and other independent interested parties. This committee provides recommendations and proposals for the development of quality measures, reporting requirements, transparency and data requirements, and value-based reimbursement methodologies. The committee is also a venue to discuss concerns relating to service by providers and MCEs.

Two public comment periods were held on this waiver application. During both periods, electronic copies of the public notice and draft application were posted in the Indiana Register and FSSA webpage. During the public comment period, the entire waiver application was posted to the FSSA website located at https://www.in.gov/fssa/public-notices/. Paper copies were also available at local Division of Family Resources and Area Agency on Aging offices. Four webinars were also hosted at which FSSA presented a summary of the waiver application and how to submit comments. The webinars were recorded and made available for replay on the FSSA website.

First Public Comment Period
The initial public comment period was held from November 8, 2023 through December 14, 2023 during which 14 comments were received. Comments below are grouped by theme, followed by state response.

Managed Care Transition: Several commenters discussed the transition to managed care. Comments supportive of PathWays included commending FSSA for requiring MCEs to reimburse at FFS rates (at minimum), extend contract offers to all waiver providers, and ensure continuity of service plans. One was concerned enrollees would be pushed to “inferior” Medicare Advantage Plans and asked how care would be coordinated for duals. One questioned why the state is moving away from AAAs performing service planning and case management and another asked how warm handoffs from a case manager to MCE service coordinator would occur. Two commenters were recipients with concerns they would not be able to keep their doctors or current services. One of the recipients was also concerned the use of EVV would put their safety at risk, given the use of GPS. Another asked what the transition process would be for moving from Health and Wellness (H&W) to PathWays. One commenter also encouraged FSSA to monitor MCE claims payment. One commenter noted the enrollment broker was unable to answer questions about PathWays when calls were made in December 2023. Finally, one commenter recommended the state require the MCEs contract with all current care managers and reimburse them at the FFS rate.

Response: The State has developed a transition plan to support implementation of PathWays, ongoing enrollment of individuals as they age out of the H&W waiver, continuity of care, conflict of interest protections, and choice of providers. These processes are described throughout the 1915(b)/(c) waivers and are supported by contract language outlining MCE obligations. FSSA has developed and described MCE oversight processes and strategies in this application and the concurrent 1915(b) application. EVV is federally mandated and is not used to track enrollee location; the state’s EVV vendor is required to share with the State a security plan for all data. Therefore, no update to waiver language was made in response to these comments. The State has worked extensively with the Enrollment Broker to address concerns raised by the commenter on current call center capabilities.

Managed Care Enrollment: There were two comments received regarding the populations required to enroll in an MCE. One sought clarification regarding the hospice opt-out and suggested this also be available in Hoosier Care Connect (HCC). Another suggested all enrollees age 60+ be permitted to stay in FFS. Additionally, one commenter recommended presumptive eligibility or expedited waiver eligibility (EWE) be implemented statewide.

Response: No updates were made to waiver language in response to these comments. The waiver already outlines the populations who may voluntarily enroll with an MCE, including those receiving hospice at the time they become eligible for PathWays. As HCC is out-of-scope for this submission, the State is not modifying its policies for that population. The

State continues to review EWE for potential future expansion.

*Due to character limitation the remaining comments and responses are located in the Main, B. Optional field of this application.

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

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

7. Contact Person(s)

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

Last Name: Loveall

First Name: Clarissa

Title: PathWays Program Manager

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

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

Address 2:

City: Indianapolis

State: **Indiana**

Zip: 46204

Phone: (317) 430-9608 **Ext:** ☐ **TTY**

Fax: (317) 234-5076

E-mail: clarissa.loveall@fssa.in.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Indiana**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

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

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

Signature: BRIAN GILBERT

State Medicaid Director or Designee

Submission Date: May 24, 2024

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

Last Name: Steinmetz

First Name:

Cora

Title:

Indiana Medicaid Director

Agency:

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

Address:

402 West Washington Street, Room W374 (MS07)

Address 2:

City:

Indianapolis

State: **Indiana**

Zip:

46204

Phone:

(317) 234-8725 **Ext:** ☐ **TTY**

Fax:

(317) 232-7382

E-mail:

cora.steinmetz@fssa.in.gov

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

The Indiana Family and Social Services Administration (FSSA) attests that no net reduction in the total unduplicated number of participants being served will result from the split of the previously approved Aged and Disabled Waiver into the two waivers hereafter known as the Health and Wellness Waiver (H&W) and PathWays for Aging Waiver (PathWays).

Indiana has developed a comprehensive transition plan to facilitate continuity of care as 1915(c) waiver enrollees transition to enrollment with a PathWays managed care entity (MCE) effective July 1, 2024. This includes a comprehensive strategy for engagement with interested parties, targeted enrollee outreach, Enrollment Broker choice counseling, continuity of care provisions, and resources through the Member Support Services Contractor.

INTERESTED PARTY ENGAGEMENT
FSSA has implemented an extensive enrollee and interested party education and engagement strategy to assist in transition, ensure understanding of the PathWays program, and promote a collaborative effort to enhance the delivery of high-quality services to waiver enrollees. For example, in designing the PathWays program, FSSA leveraged over 200 meetings with interested parties, including representation from diverse groups such as recipients and families, caregivers, nursing homes, assisted living facilities, home- based providers, health care providers, Area Agencies on Aging (AAA), AARP, advocates, experts in the needs and wellness of older adults, and health coalitions. Interested parties spent over 1,700 hours with FSSA in co-design and workgroup sessions. FSSA interested parties contributed 75% of a Request for Information (RFI) released to MCEs in the summer of 2021. This RFI, along with continued stakeholder engagement and peer-state best practices informed the final program design and MCE Request for Proposals (RFP).

Ongoing engagement with interested parties regarding PathWays implementation is assured through a variety of strategies. For example, FSSA has formed an independent Aging and LTSS Advisory Committee. The Committee includes a cross-representation of individuals, formal and informal caregivers, individual advocates, aging and disability-led advocacy groups, subject matter experts, and other independent interested parties. This committee provides recommendations and proposals for the development of PathWays program policies and is a venue to discuss concerns relating to service by providers and the MCEs.

MCEs are also required to convene enrollee and informal caregiver advocacy committees. These committees provide enrollee, informal caregiver, and advocate input into program development and feedback on the enrollee experience. MCEs present information to the committee and seek its advice regarding the experience of enrollees and their informal supports, service gaps, approaches to enrollee outreach and education, reinvestment opportunities, and the MCE’s proposed approaches to initiatives and interventions to improve quality of care. Additionally, MCEs are required to develop a formal process, subject to State review, for ongoing education of interested parties prior to, during, and after implementation of PathWays. This includes publicizing methods by which enrollees can ask questions regarding PathWays. Interested parties include, but are not limited to, providers, advocates, and enrollees.

FSSA is also implementing a comprehensive public engagement campaign to support enrollee transition and waiver providers through strategies such as direct mail, social media, website content, webinars, and media advertising. Waiver providers have also been extensively engaged in the transition. FSSA conducted an environmental scan and needs assessment of waiver providers to gauge their readiness for managed care and identify areas where FSSA could support provider agencies in readying for PathWays’ transition. Based on findings from this assessment, FSSA conducted a series of business acumen sessions addressing topics raised by the provider community and provided grant funding to waiver providers conducting business practice updates to support transition to PathWays. Providers will also be taking part in system testing activities around claims and prior authorization. This strategy is intended to identify any abrasion points for MCEs to correct prior to PathWays implementation. FSSA has also brought together PathWays MCEs and providers to support provider contracting and understanding of MCE requirements and operations. FSSA will continue targeted outreach to providers after go-live and will be reviewing MCE reporting metrics on a weekly basis to promptly identify any provider-related transition issues requiring immediate remediation.

TARGETED ENROLLEE OUTREACH
Six months prior to PathWays implementation, targeted outreach to eligible PathWays 1915(c) waiver enrollees will begin. The Enrollment Broker will be responsible for sending multiple notices to enrollees, and their authorized representatives, regarding the PathWays program, enrollment process, and MCE options. They will also conduct outreach to facilitate choice counseling in accordance with 42 CFR 438.71. As individuals select an MCE, pertinent information will be accessible to the selected MCE to permit continuity of care and initiate key care coordination and service planning prior to go-live. This will include information such as outstanding prior authorizations, claims data, care management information, and service plans. Individuals will have a minimum of 60 days to select an MCE prior to being auto-assigned and auto-assignment will occur a minimum of 60 days before program go-live. This prospective assignment process has been designed to facilitate advanced care planning and ensure sufficient transition activities. Individuals will have the opportunity to change MCEs prior to program go-live and in the first 90 days of enrollment without cause. Aged and Disabled 1915(c) waiver enrollees who are otherwise ineligible for PathWays enrollment as defined in the PathWays 1915(b) waiver will continue to receive services through the fee-for-service delivery

system as outlined in the Health and Wellness 1915(c) waiver.

CONTINUITY OF CARE
Several MCE contract provisions have been implemented to facilitate continuity of care. For example, MCEs must honor existing service plans for a minimum of 90 calendar days from MCE enrollment, unless the enrollee would like to modify services and/or providers or the MCE or FSSA identifies a need for reassessment. Modifications to the service plan can be made based on the reassessment supporting the change. FSSA will verify that providers remain on service plans of the individuals they currently serve (if agreed upon by the member). Following the 90-day continuity of care period, services may not be reduced or terminated in the absence of an up-to-date assessment of needs that supports reduction or termination. OMPP will also conduct extensive monitoring to ensure appropriate service planning and continuity of care practices are in place, as further described in Appendix D-1-g. PathWays 1915(c) waiver service definitions and coverage policies are also aligned with those previously available to impacted enrollees under the Aged and Disabled and Health and Wellness 1915(c) waivers to further facilitate continuity of services as individuals transition to managed care.

Within five days of MCE enrollment, the MCE must send enrollment materials to the PathWays 1915(c) waiver enrollee. This includes written information confirming enrollment with the MCE, how to contact the MCE, specific information on coordination of care with current providers, how enrollees can receive care coordination assistance, and the Member Handbook. Additionally, the enrollee's service coordinator must conduct an initial face-to-face visit with each PathWays 1915(c) waiver enrollee within 90 days of implementation. If at any time prior to this visit the MCE becomes aware of an increase in an enrollee's needs, the service coordinator must immediately conduct a functional needs assessment, update the service plan, and ensure all new or adjusted HCBS on the service plan are initiated within ten days of becoming aware of the change in needs.

Additionally, MCEs must provide for continuation of care with a waiver service provider, regardless of the provider's contracting status with the MCE. Further, MCEs are required to extend all FSSA enrolled 1915(c) waiver providers an opportunity to be part of its provider network. Providers who opt not to join the MCE network must be reimbursed at no less than the fee-for-service rate for the provision of PathWays 1915(c) waiver services.

FSSA has also implemented MCE contract provisions to facilitate continuity of care in waiver care managers. For example, the MCEs must provide waiver service coordination to at least 50 percent of its PathWays 1915(c) waiver enrollees through Aged and Disabled 1915(c) waiver care management entities. For those enrollees for whom there is not continuity of care manager assignment at PathWays go-live, FSSA has implemented a transition strategy to facilitate coordination between the new MCE service coordinator and the enrollee's current 1915(c) waiver care manager. For example, through warm-handoff meetings with the enrollee and incoming/outgoing care manager and service coordinator to facilitate a smooth transition for the enrollee.

MEMBER SUPPORT SERVICES CONTRACTOR
FSSA has also contracted with a Member Support Services Contractor that provides beneficiary support system services in accordance with 42 CFR 438.71(d). This vendor will serve as an additional, independent resource to PathWays 1915(c) waiver enrollees as they transition to managed care. The Member Support Services Contractor is tasked with educating PathWays enrollees and supporting them in obtaining services through their MCE.

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):

Summary continued from "Public Input" section:

Managed Care Operations: One commenter suggested language indicating participants should not be required to repeatedly request interpretation and translation to their preferred language. Another suggested language be added specifying the state understands participants must be given a choice of provider and it will enforce these requirements. Questions were also received asking for clarification surrounding how MCE assessments and service coordination interact with 1915(c) waiver services such as IHHC and emergency plans/caregiver assessments under Caregiver Coaching.

Response: The State updated Appendix B-8 to specify “In accordance with MCE policies to promote health equity, preferred language must be captured and stored by the MCE within its systems to ensure continued communication and interpretation in the appropriate language without the need for repeated request by enrollees.” No language was added regarding the state enforcing provider network requirements as the 1915(b) waiver already speaks to FSSA monitoring this requirement. Clarifications on interactions between MCE processes and 1915(c) waiver services will continue to be provided through provider education versus updating service definitions.

Services: Multiple comments were received regarding waiver service definitions. In addition to the service-specific comments outlined below, one comment was received suggesting the state review and revise service definitions “with a lens towards the public reader” and to ensure the service eligibility criteria was clear.

Response: Service descriptions are made available to the public in more readable format via other document sources, such as enrollee handbooks, which are approved by FSSA. Therefore, the State does not agree the 1915(c) waiver is the appropriate document to modify to address readability.

Multiple comments were received regarding Structured Family Caregiving (SFC). One requested transportation be allowed, another noted the terms “Structured Family Caregiving” and “Structured Family Care” are both used and suggested consistency, and recommended specifying the assessment used is developed by FSSA. One commenter asked the State to consider permitting SFC services to continue during short-term hospital stays, noting this may not be feasible until a future amendment.

Response: The State updated the SFC service definition to remove transportation from the list of activities not allowed, ensure consistent use of the term “Structured Family Caregiving,” and specify the caregiver assessment is developed by FSSA. The State continues to review the appropriateness of permitting continuation of SFC during short-term hospital stays.

One comment was received regarding Attendant Care. They requested the use of hoyer lifts be added as an allowable activity, noted transportation should not be considered duplicative of ATTC, and believed the description of medication administration was not aligned with state statute.

Response: The Attendant Care service definition was updated to clarify assistance with mobility includes lifting with mechanical assistance with appropriate training. No other updates were made as the State agrees the service definition already permits the provision of transportation in the scenario raised by the commenter and has aligned the medication administration provisions with state statute.

One commenter suggested the Assisted Living service definition be updated to specify only providers whose facilities have been determined to meet the HCBS settings rules can provide the service.

Response: The State did not update the service definition as the requirement to comply with the HCBS settings rule applies to all waiver services, is accounted for in the provider enrollment process, and is already described within other sections of the waiver application.

Multiple comments were received regarding Caregiving Coaching and Behavior Management. This included confusion over the term “lay caregiver” within the service definition and recommendation to rename the service “Caregiver Coaching” to prevent confusion with the “Behavior Management” service available under other waivers. One commenter was “very pleased” the service is included and recommended caregiver coaching be added to other service definitions.

Response: The State updated the service title from “Caregiver Coaching and Behavior Management” to “Caregiver Coaching” and replaced references to “lay caregivers” with “unpaid caregivers.”

Two comments were received regarding Specialized Medical Equipment and Supplies. One suggested the definition be made less restrictive, including removing references to “medically prescribed items” and clarifying the allowable activities list is not exhaustive. Another felt the description of interpretation services was too limited.

Response: The State has a process in place, as noted in the service definition, to permit requests for equipment and supplies not listed. Approvals are granted if the request meets the participant's need. Additionally, the MCEs are contractually required to provide or arrange for interpretation services. Therefore, no changes are being made to the waiver in response to these comments.

One commenter noted the Vehicle Modifications service definition refers to a "lifetime cap" while also indicating the service is only available every ten years.

Response: The State updated the Vehicle Modification service definition to reflect a ten-year cap.

One commenter encouraged the state to allow the purchase of bus passes.

Response: The State will review the potential use of bus passes to determine if language updates are needed in supplemental policy guidance documents or future waiver amendment.

Provider Enrollment: One commenter had questions about enrolling as a provider, including if they would need to become a BDDS provider for participation in PathWays. Another suggested criteria be added regarding criminal background checks required by 455 IAC 2-15-2.

Response: The State confirms providers do not need to enroll as a BDDS provider to participate in PathWays and will evaluate the referenced IAC to determine if regulatory updates are appropriate to reflect the criminal background check process.

Service Planning: One comment suggested additional detail on assessments and service planning such as ensuring the continuity of care period is a minimum requirement; removing language which may suggest providers are revising services plans outside the person-centered planning process; clarifying service coordinators must have telephonic contact at least monthly; and detailing the service plan audit process. Another suggested a maximum care manager caseload of 45 and the use of LifeCourse principles. One suggested the state clarify if service plans for new recipients also be accepted for new recipients.

Response: The waiver was updated to reflect the service plan continuity period is a minimum requirement; this also applies post-PathWays implementation. The following language was removed from all applicable service definitions: "Notification to the participant's Service Coordinator/Care Manager and other un-skilled provider, within 48 hours, upon any changes to the participant's person-centered service plan." Monthly telephonic contact was already referenced in the waiver; caseload limits are determined based on the acuity level of enrollees; and care managers will be required to go through person-centered planning training. As such, no additional changes were made to the waiver on these topics.

Self-Direction: Three commenters discussed self-direction, including the importance of continuing PDACS, recommending expansion of PDHCS beyond the current zip codes and individuals living alone, and removing requirements imposed on informal caregivers being a paid caregiver through PDHCS. One commenter also did not think termination of participant-directed caregivers should be determined by the fiscal intermediary or service coordinator.

Response: FSSA is working to expand participant direction opportunities across all 1915(c) waivers and intends to submit an amendment following PathWays implementation. These comments will be considered for future inclusion. Language is already in the waiver indicating requests for involuntary termination from participant-direction must be sent to OMPP for review and approval.

LRI: Three comments were received recommending removal of limitations on paying legally responsible individuals (LRI). One commenter suggested language should be added to reflect family members cannot be required to be a caregiver and participants should not be rendered unable to receive a service they need because a family member "can but won't." They also thought the family caregiver assessment should be described.

Response: Given the updates to LRI descriptions in the waiver posted for the second public comment period, responses to these comments are addressed in the LRI section of the second public comment period summary.

Miscellaneous: One commenter recommended the following language be removed: "The MCE must ensure that members are immediately separated from an alleged abuser and transitioned to another setting," indicating this should be a fact-specific determination, and if the abuser is removed, the member should not also have to be transitioned. They also recommended language indicating the MCE should notify the state when they remove providers from their network for founded allegations. One commenter requested the term "mental retardation" be removed and replaced with "intellectual disability."

Response: The State confirmed the use of the term “mental retardation” was not used in the waiver application. The waiver was updated to address the critical incident comments.

Second Public Comment Period
The second public comment period was held from January 17, 2024 through February 16, 2024 during which 25 PathWays-specific and over 2,000 comments regarding changes to Attendant Care for LRIs were received. Comments below are grouped by theme, followed by state response.

PACE: Four commenters are "supportive of the state offering additional coordinated, community-based programs to serve seniors" but raised concerns that insufficient information is being provided regarding PACE as an option. They request information specific to PACE be added to the PathWays website, enrollee notices, and call centers.

Response: No updates were made to the application as PACE is outside the scope. The State appreciates the feedback and will add PACE content in applicable communication materials.

Reimbursement: Four commenters were concerned about the pause in 2% rate indexing, acknowledging budgetary constraints, and urging resumption as soon as possible. One commenter was concerned the transition to managed care will lead to decreased funding for LTC pharmacies through MCEs reducing the dispensing fee and requested a reimbursement floor.

Response: Statutorily, FSSA may provide annual rate adjustments up to 2% in years when there is not a detailed rate review. The State is temporarily pausing this indexing. No updates have been made to waiver as current language is flexible to permit resumption of rate indexing when determined feasible. Because pharmacy reimbursement is not authorized via this waiver, no updates were made to the draft; however, the State agrees with the importance of maintaining sufficient reimbursement and will review expectations with the MCEs to ensure appropriate claims payment.

Managed Care: There were three comments received expressing general opposition to managed care. They cited concerns over individuals with special needs being able to pick their physicians. One of the commenters was concerned she would receive a new case manager and her privacy would not be protected under EVV. Three commenters raised concerns regarding the timeline for enrollee selection of an MCE, indicating insufficient information on provider networks is available. One commenter was also concerned the current A&D Waiver case managers do not have adequate information to discuss the transition process. One commenter described various features that should be included in managed care such as ability to change providers, a robust grievance process with expedited reviews and neutral third parties in appeal decisions, sufficient rehabilitation services to allow individuals to return home.

Response: The State is committed to ensuring enrollees have a choice of providers under PathWays. Several continuity of care and network adequacy provisions have been imposed within the MCE contracts to support these goals. As new providers and service coordinators are added to the MCE networks, updates are continually made available to the Enrollment Broker to facilitate choice counseling. Additionally, enrollees maintain the opportunity to change MCEs following assignment. The State is also requiring MCEs to contract with any willing HCBS provider and maintenance of an open network for three years. Additional training is being rolled out for A&D waiver care managers regarding the PathWays program as well. The State appreciates the detailed comment regarding the important components of managed care. As suggested by the commenter, enrollees will have the opportunity to freely changes providers, have access to an expedited appeals process, and neutral third-party assistance through the Member Support Services Contractor and the Independent Review Organization process for adverse medical necessity determinations. No updates to waiver language were made as a result of these comments as the waiver already describes these components.

Continuity of Care: Four commenters were concerned about the change from a 180 to 90-day period during which MCEs must honor existing service plans, with one commenter also requesting a stringent review by FSSA of any reductions following the initial 90-day period. One commenter recommended FFSA ensures continuity of care by requiring MCEs to contract with all that are currently certified to provide Care Management that will be moving into Service Coordination.

Response: The state shares the commenters commitment to ensuring continuity of care. MCEs must honor service plans for a minimum of 90 days from enrollment unless the enrollee would like to modify services and/or providers or the MCE or FSSA identifies a need for reassessment. Modifications can only be made based on a reassessment supporting the change and input from the individual care team. The state has developed extensive MCE oversight processes to ensure these requirements are appropriately followed. While MCEs will not be required to contract will all current care managers, they are contractually required to provide waiver service coordination to at least 50% of its PathWays 1915(c) waiver enrollees through A&D waiver case management entities. The state is also implementing a transition strategy to facilitate coordination between the new MCE

service coordinator and the enrollee's current waiver care manager. Therefore, no changes to the waiver were made in response to these comments.

Services: Multiple comments were received regarding waiver services, including support for the update made in response to the first public comment period clarifying the vehicle modification cap. One commenter indicated home modification assessments are completed by the same company completing the home modification which they believe is a conflict of interest and suggested OTs and PTs be able to offer this service.

Response: As outlined in the service definition for home modification assessments, the assessment must not be performed by the same provider that performs the subsequent home modification. The state has not updated the provider qualifications for this service but will consider the recommendations for future revisions.

One commenter noted individuals utilizing IHCC typically have COPD, diabetes, and heart disease and suggested listing these may help service coordinators understand who could benefit from the service. Another commenter encouraged the state to allow individuals with a BSW to provide the social work component of IHCC.

Response: Updates were not made to the IHCC service definition as the State does not want to unintentionally narrow who is eligible. However, this feedback will be taken into consideration for service coordinator training. The State will further consider the suggestion for a BSW versus master's level social worker and has not made waiver updates at this time.

One commenter suggested expanding interpretation services and supports to allow individuals access and inclusion in the community.

Response: The MCEs are contractually required to arrange for oral interpretation to its members free of charge for services it provides and to ensure its provider network arranges for oral interpretation services to members seeking healthcare related and LTSS services in a provider's service location. Therefore, no changes were made to waiver language.

One commenter recommended a caseload limit of 45 and use of the LifeCourse framework.

Response: Caseload limits are determined based on the acuity level of enrollees. Additionally, care managers will be required to go through person-centered planning training. As such, the state has not made a change to the waiver language.

One comment was received regarding Adult Day Services (ADS). Themes raised included concerns there were references to counseling to assess and address psychosocial needs and therapeutic interventions, noting they do not have LCSW or PT/OT staff. They encouraged discontinuing the requirement for a PPD/TB test as noted in 455 IAC 2 noting this is not aligned with CDC recommendations and is costly. They also indicated service coordinators do not always describe all available services and suggested this be added to training, requested clarification on when participants should be signed into the service (time of pick up or arrival), and believe ADS has more nursing-specific regulations than assisted living.

Response: Regarding the service definition reference to counseling, the RN would assess the need for additional resources and supports and make referrals for those additional services. Therapeutic interventions are part of the design of the ADS program and the provider is responsible for providing these services. Therefore, no waiver updates were made in response to this comment. The State will review the requirements currently documented in 455 IAC 2 regarding the PPD/TB test requirements. We are aware this is not aligned with national standards. No changes were made to waiver language as this update would be promulgated through an administrative code update. Providers should bill for the number of units the individual participates in. Regarding the perception that ADS has more regulations than assisted living, assisted living facilities have several requirements imposed, and must possess a Residential Care Facility License as outlined in statute and regulation, in addition to the requirements they must meet to become a waiver certified provider. The state appreciates the feedback regarding training service coordinators and is in the process of rolling out additional training with the roll-out of PathWays.

One commenter requested clarification on what steps are needed to enter someone into Caregiver Coaching, noting different case management companies require different assessments and that it would be helpful if these assessments were passed on to the service provider. Another commenter expressed support for inclusion of this service.

Response: FSSA requires the MCEs use a standard state-developed Informal Caregiver Assessment and will share this tool. As this is an operational, versus service definition clarification, no updates were made to waiver language in response to the comment.

One commenter asked that "mechanical assistance" be defined for Non-Medical Transportation and described the costs

associated with not being able to bill for no-shows. Another commenter encouraged the state to allow the purchase of bus passes.

Response: Mechanical assistance refers to upfitted vehicles to accommodate wheelchairs or special seating. The State will review this comment, and the potential use of purchasing bus passes, to determine if language updates are needed in supplemental policy guidance documents, and as necessary may make changes in future policy or waiver documents. In accordance with federal requirements, the State is unable to reimburse for no-shows.

One commenter proposed edits to the Home Delivered Meals, including specifically referencing “applicable” laws and regulations; adding the statement “is obtained for the meals as part of the provider’s menu” for all references indicating meals shall contain less than a percent calorie or milligram sodium threshold; and adding “use by date” in addition to references to an “expiration date.”

Response: The State has not made updates to the service definition but will consider for potential guidance such as the Waiver Module which typically offers more specific operational guidance than the 1915(c) waiver service definition.

One commenter was concerned a pharmacy was providing pill packs and had been told to include this as “medication dispenser” on the service plan, leading to additional charges and suggesting this should require documentation under Specialized Medical Equipment.

Response: The State is aware of this issue and reviewing accordingly. No changes are made in the waiver service definition.

Two comments were received regarding SFC. One was supportive of changes made since the first public comment period but asked to restore the qualifier “unskilled” in regard to respite within SFC; remove references to Adult Foster Care; and replace references to “Home and Community Assistance care services” and “Attendant care services” with “Assistance with ADLs and IADLs.” The other commenter also asked for clarification on respite being “skilled” or “unskilled” and suggested removal of requirement that provider agencies must demonstrate three years of delivering services.

Response: The State has reverted to use of the terminology “unskilled respite” in the SFC definition. The State has also replaced the term “Adult Foster Care” with “Adult Family Care.” No additional changes were made to ensure alignment with other service definitions.

Waiting List: Two commenters encourage the state to continue avoiding the use of a waiting list, with one expressing concern allocating slots between H&W and PathWays will cause one. One of the commenters also cited the cost savings associated with allowing an individual to age at-home.

Response: The State shares the commenters commitment to providing appropriate supports and services. The State’s budget process drives the number of annually available waiver slots. Additional waiver slots become available each waiver year. When the number of people seeking services exceeds the number of waiver slots, the State may have to implement a waiting list until waiver slots become available. Additionally, the State is not reducing the total number of available waiver slots with the transition of individuals age 60+ from H&W to PathWays.

Self-Direction: One commenter suggested the addition of self-directed respite provider and attendant care.

Response: The State is in the process of evaluating its self-direction program for future expansion and notes that attendant care can currently be self-directed under the waiver. As such, no updates were made to waiver language in response to this comment.

FSSA received over 2,000 public comments from waiver recipients, their families, providers and their associations, and other stakeholders regarding provision of certain HCBS waiver services by Legally Responsible Individuals (LRIs).

These comments are the result of a recent practice within the state that was out of alignment with approved waiver language. Parents of minor children as well as spouses have been engaged in the practice of providing attendant care or similar services when employed by or contracted with an OMPP-approved service provider. FSSA initially proposed to add an allowance for LRI’s to provide attendant care (ATTC) on three waivers (PathWays, H&W, and TBI) when a threshold for extraordinary care was met. FSSA subsequently determined that this change was not financially feasible, and have reverted to the language in the currently approved waiver. Waiver amendments were put out for a second public comment period following these adjustments with a targeted effort to notify stakeholders of the need to adjust this practice and come back into compliance with approved waiver provisions. FSSA continues to work towards enhancing pathways to support individuals and families including provisions in these proposed waiver amendments that provide a pathway for LRIs to provide services under the Structured Family Caregiving service as well as creating a new allowance for legal guardians of adults to provide ATTC.

The comments are summarized by the overall themes below.

Uncertainty & misunderstanding: Comments exhibited the following areas of confusion: ATTC is going away altogether, what SFC is and who can provide it, skilled vs. unskilled care, timing of change, impacted waivers/programs, and skepticism around cost-savings.

Response: FSSA has issued and presented a number of resources that are publicly available to help stakeholders, clarifying: attendant care is continuing as a vital service on the waivers, explain structured family care (SFC), explain how SFC is alike and different from attendant care, and clarify the timeline for families to select an alternate attendant or choose SFC. FSSA has also clarified the difference between skilled and unskilled care as many families have demonstrated confusion regarding what is allowable under attendant care and what should be accessed via another benefit such as home health and state plan services. Further, FSSA is training waiver case managers to assist with questions from recipients and their families and to help recipients update their service plans, as needed. FSSA has numerous points of contact to help families understand service provisions. Please visit the Medicaid Strategies page for more information. https://www.in.gov/fssa/medicaid-strategies/
No waiver update needed.

Relationship Confusion: Stakeholders were unclear about the ability of family members to provide services (e.g., step-parent and biological parent eligibility) and expressed uncertainty.

Response: Stakeholders shared confusion about the ability of family members to provide services (e.g., step-parent and biological parent eligibility). FSSA continues to clarify the term “legally responsible individuals” for stakeholders, as defined by CMS. FSSA developed a specific relationship primer outlining what the PathWays, H&W, and Traumatic Brain Injury waivers permit related to service provided by certain family members in order to make this information more accessible for recipients, families, care managers, and other stakeholders. Guidance can be found in the relationship document: https://www.in.gov/fssa/files/ATTCandSFCRelationshipGuidance.pdf
Minor adjustments to ensure alignment with the relationship document to make it more expansive than current waiver.

Lack of Transparency & Communication: Stakeholders expressed concerns that there was little transparency, data gathering, or proactive communication done prior to decision making. Previous public comments in conflict with change.

Response: FSSA has communicated with stakeholders and encouraged stakeholders to share information and ask questions. Not only did FSSA conduct the traditional and required public comment period but also established other methods for providing and receiving information including: a dedicated webpage and email address, numerous public presentations, and communications with clarifying information. FSSA will continue to publicly share information as it relates to the oversight and monitoring of its current and future waivers.
Outreach has included:

- Public Comment Recorded Webinars (posted on 1/17)
- Webinars hosted by the Arc (held on 2/08 and 2/12)

No waiver update needed.

Compensation & Quality of Life: Stakeholders expressed concerns about the level of compensation provided by SFC and how families would make ends meet or maintain quality of life.

Response: The primary objective of the waiver is to serve as many Hoosiers as possible within the available budget. SFC has the flexibility to be adjusted based on a participant’s need and is a bundled service containing support for the principal caregiver. FSSA is committed to fair and equitable reimbursement for its Medicaid services. It is for this reason FSSA conducted a thorough rate review in 2023 and implemented CMS-approved HCBS waiver service rates effective July 2023, for which many services received a substantial increase. FSSA will continue to monitor its rate structure to determine its impact on the waiver service network. No waiver update needed.

Member Health & Well-Being: Stakeholders shared ongoing challenges to find and retain quality, trusted caregivers. Some stakeholders shared fear of institutionalization and expressed that the family member is the most qualified individual to provide the service.

Response: FSSA is committed to maintaining a robust HCBS program and providing alternatives to institutional settings. The

changes being made reflect the need for enhanced financial sustainability and oversight in order that all Medicaid recipients have access to services, including those receiving services through the HCBS waivers. FSSA understands that many waiver recipients prefer a family member to provide care, and for this reason has expanded the availability of structured family care via this waiver submission. FSSA has established a process to provide a prioritized path for new providers to enroll in SFC to help foster a seamless transition from service provision under ATTC to SFC to maintain provider capacity and quality. No waiver update needed.

Quality of Providers: Some stakeholders expressed concerns there was limited access to unskilled and/or skilled care outside of their families. Other stakeholders expressed concerns about potential provider abuse.

Response: FSSA has previously acknowledged the national and state direct service workforce shortage and has been working diligently to recruit, retain, and train its direct service workforce. These efforts are ongoing, and the problem cited was a key driver in seeking CMS approval for increases to HCBS waiver rates for many services in 2023. FSSA takes provider waste, fraud, and abuse seriously, and is addressing compliance issues stakeholders have raised. FSSA addresses through appropriate means. It appears there was concern by commenters that having extra people in the home might increase the possibility of abuse. Family members will remain able to provide care under SFC, and FSSA has multiple mechanisms through the investigations of ANE to address any concerns or instances of potential abuse. No waiver update needed.

Appendix A: Waiver Administration and Operation

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

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

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

◉ **The Medical Assistance Unit.**

Specify the unit name:

Office of Medicaid Policy and Planning (OMPP)

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within

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

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

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

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

Appendix A: Waiver Administration and Operation

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

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

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

MANAGED CARE ENTITIES (MCE)

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

FISCAL AGENT

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

ACTUARIAL CONTRACTOR

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

EXTERNAL QUALITY REVIEW ORGANIZATION (EQRO)

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

NCI SURVEY CONTRACTOR

FSSA contracts with an entity responsible for NCI survey administration.

UTILIZATION MANAGEMENT CONTRACTOR

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

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

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

Program Integrity receives allegations of Medicaid provider fraud, waste, and abuse and tracks these in its case management system. To begin investigating these allegations, Program Integrity vets the providers with the

Medicaid Fraud Control Unit (MFCU). Once it receives MFCU's clearance PI determines how to best validate the accuracy of the allegation.

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

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

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

Appendix A: Waiver Administration and Operation

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

○ **Not applicable**

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

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

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

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

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

Area Agencies on Aging (AAAs), in their role as Indiana's designated Aging and Disability Resource Centers, are responsible for disseminating information regarding PathWays to potential enrollees, assisting individuals in the waiver enrollment application process, and performing level of care (LOC) evaluation activities. Additionally, at the time of options counseling, the AAAs provide individuals interested in enrolling in PathWays with support in connecting with the Enrollment Broker for choice counseling in accordance with 42 CFR 438.71(c). AAAs may also develop an initial service plan for newly eligible PathWays enrollees.

Appendix A: Waiver Administration and Operation

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

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

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

The Division of Aging (DA) is responsible for assessing performance and oversight of operations for the AAAs. The DA is a division under FSSA, the single state Medicaid agency.

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

Appendix A: Waiver Administration and Operation

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

MANAGED CARE ENTITIES (MCE)

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

FISCAL AGENT

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

ACTUARIAL CONTRACTOR

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

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

The Actuarial Contractor’s contract is not a performance based contract.

EQRO

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

NCI SURVEY ADMINISTRATOR

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

AREA AGENCIES ON AGING (AAA)

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

UTILIZATION MANAGEMENT CONTRACTOR

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

Appendix A: Waiver Administration and Operation

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

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☒	☐	☒
Waiver enrollment managed against approved limits	☒	☐	☐
Waiver expenditures managed against approved levels	☒	☐	☐
Level of care 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 percentage of quarterly reports submitted to OMPP by Managed Care Entities (MCE) within the required time period. Numerator: Number of quarterly reports received. Denominator: Number of quarterly reports due.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Every two months	

Data Aggregation and Analysis:

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

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

number of providers assigned a Medicaid provider number by the fiscal agent according to the required timeframe specified in the contract. Denominator: The total number of providers assigned a Medicaid provider number.

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

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

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

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

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

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

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

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

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

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

Specify:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Specify the percentage:

○ **Other**

Specify:

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

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

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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	39842
Year 2	47868
Year 3	50843
Year 4	53017
Year 5	54658

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

:

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

Purpose(s) the state reserves capacity for:

Purposes
Age-out of Health & Wellness 1915(c) Waiver
Community transition of institutionalized person due to "Money Follows the Person" initiative

Appendix B: Participant Access and Eligibility

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

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

Age-out of Health & Wellness 1915(c) Waiver

Purpose *(describe):*

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

Describe how the amount of reserved capacity was determined:

The state utilized as baseline data the number of individuals on the Aged and Disabled waiver turning 60 during the most recently completed year (SFY 2023) and projected the number to grow proportionately with the number of unique individuals served on the PathWays and Health and Wellness 1915(c) waivers.

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

Waiver Year	Capacity Reserved
Year 1	969
Year 2	1170
Year 3	1229
Year 4	1268
Year 5	1292

Appendix B: Participant Access and Eligibility

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

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

Community transition of institutionalized person due to "Money Follows the Person" initiative

Purpose *(describe):*

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

Describe how the amount of reserved capacity was determined:

The State reviewed the number of patients currently receiving institutional care above age 60 and determined, based upon the number of waiver slots, the realistic number of individuals that could be transitioned in year 1 through 5. It was determined that we could move a total of 1,000 individuals over the course of this waiver term. Indiana plans to continue transitioning persons from the nursing facility to HCBS settings maximizing the MFP program.

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

Waiver Year	Capacity Reserved
Year 1	200
Year 2	200
Year 3	200
Year 4	200
Year 5	200

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:

Until all general waiver capacity slots for a given year have been utilized, eligible individuals will enter the waiver on first come first served basis by date of application. Eligible individuals who meet reserve capacity criteria will be assigned a reserve capacity slot when available.

Once the general waiver capacity slots are full (excluding reserve capacity slots), applicants are added to the single statewide wait list until a slot becomes available.

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 are given priority waitlist status by date of application.

Other eligible individuals will enter the waiver first come first serve basis by date of application.

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**

☒ **SSI recipients**

☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**

☐ **Optional state supplement recipients**

☒ **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)**

☒ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☒ **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)**

☒ **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

Section 1925 of the Act - Transitional Medical Assistance

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

☒ **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:

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

For Expedited Waiver Eligibility, the qualifications are the same.

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.

All applicants to the PathWays Waiver are screened for nursing facility level of care (NFLOC). 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 PathWays waiver if the need for medical or nursing supervision and attention is determined by any of the following findings from the functional screening:
- Need for direct assistance at least 5 days per week due to unstable, complex medical conditions.
- Need for direct assistance for 3 or more substantial medical conditions including activities of daily living

Indiana has established the Eligibility Screen (E-Screen), a tool that is used to determine basic level of care criteria that identifies NFLOC (405 IAC 1-3-1 through 405 IAC 1-3-3). The E-Screen is required to be completed as part of the Level of Care packet. An E-Screen will not be accepted by the computer system if not all the pages of the E- Screen have been addressed. AAAs (or care managers for FFS) complete an interRAI-HC assessment tool that aids in the discovery of the information needed for completion of the E-Screen.

The final level of care determination is documented in the section of the Transmittal for Medicaid Level of Care Eligibility form (State Form 46018 HCBS7).

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:

INITIAL EVALUATIONS
All initial evaluations are performed by the Area Agency on Aging (AAA) which are Indiana's designated Aging and Disability Resource Centers with recommendations routed to designated staff members within the FSSA for subsequent approval or denial. If the individual has been in a nursing facility for at least 90 days, they have already received a long term level of care designation for a nursing facility stay, which will serve as the initial evaluation. Indiana has established the E-Screen, a tool that is used to determine basic level of care criteria that identifies NFLOC (405 IAC 1-3-1 through 405 IAC 1-3-3).

RE-EVALUATIONS
NFLOC re-evaluations are completed annually or when a participant is discharging 60 days after a nursing facility admission. Re-evaluations are conducted by the AAAs (or care manager for FFS enrollees) with recommendations routed to designated staff members within the FSSA for subsequent approval or denial.

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):*

MCEs are required to track and monitor level of care (LOC) end dates based on information provided via the HIPAA 834 transaction. Prior to the LOC end date, MCEs coordinate with the AAAs to support timely re-evaluation. OMPP provides oversight of timely completion through regular review of ongoing monitoring reports.

For FFS enrollees, an FSSA reporting tool generates a report at least 60 calendar days prior to the annual LOC reevaluation to advise a care manager that reviews are due. The report was designed to establish trends and needed education regarding annual level of care.

Notifying the care managers at least 60 days prior to the annual LOC reevaluation due date will assist care managers in returning the annual LOC reevaluation within the required timeframe. The FSSA is able to monitor which care managers submit a late annual reevaluation and therefore will be able to provide educational training and assistance to those care managers who are consistently late in their submissions.

The FSSA runs a monthly report that identifies participants whose reevaluation are due within 60 days and sends the listing to care managers. After the due date, the FSSA re-runs the report that identifies those who are late in submitting the annual LOC reevaluation and notifies the care managers that the reevaluation is due within 15 days. If the reevaluation is not received by the FSSA within 15 days of notification, the FSSA submits the listing of delinquent care managers to the unit within the FSSA for corrective action.

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 care management database maintained by the FSSA.

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 applicants who received a Level of Care (LOC) evaluation prior to waiver enrollment. Numerator: Number of applicants who received an LOC evaluation prior to waiver enrollment. Denominator: Number of applicants.

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: Division of Aging - a Division under the single state agency	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: Division of Aging - a Division under the single state agency	☐ **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 (LOC) assessments were completed in accordance with established LOC criteria. Numerator: The total number of individuals whose initial LOC assessment was completed in accordance with established LOC criteria. Denominator: The total number of individuals with an initial LOC assessment.

Data Source (Select one):
Other
If 'Other' is selected, specify:
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: Division of Aging	☐ **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: Division of Aging	☐ **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 LOC in the waiver. Numerator: The total number of individuals whose annual LOC assessment was conducted based on requirements for determining LOC in the waiver. Denominator: The total number of individuals due for an annual LOC assessment.

Data Source (Select one):
Other
If 'Other' is selected, specify:
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**	☐ **Weekly**	☒ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Division of Aging	☐ **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: Division of Aging	☐ **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):*

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 and identifies LOC program non-compliance, which is identified in the performance measures. All documentation of resolution activities will be maintained within the electronic case management database or other electronic tracking system.

If the FSSA, or any other entity, identifies any instance of a new applicant not having received a LOC evaluation prior to enrollment, FSSA will ascertain any related MCE capitation payments that have been made and reconcile and recoup accordingly. The MCE, FSSA, and AAA will collaborate to ensure a proper LOC evaluation is conducted immediately. If it is identified that the applicant does not meet the LOC criteria, the service coordinator is required to explore other community or public funded services that may be available to the individual. The FSSA staff will report any finding of evidence of malfeasance to FSSA Program Integrity for review. 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 there is any evidence that the evaluation was intentionally inaccurate, the FSSA will handle this as a formal complaint with potential sanctions up to and including termination as a waiver provider.

If redetermination reveals that the individual does not meet the approved LOC category, any MCE capitation payments will be reconciled and recouped accordingly back to the date of expiration of the prior LOC period. The service coordinator will be advised to refer the individual for any other services which may be available and the individual will be informed in writing that they have the right to request a formal appeal and are entitled to a Medicaid Fair Hearing to dispute any LOC determination decision.

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

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☒ **Other** Specify: Division of Aging	☐ **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 service coordinator (or care manager for FFS enrollees) is responsible for explaining all available PathWays service options, including choice of institutional or HBCS, through the person-centered service planning process. This includes informing individuals about available LTSS, service alternatives, and service delivery options. The service plan must reflect that this was discussed with the enrollee and signature must be obtained from the member, their designated representative (if applicable), and any others involved in the service planning process.

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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 Service**		
Statutory Service	**Attendant Care**		
Statutory Service	**Care Management**		
Statutory Service	**Home and Community Assistance Service**		
Statutory Service	**Skilled Respite**		
Other Service	**Adult Family Care**		
Other Service	**Assisted Living**		
Other Service	**Caregiver Coaching**		

Service Type	Service		
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	Participant Directed Home Care Service		
Other Service	Personal Emergency Response System		
Other Service	Pest Control		
Other Service	Specialized Medical Equipment and Supplies		
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 Service

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04050 adult day health

Category 2:

04 Day Services

Sub-Category 2:

04060 adult day services (social model)

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

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:

- Monitoring all activities of daily living (ADLs) defined as dressing, bathing, grooming, eating, walking, and toileting with hands-on assistance provided as needed
- Comprehensive, therapeutic activities for those with cognitive impairment in a safe environment
- Initial Health assessment conducted by a registered nurse (RN) consultant prior to beginning services at the adult day, and intermittent monitoring of health status
- Monitoring 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' psychosocial needs.

DOCUMENTATION STANDARDS
Service Coordinators/Care Managers must maintain the following documentation:

- Justification for the service is documented
- The documented need for the service is to include, but not be limited to the following: Describe the structure needed for the participant (medical, social, recreational), types of ADL care the participant may require, and level of assistance needed.
- Level of service is determined in the person-centered planning process, which is given to provider.

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

Adult Day Services are allowed for a maximum of 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 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 Service

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 Individuals personal file; site of service delivery

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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 ADLs. The participant is the employer for Participant Directed ATTC or appoints a representative to be the employer on their behalf.

ALLOWABLE ACTIVITIES
All non-skilled ADL care as identified in the person-centered service plan that includes but is not limited to the following:

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

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

Provides assistance with elimination, which includes:
- Assisting 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
- Identifying and eliminating safety hazards
- Practicing health protection and cleanliness by appropriate techniques of hand washing
- Waste disposal, and household tasks
- Reminding individual to self-administer medications
- Providing assistance with correspondence and bill paying
- Transportation of individuals to community activities. Out of State transportation is limited to within 50 miles of State geographic limits. Escorting of participants does not include mileage or other costs that are not associated with the provision of personal care.

SERVICE STANDARDS

ATTC may be provided from the following:
- Agency—an agency enrolled in the program is responsible to hire and render services
- Participant Directed—the participant is the employer and acts as the agency directing their care.

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

Service Coordinators/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 or participant-directed) 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 E-screen.
- If the participant has skilled LOC, the Service Coordinator/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, documentation must describe who will be providing ATTC, the frequency of care, and activities being performed.
- Participant Directed ATTC. The Service Coordinator/Care Manager must document who the employer is, who the employee/direct worker is and their relationship to the participant.

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.

DOCUMENTATION STANDARDS

Service Coordinators/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 or participant-directed) 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 E-screen.
- If the participant has skilled LOC, the Service Coordinator/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, documentation must describe who will be providing ATTC, the frequency of care, and activities being performed.
- Participant Directed ATTC. The Service Coordinator/Care Manager must document who the employer is, who the employee/direct worker is and their relationship to the participant.

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 nursing 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.
- ATTC will not be provided to household members other than to the participant.
- This service will not be reimbursed when provided by 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.
- ATTC services to participants receiving Adult Family Care waiver service, Structured Family Caregiving 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 Personal Services Agency
Agency	Licensed Home Health Agency
Individual	FSSA/OMPP approved Attendant Care Individual

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:

OMPP

Frequency of Verification:

Up to three 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:

OMPP

Frequency of Verification:

Up to three years

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):*

IC 16-27-4

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
455 IAC 2-6-1 Provider qualifications: becoming an approved provider; maintaining approval
455 IAC 2-6-2 (a)(1)(B) Provider qualifications: general requirements
455 IAC 2-11-1 Property and personal liability insurance
IC 12-10-17.1-10 Registration; prohibition
IC 12-10-17.1-11 Registration requirement
IC 12-10-17.1-12 Registration by the division; duties of the division

The division may reject any applicant with a conviction of a crime against persons or property, a conviction for fraud or abuse in any federal, state, or local government program, (42 USC §1320a-7) or a conviction for illegal drug possession. The division may reject an applicant convicted of the use, manufacture, or distribution of illegal drugs (42 USC §1320a-7). The division may reject an applicant who lacks the character and fitness to render services to the dependent population or whose criminal background check shows that the applicant may pose a danger to the dependent population. The division may limit an applicant with a criminal background to caring for a family member only if the family member has been informed of the criminal background.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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. Care Management is delivered to waiver participants receiving PathWays 1915(c) waiver services through FFS and is the equivalent of Service Coordination delivered to waiver participants receiving PathWays 1915(c) waiver services through an MCE as identified in Appendix C-1-b.

ALLOWABLE ACTIVITIES

Person Centered Planning. This activity includes but is not limited to discovering the individuals' strengths, needs, goals, and preferences. The Care Manager will appropriately facilitate the assessment process through use of person centered discovery tools and practice to engage the individual and their circle of support. The assessment and planning phase can include but is not limited to, brokering community resources, action and/or service planning, and eligibility for funded services.

Development and implementation of a Person Centered Support Plan, including action and/or service plans. Action Planning is a process to determine community resources to meet the individual's functional and social needs. Service Planning is a process to determine funded services and eligibility 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 15 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 OMPP 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 eligibility and 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, and 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 manager's 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 OMPP 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 not limited to discovering the individual's strengths, needs, goals, and preferences. The care manager will appropriately facilitate the assessment process to engage the individual and their circle of support. The assessment and planning phase can include but 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 and eligibility 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 15 days from initial service plan activation to ensure implementation of services.

The care manager is responsible to complete annual eligibility and 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 CM agency the current CM agency is to fully assist the individual in their transition, to the new agency or individual CM 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 the FSSA 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 case 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 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 Case Management Agency
Individual	FSSA/OMPP approved Case 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 Case 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 Case 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
- A Bachelor's Degree in any field with a minimum of two years full-time, direct service experience with older adults or person with disabilities (this experience includes assessment, care plan development, and monitoring); or
- A Master's degree in Social Work, Psychology, Counseling, Gerontology, Nursing or Health & Human Services; or
- An Associate's degree in any field with a minimum four years full-time, direct service experience with older adults or persons with disabilities (this experience includes assessment, care plan development, and monitoring).

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three 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 Case Management Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

Home and Community Assistance Service

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

ALLOWABLE ACTIVITIES

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

- 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
- Assistance with outdoor tasks including raking leaves, snow removal, lawn mowing, and weeding

SERVICE STANDARDS
The Service Coordinator/Care Manager will document through the person-centered planning process the need for HCA, the frequency of need, the required type of HCA activities.

DOCUMENTATION STANDARDS
Service Coordinator/Care Manager:
The Service Coordinator/Care Manager will document through the person-centered planning process the need for HCA, the frequency of need, and the required type of HCA 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 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, Structured Family Caregiving 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
Individual	FSSA/OMPP approved Homemaker Individual
Agency	Licensed Home Health Agency
Agency	Licensed Personal Services Agency

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

FSSA/OMPP approved Homemaker Individual

Provider Qualifications

License *(specify):*

IC 16-27-4

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:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

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

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

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:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

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

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

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:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Skilled Respite

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09012 respite, in-home

Category 2:

05 Nursing

Sub-Category 2:

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 can occur 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 (RSKNU)

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 Service Coordinator/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 Service Coordinator/Care Manager of hours used as well as hours remaining.

RSKNU authorized hours will roll over month to month through the duration of the annual service plan. If a request for an increase in RSKNU during the annual service plan is needed, the Service Coordinator/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

Service Coordinator/Care Manager Documentation Standards:

The Service Coordinator/Care Manager must identify the primary caregiver being relieved. The Service Coordinator/Care Manager needs to identify the primary caregiver is not being paid by the agency to skilled respite themselves during this time.

The Service Coordinator/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 Service Coordinator/Care Manager that involved the participant also needs to be documented
- 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 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
IC 16-27-4

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

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

Service Definition *(Scope):*

Adult Family Care (AFC) is a comprehensive service in which a participant resides with an unrelated caregiver. The participant and up to three other participants 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). Service Coordinators/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 AFC:
- Attendant care related to ADLs
- Home and Community Assistance care related to IADLs
- Medication oversight (to the extent permitted under State law)

SERVICE STANDARDS:
- AFC 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 their 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.

Service Coordinator/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 provided to meet the individual's needs and assure it is accurately shown in the level of care E-screen.
- If the participant requires skilled care, the Service Coordinator/Care Manager must explain how the skilled need will be met and by whom. The documentation must describe the reason to use ATTC, who will be providing this service, the activities that are expected to be performed and frequency.
- Service Coordinator/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 Service Coordinator/Care Manager from the AFC caregiver.

Maintenance of participant's personal records to include:
- Social security number
- Medical insurance number
- Birth date
- Emergency contact(s)
- All medical information available including all current prescription and non-prescription drug medication
- Most recent prior residence
- Hospital preference
- Primary care physician
- Mortuary (if known)
- Religious affiliation and place of worship, if applicable
- Strengths
- Risks
- Any goals identified by the participant and support provided by AFC staff to help the 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 Service Coordinator/Care Manager on an ongoing basis if there are changes to these documents:
- Advance Directive
- Living Will
- Power of Attorney
- Health Care Representative
- Do Not Resuscitate (DNR) Order
- Letters of Guardianship

NOTE: If applicable, copies of personal record must be placed in a prominent place in the 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 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 AFC service per diem does not include room and board.
- Separate payment will not be made for Home and Community Assistance, Skilled Respite, Home Modifications, Attendant Care, Home Delivered Meals, Pest Control, Community Transition, or Structured Family Caregiving services furnished to a participant selecting AFC services as these activities are integral to and inherent in the provision of AFC 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 Adult Family Care Agency
Individual	FSSA/OMPP approved Adult Family Care Individual

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 Family 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:

OMPP

Frequency of Verification:

Up to three years

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 Family 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:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assisted Living

HCBS Taxonomy:

Category 1:

02 Round-the-Clock Services

Sub-Category 1:

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 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 for assisted living services: Attendant care related to ADLs; Home and Community Assistance care related to IADL's; medication oversight (to the extent permitted under state law); non-emergency non-medical transportation; and therapeutic social and recreational programming.

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

If the participant requires skilled care, the Service Coordinator/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
Service Coordinator/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 Service Coordinator/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.

The Service Coordinator/Care Manager must give the completed person-centered service plan to the Assisted Living provider.

Provider Documentation Standards:
Complete and accurate documentation to support daily services rendered by the AL to address needs identified in the Service 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 Service Coordinator/Care Manager from the assisted living service

Maintenance of participant's personal records to include:
- Social security number
- Medical insurance number
- Birth date
- Emergency contact(s)
- Available medical information including known current prescription and non-prescription drug medication
- Hospital preference
- Primary care physician
- Mortuary (if known)

Participant's personal records must include copies of the following documents, if available, which the assisted living caregiver will also provide to the participant's Service Coordinator/Care Manager on an ongoing basis if there are changes to these documents:
- Advance directive
- Living will

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

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

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

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

ACTIVITIES NOT ALLOWED:

The Assisted Living service per diem or monthly rate 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 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 services furnished to a participant selecting Assisted Living Services as these activities are integral to and inherent in the provision of the Assisted Living 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 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:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Caregiver Coaching

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
10 Other Mental Health and Behavioral Services	10090 other mental health and behavioral services
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

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

Caregiver Coaching is a training and support service for unpaid caregivers. The purpose of Caregiver Coaching is to enable the stabilization and continued community tenure of a waiver participant by equipping the participant's unpaid caregiver(s) with the necessary skills to manage the participant's medical conditions and associated behavioral health needs related to a cognitive impairment and/or dementia. This is not a service provided directly to the waiver participant, but to their unpaid caregiver(s). This service allows family caregivers who are not eligible to participate in Structured Family Caregiving (i.e.) to access support. This service is available to any and all caregivers who are not served through structured family caregiving.

The waiver participant will receive additional waiver services outside of what the unpaid caregiver delivers. The goal of the caregiver coaching service is to address the caregiver's needs as far as training and education on how to best support the person. If the unpaid caregiver raises issues about service delivery, the concern is documented in the caregiver's service plan with the caregiver coach and service coordinator/care manager.

Technology will be used between the agency performing caregiver coaching, and the unpaid caregiver(s). If the unpaid caregiver needs assistance with the technology, the assigned caregiver coach will visit with the unpaid caregiver to provide a tutorial.

Caregiver coaching is a service targeted toward the unpaid caregiver to support their needs in order for the unpaid caregiver to continue supporting the waiver participant. The caregiver coach will assess strengths and goals as well as any health and safety risks of the unpaid caregiver, such as burnout and compassion fatigue, or that the unpaid caregiver is concerned about, related to the waiver participant. These strengths, goals, and health and safety concerns will be documented in the person-centered service plan along with interventions to ensure health and safety. The interventions will be assessed during each bi-weekly visit between caregiver coach and unpaid caregiver, and modified as needed as well as updates to the service coordinator/care manager about health and safety concerns and interventions.

The emergency/crisis plan is developed among all parties (service coordinator/care manager, participant, caregiver, and caregiver coach). This way, the participant and the participant's circle of support will have the same knowledge and understanding of the participant's backup plan, and emergency plan, and will support the participant in implementing that plan if needed. If there are modifications to the plan, all parties shall be involved in the plan changes as well as aware of the changes.

Since the waiver participant receives services through the PathWays Waiver as well as State Plan, the medically complex needs will be addressed through those services. Additionally, there are often times when unpaid caregivers render those services (if the provider is not available). The caregiver coach will identify with the unpaid caregiver the supports being rendered on an informal basis, by the unpaid caregiver to support the waiver participant. These services will be documented in the unpaid caregiver's person-centered service plan. The caregiver coach will review the services with the unpaid caregiver and PathWays Service Coordinator/Care Manager on a bi-weekly basis (or as communicated by the unpaid caregiver if more than bi-weekly). If the unpaid caregiver has questions or concerns about service delivery, the caregiver coach will provide training and education about delivery and/or connect with the participant, participant's service coordinator/care manager, and other providers to ensure services are rendered as specified by the participant.

Covered Services
- Initial consultation for assessment of the caregiver to determine initial coaching needs, and understand the caregiver's goals, values, needs and strengths.
- Caregiver Coaching provided in the community of the participant, virtually or telephonically, or other identified location meaningful to the unpaid caregiver, and through HIPAA secure communication platforms that allow for real-time and asynchronous communication between caregivers and caregiver coaches and collaboration with service coordinators/care managers.

Service Standards
- Caregiver Coaching services are family-centered, individualized to the needs of the participant and caregiver, and informed by an assessment of each caregiver's goals, values, needs, and strengths.
- A caregiver coach with expertise working with unpaid caregivers will conduct a caregiver assessment developed by FSSA and deliver ongoing education and coaching that is informed by the assessment.
- Caregiver Coaching services may be delivered telephonically and through HIPAA secure electronic communication platforms that enable a caregiver coach and a caregiver to communicate efficiently and, in a manner

convenient to the caregiver. Provider agencies must capture any caregiver communications received through an electronic communication platform, such as an app or e-mail, to facilitate the sharing of relevant information with service coordinators/care managers. Providers will communicate with service coordinators/care managers through traditional means to share any relevant information. The service does not require any specific percentage of in-person visits versus virtual visits.

• The service is designed to equip the participant's unpaid caregiver(s) with the necessary skills to manage the participant's medical conditions and associated behavioral health needs related to a cognitive impairment and/or dementia. Part of the caregiver assessment rendered by the caregiver coach will address areas of the caregiver's life that promote socialization and involvement within the community, but ultimately, the decision is based on where the caregiver needs support. If community integration is an area important to the waiver participant, the caregiver coach will support the caregiver in ensuring the participant's goals with regards to community integration are met. Additionally, a caregiver's community integration and supporting a waiver participant's community integration may change over time and will be consistently modified as necessary.

• A caregiver coach engages with a caregiver on a bi-weekly basis to understand the evolving needs of the participant and caregiver and deliver content, strategies and tools related to the management of the participant’s needs and behaviors and the caregiver’s self-care needs.

• Caregiver training will include how to address necessary precautions to prevent COVID-19 infection/spread in the home and address anxiety that consumers may experiencing related to the crisis; behaviors and triggering events; effective verbal and non-verbal communication strategies; strategies for managing challenging behaviors; and how to address home safety concerns. Coaching will also support a caregiver to apply stress reduction techniques and reduce caregiver isolation.

• Caregiver coach will assist the caregiver and client in creation of a crisis management/emergency plan to address the person and environment. Plan will be reviewed and updated (as needed) on a monthly basis and provided to service coordinator/care manager and waiver/State Plan/Hospice providers as well as emergency contacts and backup caregiver. Plan shall include but is not limited to the following:

- Health conditions
- Advanced directives, will planning, physician orders for life sustaining treatment
- Medications and medication management/assistance to prevent medication errors
- Fall prevention interventions
- Sundowning interventions
- Healthcare providers including contact information
- Emergency contacts
- Identification and contact information for back-up caregiver
- Contact information for caregiver coach and service coordinator/care manager
- Caregiver resources available within the caregiver’s/participant’s community of choice.

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

• Medicaid- participating Structured Family Caregiving agencies may be service providers; agencies must employ caregiver coaches with the experience and qualifications appropriate to the needs of each family. Educational content delivered by provider agencies to caregivers and delivery methods must be appropriate to the needs of unpaid caregivers.

• Caregiver coaching services will not duplicate services provided under the Medicaid State Plan or any other waiver service.

• Separate payment will not be made for Structured Family Caregiving.

• This service will not be reimbursed when provided by 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.

Maximum billable quarter hour units per month is 32.

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 Provider or FSSA/OMPP Approved Adult Day Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Caregiver Coaching

Provider Category:

Agency

Provider Type:

FSSA/OMPP Approved Structured Family Caregiving Provider or FSSA/OMPP Approved Adult Day Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

455 IAC 2

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transition

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

Note: “Own Home” is defined as any dwelling, including a house, an apartment, a condominium, a trailer, or other lodging that is owned, leased, or rented by the participant.

Items purchased through CTS are the property of the participant receiving the service, and the participant takes the property with them in the event of a move to another residence. For those receiving this service under the waiver, reimbursement for approved CTS expenditures are reimbursed by the MCE. The Service Coordinator/Care Manager maintains all applicable receipts and verifies the delivery of services. For FFS enrollees 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.

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 including but not limited to 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

SERVICE STANDARDS

CTS must follow a written service plan addressing specific needs determined by the person-centered planning process.

The MCE is required to utilize its housing coordinator to support the service coordinator/care manager in community transition items that will best meet the participant’s needs upon transitioning from an institutional setting.

DOCUMENTATION STANDARDS

Service Coordinator/Care Manager 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 Service Coordinator/Care Manager requests the full $1,500 lifetime cap and not all funds are used, then the Service Coordinator/Care Manager 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 CTS is limited to a lifetime cap for set up expenses, up to $1,500. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. CTS do not include monthly rental or mortgage expense; food; regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

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

The state will not bill for FFP until after the individual departs the institution and meets waiver eligibility.

This service will not be reimbursed when provided by 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 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:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

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

Home delivered meals may include but are not limited to:
- 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 MCE (or OMPP for FFS) or Registered Dietitian approval.

Meals shall contain less than 10% of daily calories from saturated fats unless prior MCE (or OMPP for FFS) or Registered Dietitian approval.

Meals shall contain less than 2,300 mg of sodium per day unless prior MCE (or OMPP for FFS) or Registered Dietitian approval.

DOCUMENTATION STANDARDS

Service Coordinator/Care Manager Documentation Standards:
Responsible for documenting the need for home delivered meals and amount being requested.

Provider Standards:
Date of delivery, how many meals are included, and the name of the care professional or service coordinator/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

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
This service will not be reimbursed when provided by 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 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:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

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 service coordinator/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 service coordinator/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 service coordinator/care manager become aware of discrepancies for complaints about the work being completed, the provider shall stop work immediately, and contact the service coordinator/care manager and MCE for further instruction.

Additional assessment visits may be requested 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 MCE will be responsible for maintaining related records that can be accessed by OMPP. For FFS enrollees, 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 $574.38 is available for home modification assessment services, unless the MCE (or OMPP for FFS) 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 service plan
Modification must address the participant's level of service needs
Any discrepancy noted by the provider, Service Coordinator/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 $574.38 is available for home modification assessment services, unless the MCE (or OMPP for FFS) 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.

This service will not be reimbursed when provided by 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.

Payment will not be made for home modifications under this service.

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):*

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

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three 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 an 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:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

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 his/her 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 MCE (or OMPP for FFS) to be able to intervene in a resolution.

Choice of Provider

The participant chooses the certified providers to submit bids for the home modifications. If the participant chooses to continue with the home modification after receiving the bids, then the lowest bid that meets the minimum requirements shall be chosen, such as, timeframe to start service. There is a minimum requirement to gather two bids for any expected amount over $5,000.00.

ALLOWABLE ACTIVITIES

Home modifications may include but are not limited to the following:
Adaptive door openers and locks
Bathroom Modification—including but not limited to:
- Removal of existing bathtub, toilet and/or sink
- Installation of roll in shower, grab bars, toilet and sink
- Installation of replacement incidental items such as flooring, storage space, cabinets that are necessary due to the bath modification

Home Control Units—Adaptive switches and buttons to operate medical equipment, communication devices, heat and air conditioning, and lights for an individual living alone or who is alone without a caregiver for a substantial portion of the day.

Kitchen modification—including but not limited to:
- Removal of existing cabinets, sink; an/or
- Installation of sink, cabinet; and/or
- Installation of replacement incidental items such as flooring, storage space, and cabinets if necessary due to kitchen modification.

Home safety devices such as:
- Door alarms
- Anti-scald devices
- Hand held shower head
- Grab bars for the bathroom

Ramp—including but not limited to: Permanent or portable (only considered for renters)
Vertical lift and/or Stair lift
Single room air or portable conditioner(s)/single room air purifier(s)

Widen doorways—such as: Exterior or interior bedroom, bathroom, kitchen door or any internal doorway as needed to allow for access. Pocket doors may be requested.

Windows—replacement of glass with Plexi-glass or other shatterproof material when there is a documented medical/behavioral reason(s).

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.

Items requested which are not listed above, must be reviewed and decision rendered by the MCE (or OMPP for FFS). Requests for modifications at two or more locations may only be approved at the discretion of the MCE (or OMPP for FFS). Requests for modifications may be denied if the MCE (or OMPP for FFS) 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, $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.
• 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 service coordinator/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.

Service Coordinator/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 two bids if over $5,000.00. If one bid is obtained the Service Coordinator/Care Manager must document the date of contact, the provider name, and why the bid was not obtained from that provider.
• Notification to the MCE (or participant's care manager and OMPP for FFS) of any discrepancies or complaints about the work while it is being completed. Notice provided within 48 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 year, the service provider shall replace or repair any product or installation.
• If the MCE 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 MCE 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 OMPP and MCE specific guidelines and/or policies.
• Notification to the participant's Service Coordinator/Care Manager and MCE (or OMPP for FFS) of any discrepancies or complaints about the work while it is being completed. Notice provided within 48 hours upon learning of the issues.

DOCUMENTATION STANDARDS
Documentation/explanation of the service within the Request for Approval to Authorize Services including the following:

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

DOCUMENTATION STANDARDS
Documentation/explanation of the service within the Request for Approval to Authorize Services including the following:

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

ACTIVITIES NOT ALLOWED

Examples/descriptions of activities not allowed include, but are not limited to the following, such as:
A. Adaptations or improvements which do not address participant accessibility or are not of direct medical or remedial benefit to the participant such as:
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 would 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 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 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	Architect
Agency	FSSA/OMPP approved Home Modification Agency/ Contractor
Individual	Plumber
Individual	FSSA/OMPP approved Home Modification Individual

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):*

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 permits

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three 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:

OMPP

Frequency of Verification:

Up to three 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:

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:

OMPP

Frequency of Verification:

Up to three 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:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Integrated Health Care Coordination

HCBS Taxonomy:

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

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Integrated Health Care Coordination 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 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 face to face visit per month.

Not to exceed 16 hours of Health Care Coordination per month, including travel time.

SERVICE COORDINATOR/CARE MANAGER STANDARDS
Service Coordinator/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 service coordinator/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 unmet 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 face to face visit/month. IHCC is not to exceed 16 hours per month.

Services must address needs identified in the service plan as determined by the person-centered planning process.

The provider will provide a written report to pertinent parties at least quarterly. Pertinent parties include the participant, guardian, waiver Service Coordinator/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.

ACTIVITIES NOT ALLOWED

This service will not be reimbursed when provided by 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 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	Home Health Agency
Agency	Adult Day Facility
Agency	FSSA/OMPP Approved Physician Practice
Agency	Assisted Living Facility

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:

Home Health Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three years

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:

Adult Day Facility

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

FSSA/OMPP Approved Physician Practice

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three years

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:

Assisted Living Facility

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Nutritional Supplements

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

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

For FFS enrollees, reimbursement for approved Nutritional Supplement expenditures are reimbursed through the local AAA or an approved OMPP provider, who maintains all applicable receipts and verifies the delivery of services. Providers can directly relate to the State Medicaid Agency at their election.

ALLOWABLE ACTIVITIES
Enteral Formula, 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

Service Coordinator/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 Documentation Standards:
Date of delivery, how many meals were provided, care professional or Service Coordinator/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:

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

The services under Nutritional Supplements are limited to additional services not otherwise covered under the state plan but consistent with waiver objectives of avoiding institutionalization. The meals provided as part of these services shall not constitute a full nutritional regimen.

An annual cap of $1200 is available for nutritional supplement services.

This service will not be reimbursed when provided by 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

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Participant Directed Home Care Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Participant-Directed Home Care Service (PDHCS) is a health-related service that can be performed by either licensed medical personnel or trained non-medical personnel and is provided for the primary purpose of meeting the chronic personal needs of the participant to maintain a level of function that will allow for a participant to avoid unnecessary institutionalization. This service can provide skilled or attendant care activities or both. In conjunction with State Plan, PDHCS may be provided twenty-four (24) hours per day, seven (7) days a week.

Service Requirements:
• A participant shall hire either a licensed professional through a home health agency, an independent, licensed professional, or a non-clinical competency-trained unlicensed professional.
• Home Care Service requires individual and continuous services when there is no person available outside of these services to assume the role of caregiver.
• PDHCS requires a participant to be diagnosed with a chronic medical condition that may require up to twenty-four (24) of continuous hours of care, as evidenced through a physician's order that can be safely provided outside of an institution. The participant must also receive home health State Plan services.
• Home Care Attendant Service is provided according to the participant's service plan/plan of care which documents the member's specific health-related need for individual and continuous care.
• Participant must be willing to accept risks and responsibilities associated with employing his/her caregiver and directing their own care.

Limitations:
• PDHCS is offered to individuals in a non-congregate setting.
• PDHCS is offered to individuals living without family or other informal supports willing and able to be trained to care for the participant and assume a portion of the participant's care.
• PDHCS is offered to individuals residing in postal code 46260, 46143, 46202 and 46204.
• PDHCS does not include administration of level II, III, IV, and V medications.

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 spouse of a participant (also known as a Legally Responsible Individual) as outlined in C-2-d and C-2-e of this waiver.

Participant must be able to direct their own 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
Individual	Aide/Paid Caregiver
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Participant Directed Home Care Service

Provider Category:

Individual

Provider Type:

Aide/Paid Caregiver

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

OMPP Approved

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

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

No more than every three years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Participant Directed Home Care Service

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

IC 16-27-1

Certificate *(specify):*

Other Standard *(specify):*

OMPP Approved Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

No longer than every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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, but is not limited to GPS or video monitoring service.
• Remote monitoring will not be placed in participant bedrooms or bathrooms.

SERVICE STANDARDS
Personal Emergency Response services must follow a written service plan addressing specific needs determined by the individual's assessment.
Service coordinator/care manager is required to contact the waiver participant if contacted by the PERS provider that waiver participant experienced a fall.

DOCUMENTATION STANDARDS
Service Coordinator/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 service coordinator/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 Service Coordinators/Care Managers of any participant who experienced a fall within a one month timeframe

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 MCE confirms there is a back-up plan in the event of equipment failure.

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

ACTIVITIES NOT ALLOWED

Services to participants receiving Assisted Living waiver service

Services to participants receiving Adult Family Care Services

This service will not be reimbursed when provided by 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 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:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

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.

For FFS enrollees, 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 Service Coordinator/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

Service Coordinator/Care Manager 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 service coordinator/care manager direct observation or participant report that a pest is causing or is expected to cause more harm than is reasonable to accept.

This service will not be reimbursed when provided by 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 or Assisted Living waiver service. Preventive measures or on-going need for services, or eradication or prevention of mold or mold like substances.

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

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

specified in statute.

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

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

Service Definition *(Scope):*

Specialized Medical Equipment and Supplies 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).
• There should be no duplication of services between HCBS waiver and Medicaid State Plan; or
• The refusal of a Medicaid vendor to accept the Medicaid reimbursement through the Medicaid State Plan is not a justification for waiver purchase; or
• Preference for a specific brand name is not a medically necessary justification for waiver purchase; or
• 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; or
• Reimbursement is limited to the Medicaid State Plan fee schedule, if the requested item is covered under Medicaid State Plan.

B. Requests will be denied if the MCE (or OMPP for FFS) 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).

• Lift chairs-The HCBS program will cover the chair. State Plan should be pursued first for prior approval of the lift mechanism.

• Medication Dispensers

• Toileting and/or incontinence supplies, including wipes, that do not duplicate State Plan Services

• Slip resistant socks

• Self-help devices - including over the bed tables, reachers, adaptive plates, bowls, cups, drinking glasses and eating utensils

• Strollers - when needed because participant’s primary mobility device does not fit into the participant's vehicle/mode of transportation, or when the participant does not require the full time use of a mobility device, but a stroller is needed to meet the mobility needs of the participant outside of the home setting.

• Voice active smart devices

• Maintenance - limited to $1,000.00 annually for the repair and service of items that have been provided through a HCBS waiver:
o Requests for service must detail parts cost and labor cost;
o If the need for maintenance exceeds $1000.00, the Service Coordinator/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 MCE (or OMPP for FFS), if the request meets the participant's need.

• Interpreter service - provided in circumstances where the interpreter assists the individual in communication during

specified scheduled meetings for service planning (e.g. waiver case conferences, team meetings) and is not available to facilitate communication for other service provision.

SERVICE STANDARDS

Specialized Medical Equipment and Supplies must be of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and service specifications.

DOCUMENTATION STANDARDS

Service Coordinator/Care Manager Documentation Standards:
• Responsible to document the need for medical specialized equipment.
• Describe how the equipment is expected to improve the participant's quality of ADL.
• Collect two bids if over $1,000.00. If one bid is obtained the Service Coordinator/Care Manager 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 Documentation 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 $1,000.00 annually for the repair and service of items that have been provided through a HCBS waiver:
• Requests for service must detail parts cost and labor cost; and
• If the need for maintenance exceeds $1000.00, the Service Coordinator/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, but are not limited to the following:
1. Hospital beds, air fluidized suspension mattresses/beds
2. Therapy mats
3. Parallel bars
4. Scales
5. Paraffin machines or baths
6. Therapy balls
7. Books, games, toys
8. 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, play houses, merry-go-rounds
14. Swimming pools, spas, hot tubs, portable whirlpool pumps
15. Adjustable mattresses (such as, but not limited to, Tempur-Pedic), 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, but consistent with waiver objectives of avoiding institutionalization.

E. This service will not be reimbursed when provided by 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 Specialized Medical Equipment and Supplies Agency
Agency	Licensed Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

FSSA/ OMPP approved Specialized Medical Equipment and Supplies Agency

Provider Qualifications

License *(specify):*

IC 25-26-21

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:

OMPP

Frequency of Verification:

Up to three 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:

Licensed Home Health Agency

Provider Qualifications

License *(specify):*

IC 16-27-1

Certificate *(specify):*

Other Standard *(specify):*

OMPP approved
455 IAC 2-18 Warranty required

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

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:**

Service Definition *(Scope):*

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

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, Service Coordinator/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 service plan. 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 Service Coordinators/Care Managers, MCEs, 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). Service Coordinators/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 (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 three 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.
• Structured 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 training 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 eight 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 Service Coordinator/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
• Service Coordinator/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, including:
• 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 Service Coordinator/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), Service Coordinators/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
• 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 Family 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:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

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 types of service:
Level 1 Transportation - the participant does not require mechanical assistance to transfer in and out of the vehicle.
Level 2 Transportation - the participant requires mechanical assistance to transfer into and out of the vehicle.
Adult Day Service Transportation - the participant requires round trip transportation to access adult day services.

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

Services to participants receiving Adult Family Care waiver service, or Assisted Living waiver service.

This service will not be reimbursed when provided by 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 Transportation 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:

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:

OMPP

Frequency of Verification:

Up to three 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:

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 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

Compliance with applicable vehicle/driver licensure for vehicle being utilized

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Vehicle Modifications

HCBS Taxonomy:

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

Service Definition *(Scope):*

Vehicle Modifications (VMOD) are the addition of adaptive equipment or structural changes to a motor vehicle that will 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 Service Coordinator/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.
H. Items requested which are not listed above, must be reviewed and approved by the MCE (or OMPP for FFS) if they meet the medical or social needs of the participant.

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 an FSSA approved provider.
6. Only one vehicle per 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 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

Service Coordinator/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 two bids if over $1,000.00. If one bid is obtained the Service Coordinator/Care Manager 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 Documentation Standards:
Provider of services must maintain receipts for all incurred expenses related to the modification
All bids must be itemized
Must be in compliance with MCE and OMPP 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 vehicle per every ten year period for a participant's household. In addition to the applicable lifetime cap, $1,000.00 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.

ACTIVITIES NOT ALLOWED
This service will not be reimbursed when provided by 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.

Examples/descriptions of modifications/items not covered include, but are not limited to 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:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §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:

PathWays MCEs provide service coordination as an administrative function. FFS waiver enrollees receive an equivalent service, care management, as a waiver service as defined in Appendix C-3.

Appendix C: Participant Services

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

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal

history and/or background investigations of individuals who provide waiver services (select one):

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

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

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

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

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

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

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ○ **No. The state does not conduct abuse registry screening.**
- ◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; 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 participants receiving services. OMPP verifies receipt of documentation as a part of provider enrollment.

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 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 who meets 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 Service Coordinator/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.

For FFS enrollees, 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. Providers 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 MCE, state or its agents, including the service coordinator/care manager. As explained in Appendix I-2-d of the waiver application, the state uses a billing validation process to ensure FFS claims are paid only for necessary services that were properly authorized and actually provided to the participant within the authorized timeframe. MCEs are responsible for ensuring compliance with these policies, including ensuring claims are paid only for necessary services that were properly authorized and actually provided to the participant within the authorized timeframe. OMPP provides oversight of MCE compliance practices with billing subject to audit in look behind efforts of 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 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 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 (unless the service is self-directed).

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
- Assisted Living
- Participant-Directed Home Care Services
- Structured Family Caregiving Services

The state allows payment to be made to Legal Guardians for the provision of Attendant Care Services, 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.

For FFS enrollees, 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 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 MCE, state or its agents, including the service coordinator/care manager. As explained in Appendix I-2-d of the waiver application, the state uses a billing validation process to ensure FFS claims are paid only for necessary services that were properly authorized and actually provided to the participant within the authorized timeframe. MCEs are responsible for ensuring compliance with these policies, including ensuring claims are paid only for necessary services that were

properly authorized and actually provided to the participant within the authorized timeframe. OMPP provides oversight of MCE compliance practices with billing subject to audit in look behind efforts of OMPP and 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 OMPP is dedicated to increasing HCBS providers for the waiver. The OMPP is dedicated to focusing on recruitment, certification, and timely enrollment of providers by the fiscal agent, and retention of waiver providers. Information regarding HCBS services is posted on the FSSA website. The OMPP has open enrollment meaning any provider can apply at any time.

MCEs are responsible for developing and maintaining a comprehensive provider network to serve PathWays enrollees in compliance with 42 CFR Part 438. MCEs must develop and maintain a Network Development and Management Plan demonstrating adequate provider capacity to meet the needs of each PathWays waiver enrollee. The MCE must demonstrate the ability to serve members regardless of the county of residence and to meet contractually required minimum enrollee-to-provider ratios. For the first three years of the PathWays program, the MCE is contractually required to accept any willing HCBS provider into its network.

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.1.a Number and percentage of waiver services providers who met certification

standards. Numerator: Number of waiver service providers who were certified by the State. Denominator: Number of waiver services providers who requested certification from the State.

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Fiscal Agent Reporting

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **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.2 Number and percent of newly enrolled non-licensed/non-certified providers that met the provider qualifications prior to providing waiver services. Numerator: Number of newly enrolled non-licensed/non-certified providers that met the provider qualifications prior to providing waiver services. Denominator: Number of newly enrolled non-licensed/non-certified providers.

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

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

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

Data Aggregation and Analysis:

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

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

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

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

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.

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

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

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

Further, MCEs must have policies and procedures, which are reviewed and approved by OMPP, for altering conditions of a provider's participation with the MCE because of quality of care and service issues. These policies and procedures must include:

- Specific actions the MCE may take before terminating the provider's participation
- Mechanisms for reporting serious quality deficiencies to OMPP that could result in a provider's suspension or termination
- How reporting occurs and the individual staff members responsible for reporting deficiencies
- An appeals process for instances in which the MCE decides to alter the provider's condition of participation because of quality of care or service issues. The MCE must ensure that providers are aware of the appeals process.
- Mechanisms to ensure providers are treated fairly and uniformly.

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

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

ii. Remediation Data Aggregation

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

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

PathWays1915(c) waiver services are provided in the participant's home and community, based upon their preference. Additionally, Adult Day Services 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, identified in the participant's service plan, reviewed, and approved by the MCE, and subject to OMPP review. To ensure compliance of all settings, HCBS questions are addressed and recorded in the 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). MCEs may only contract with providers certified by OMPP as a PathWays waiver provider and enrolled as a Medicaid provider.

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 service coordinator/case manager, MCE, or OMPP. FSSA provides an online complaint form as well as a complaint hotline to submit reports of non-compliance.

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:

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

For Expedited Waiver Eligibility, individuals developing the initial care plan must also meet the above criteria.

All PathWays service coordinators must complete Person-Centered Thinking Training through the Learning Community for Person-Centered Practices.

☐ **Social Worker**
Specify qualifications:

☒ **Other**
Specify the individuals and their qualifications:

Area Agencies on Aging (AAAs) may also develop an initial service plan for newly eligible PathWays enrollees. AAA staff completing these initial service plans must meet the following criteria:
• An individual continuously employed as a care manager by an AAA since June 30, 2018; OR
• A registered nurse, a licensed practical nurse, or an associate's degree in nursing with at least one year of experience serving the program population; OR
• A Bachelor's degree in Social Work, Psychology, Counseling, Gerontology, Nursing or Health & Human Services; OR
• A Bachelor's degree in any field with a minimum of two years full-time, direct service experience with older adults or persons 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 persons with disabilities (this experience includes assessment, care plan development, and monitoring).

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.

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

d. 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):

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

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

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

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

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

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

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

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

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

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

e. How waiver and other services are coordinated

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

The Care Coordinator has primary responsibility for coordination of the member's physical and behavioral health. The member's Service Coordinator collaborates with the member's Care Coordinator and is a core participant in the member's Interdisciplinary Care Team (ICT). The ICT also includes any member-selected supports, including informal caregivers and incorporates additional expertise as needed based on the member's medical and behavioral health conditions, disabilities, pharmacy, environmental needs, and other urgent management needs.

Through a person-centered planning approach, MCEs assist the member, their family, and physician to develop a strengths-based Individualized Care Plan (ICP) with specific objectives, goals, and action protocols to meet identified needs. The Service Plan is a component of the ICP. Additionally, MCEs must engage the member's PMP or other significant practitioner(s) in care coordination activities through ongoing, direct interaction between the practitioner and the ICT. This involvement includes semi-annual care conferences based on the member's assessment and evaluation.

In the PathWays FFS delivery system, the care manager is responsible for coordination of all services and to assure needs are met. The care manager is responsible for the implementation and monitoring of the service plan. This plan is finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.

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

MCEs must ensure services outlined on the Service Plan are initiated within 20 business days of receiving the NFLOC

determination. When the initial Service Plan is activated, the service coordinator/care coordinator must either call or visit the member within 15 days from initial Service Plan activation to ensure implementation of services. Additionally, service coordinators/care managers are responsible for monitoring and assessing the quality and effectiveness of the member's Service Plan in a face-to-face contact every 90 days. At least two of these face-to-face contacts per year will be in the member's home setting, consistent with the member's preference. Additionally, members are contacted by their service coordinator/care manager at least monthly either in person or by telephone, unless the member specifically requests to opt out or otherwise reduce the frequency of these monthly contacts. The service coordinator/care manager may also meet more frequently with the member when appropriate based on the member's needs and/or request.

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

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

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

Care 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.

Expedited Waiver Eligibility (EWE): The state will implement interim plans for participants meeting EWE criteria, which includes completing all standardized assessment and person-centered planning service processes. The interim plan will span a duration which will not exceed 60 days.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Risks are assessed during both the NFLOC and service planning processes. During the initial and renewal NFLOC processes, the Eligibility Screen tool is used to identify potential risks and vulnerabilities. Service Plan development takes into account risks identified during the assessment. The person-centered service planning process must include protecting a member's health, welfare, and safety, including developing an emergency plan. Service plans must address member's assessed needs, including health and safety risks factors and documentation of appropriate interventions to mitigate risk while balancing the member's overall quality of life and individual choice. The 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 service coordinators/care managers to recognize and respect the participant's participant desires and preferences when formulating risk mitigation strategies.

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

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

For FFS, an electronic database is maintained by FSSA that contains information regarding all qualified waiver providers for each service on the PathWays waiver. Care managers are able to generate a list of all qualified providers for each service on the waiver for the participants' use. As a service is identified, participant or guardian with the circle of support are encouraged to call and interview potential service providers and make their own choice. The participant's person centered service plan must document the provider-choice process. 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 waiver services. The care manager will assist the participant with obtaining information about any and all providers available for a given service.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ○ **Every twelve months or more frequently when necessary**
- ◉ **Other schedule**

Specify the other schedule:

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

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that*

applies):

☐ **Medicaid agency**

☐ **Operating agency**

☐ **Case manager**

☒ **Other**

Specify:

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

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan 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.

MCEs must ensure services outlined on the Service Plan are initiated within 20 business days of receiving the NFLOC determination. When the initial Service Plan is activated, the Service Coordinator/Care Manager must either call or visit the member within 15 days to ensure implementation of services. Additionally, Service Coordinators/Care Managers are responsible for monitoring and assessing the quality and effectiveness of the member's Service Plan in a face-to-face contact every 90 days. At least two of these face-to-face contacts per year will be in the member's home setting, consistent with the member's preference. Additionally, members are contacted by their Service Coordinator/Care Manager at least monthly either in person or by telephone, unless the member specifically requests to opt out or otherwise reduce the frequency of these monthly contacts. The Service Coordinator/Care Manager may also meet more frequently with the member when appropriate based on the member's needs and/or request.

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

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 percentage of service plans that address the participants needs and personal goals. Numerator: Number of service plans that address the participants needs and personal goals. Denominator: Number of service plans audited by the State.

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

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

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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.

Performance Measure:
D.2 Number and percentage of service plans audited that were developed in accordance with policies and procedures. Numerator: Number of audited service plans compliant with service plan policies and procedures. Denominator: Number of service plans audited.

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):

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

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

Data Aggregation and Analysis:

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

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:

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.5.a Number and percentage of service plans audits that reflect participant choice between/among waiver services. Numerator: Number of services plans audited that reflect choice between/among waiver services. Denominator: Number of services plans audited.

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

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

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

Data Aggregation and Analysis:

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

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

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix E: Participant Direction of Services

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

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

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

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

The care manager, options counselor, or service coordinator will provide detailed information during the service planning development phase to individuals, caregivers, and families about the option to direct services. Participants receiving attendant care on the PathWays 1915(c) Waiver are offered the Participant-Directed Attendant Care Service (PDACS). Additionally, participants may also elect to receive the participant directed home care service (PDHCS). The two options are described below.

1. PARTICIPANT DIRECTED HOME CARE SERVICES (PDACS)

In PDACs, participants are empowered to choose their own personal attendants. This program allows participants receiving care, or their representatives on their behalf, to select, schedule, train, supervise, and (if necessary) terminate their own personal attendants. The participant directing care, or their representative, takes on all the responsibilities of being an employer except for payroll management, which is handled by the fiscal intermediary.

Some of the opportunities afforded to the participant receiving PDACS include:
- An opportunity to exercise more autonomy, to arrange the care more conveniently for the participant, and to work with attendants who are chosen by the participant.
- An alternative to agency-based care or care provided by independent care providers.
- The opportunity to arrange for services from more than one personal attendant or from a combination of agency-based care and self-directed attendant care, depending on the participant's service plan.

Attendant care providers shall be recruited, hired, trained, paid, and supervised under the authority of the participant or representative acting on the participant's behalf, if the participant chooses to self-direct the attendant care providers. The participant or their representative assumes the responsibility to initiate self-directed attendant care service and exercise judgment regarding the manner in which those services are delivered, including the decision to employ, train, and dismiss an attendant care provider.

Attendant Care services are defined in Appendix C1/C3 Service Specifications.

PDACS offers participants employer authority only.

Service coordinators/care managers are an integral part of the success of the PDACS Program. The service coordinator/care manager is responsible for oversight and monitoring of the service plan of the participant; assessing the participant for participation in PDACS; assisting the participant who is directing care; evaluating whether PDACS is appropriate for meeting the participant’s needs; and assessing whether the participant or the participant's representative is interested in taking on the responsibilities associated with the PDACS Program.

For the PDACS Program, the service coordinator/care manager is required to have face-to-face contact with the participant at least every 90 days, or more often as the needs of the participant change. The service coordinator/care manager reviews the person-centered service plan with the individual for continuing use of PDACs every 90 days. The service coordinator/care manager shall evaluate for quality and ask the participant to verify whether they are satisfied with the services they are receiving. The participant will be asked to sign the Participant Directed 90 Day Review Checklist facilitated by the service coordinator/care manager. Representatives directing care on behalf of the participant will be required to sign the 90 Day Participant Directed Review Checklist and verify weekly face-to-face visits between the caregiver and the participant.

The Division of Disability and Rehabilitative Services, a division under the single state Medicaid agency, contracts with a fiscal intermediary whose responsibilities include serving as the payroll department; obtaining limited criminal background history checks on providers; issuing paychecks per submitted timesheets; withholding all necessary taxes; filing monthly, quarterly, and annual tax and labor reports; issuing annual W-2 wage statements; managing service units; providing participants, employers and service coordinators/care managers with monthly reports of spending on participant’s behalf; and responding to all questions posed by the MCE, participant, provider, and state officials. MCEs are required to allow enrollees electing self-direction to utilize this fiscal intermediary.

Participant directed care providers are required to document the activities performed. Appendix C contains the service definition for attendant care and must be followed for participant direction of care.

2) PARTICIPANT DIRECTED HOME CARE SERVICE (PDHCS)

PDHCS is a health-related service that can be performed by either licensed or trained non-medical personnel, and is provided for the primary purpose of meeting chronic medical needs, and maintaining, as opposed to improving, a level of function, to an extent that allows for a participant to avoid unnecessary institutionalization. In conjunction with State Plan services, PDHCS can be provided twenty-four (24) hours per day, seven (7) days a week.

PDHCS is defined in Appendix C1/C3 Service Specifications. New service plans with PDHCS will be subject to additional state review at least annually, to ensure services are provided in accordance with service specifications.

The PDHCS offers both employer and budget authority.

This program expects participants receiving care to select, schedule, train, supervise, and (if necessary) terminate their own provider. The participant directing his/her provider takes on all of the responsibilities of being an employer except for payroll management, which is handled by a fiscal intermediary.

Some of the opportunities afforded to the participant receiving PDHCS include:
-An opportunity to exercise autonomy, to arrange the care conveniently for the participant, and to work with provider(s) who are chosen by the participant.
-An alternative to agency-based care or care provided by independent care providers.
-Allows the participant the opportunity to arrange for services from more than one provider or from a combination of agency-based care and self-directed skilled care, depending on the participant's service plan.

Providers shall be recruited, hired, trained, paid, and supervised under the authority of the participant.

Service coordinators/care managers are an integral part of the success of the PDHCS. The service coordinator/care manager is required to:
- Provide oversight and monitoring of the Service Plan of the participant.
- Assess the participant for participation in the PDHCS and complete the participant-directed checklist before the service may be added to the service plan and at the initial, quarterly review, annual, and re-entry assessments.
- Assist the participant in directing care in evaluating whether the PDHCS is appropriate for meeting the participant's needs.
- Assess the needs of the participant through a person-centered planning process and establish an annual cost limit based on the authorized plan of care. For waiver participants, annual cost per participant is determined by an algorithm established by the FSSA. The service coordinator/care manager will develop a person-centered plan that aligns with all setting rule requirements and meets those needs and service requests, and a dollar amount will be assigned to the plan using the FSSA's algorithm. The service coordinator/care manager must document the budget process and review with the participant.
- Document the medical need for a skilled service and types of skilled care the participant may require.
- Document the frequency, duration, and types of appropriate skilled activities that will meet the participant’s needs and assure it is accurately documented in the skilled level of care E-screen.
- Have the participant sign a waiver liability form.
- Document who is the employer, who is the employee/direct worker and their relationship to the participant.
- Document the back-up plan for the participant for when the direct worker is unavailable to deliver skilled care.
- Monitor the enrollment process for the participant and their employee/direct worker.
- Collect all training paperwork containing signatures for the file.
-Monitor service delivery every month. The service coordinator/care manager shall coordinate service delivery (frequency, activities) with the employee/direct worker and also contact the fiscal intermediary agency to verify.

If a participant selects an un-skilled provider to furnish PDHCS, the rate will be reimbursed at the PathWays Waiver Attendant Care rate. If a participant selects a skilled provider to furnish PDHCS, the rate will be reimbursed per the rate methodology developed by the OMPP for the skilled Home Healthcare Aide.

-For PDHCS, have face-to-face contact with the participant at least every thirty-one (31) days, or more often as the needs of the participant change.
-To reauthorize the participant in the PDHCS every ninety (90) days. The service coordinator/care manager shall evaluate for quality and ask the participant to verify whether they are satisfied with the services they are receiving. The participant shall be asked to sign the 90 Day Participant -Directed Review Checklist facilitated by the service coordinator/care manager.

The Division of Disability and Rehabilitative Services, a division under the single state Medicaid agency, also contracts with a fiscal intermediary whose responsibilities include:
-Serving as the payroll department, and;
-Obtaining limited criminal background history checks, and;
-Obtaining professional licensing documentation if applicable; issuing paychecks per submitted timesheets; withholding all necessary taxes; filing monthly, quarterly, and annual tax and labor reports; issuing annual W-2 wage statements; managing service units; providing participants, employers and service coordinators/care managers with monthly reports of spending on participant's behalf; and responding to all questions posed by the participant and the provider and State officials.

PDHCS providers are required to document the activities performed.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

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

- ☐ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☒ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

PDACS is available to participants who do not live in a congregate setting. PDCHS is only available to participants who live in their own private residence.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or**

all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

PDACS and PDHCS are the only services that can be self-directed by the participant. MCEs are contractually required to educate enrollees on the opportunity to self-direct services as an alternative to the traditional agency model. The option to self-direct care is presented to the participant by the service coordinator/care manager. The service coordinator/care manager assesses enrollee interest in participant-direction and provides the enrollee with information regarding the philosophy of self-direction and the availability of PDACS and PDHCS. The information provided to enrollees includes:
- A clear explanation that participation is voluntary;
- An overview of the supports and resources available to assist enrollees in PDACS/PDHCS; and
- An overview of enrollee rights and responsibilities, including actions that may result in removal of participation in PDACS/PDHCS, and the enrollee's right to participate in the grievance process.

Individuals on the PathWays waiver determine whether they are willing and able to self-direct services and supports. To assist an individual in determining whether self-direction is the right choice for them, PathWays service coordinators/care managers are required to utilize the "Self-Direction Pre-Screening Tool" for individuals who are interested in self-direction as well as designated self-direction representatives. Based upon the individual's preference, the screening tool may be completed by the person independently or with the assistance of the service coordinator/care manager.

If the enrollee elects to participate in self-direction, the Enrollment Checklist is completed and signed by the participant. The following is included on the Enrollment Checklist:
- Participant accepts full responsibility for direction of personal care and managing the hours that have been approved in the service plan.
- Participant is prepared to hire, train, supervise, and dismiss (if needed) an employee who will perform the duties of their personal paid caregiver.
- Participant understands they will be receiving an enrollment packet from the Fiscal Intermediary and will need to complete all necessary paperwork required to become an employer.
- Participant understands their employee(s) will need to complete the necessary paperwork provided by the Fiscal Intermediary before starting work.
- Participant understands the process of reporting the time their personal attendant has worked and understands the program's timekeeping procedures.
- Participant is aware that each paid caregiver cannot provide more than 40 hours of service in one-week, and the participant will arrange for service from another provider if additional services are required.
- Participant is aware they must inform the Fiscal Intermediary of any changes of employment.
- Participant has developed a written back-up plan for a situation in which a provider is unavailable.
- Participant has identified emergency information which will be available to the personal attendant and/or nursing staff.
- Participant understands they are responsible for addressing any quality of care issues directly with their provider.
- Participant is aware of how to report abuse or neglect promptly to the specified authorities and to the service coordinator/care manager.
- For PDACS, participant understands that the service coordinator/care manager will be checking in at a minimum of 90-day intervals and will file an incident report to the State to report any quality-of-care issues or lapses in participant/employer responsibilities.
- For PDHCS, participant understands that the service coordinator/care manager will be checking in at a minimum of 31-day intervals and will file an incident report to the State to report any quality-of-care issues or lapses in participant/employer responsibilities.
- Participant is aware of the MCE member helpline, Ombudsman, and assigned service coordinator/care manager and how to contact each entity.

While FSSA supports individuals who elect to direct their services, the following are reasons a member may be involuntarily disenrolled from self-direction:
• Loss of financial eligibility;
• Loss of functional eligibility;
• Mismanagement of Budget Authority responsibilities (misappropriation of funds);
• Mismanagement of Employer Authority responsibilities;
• Unable to contact for an extended period of time;
• Health and safety cannot be assured;
• Substantiated fraud;

• Movement to an ineligible living setting.

In all instances of terminations, the service coordinator/care manager must ensure there is no gap in services during the transition from self-direction to other services

Every 90 days, the enrollee is asked to sign the Participant Directed 90 Day Review Checklist, which includes the following questions:
- Participant continues to be capable of performing the duties required of an employer.
- The number of hours of care the paid caregiver has delivered is in line with the participant's service plan.
- No paid caregiver has provided more than 40 hours of service in any given one-week period within the service plan.
- Participant has submitted timesheets and completed all necessary paperwork as requested by the Fiscal Intermediary.
- Participant has hired, trained, and is actively supervising the paid caregiver.
- Participant is able to address quality of care and/or performance issues with the paid caregiver.
- Paid caregiver is delivering all services appropriately as stated in the participant's service plan and as described in the responsibilities worksheet.
- Participant has a written back-up plan for care when provider is unavailable.
- Back-up provider is still available to provide care.
- Emergency information is up to date and available to paid caregivers.
- There are no issues of abuse, exploitation, or neglect.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Information pertaining to participant/representative responsibilities is provided to participants when they are contemplating accessing self-direction opportunities prior to beginning a new self-directed service arrangement. At that time, the care manager or service coordinator must make sure the individual receives appropriate training/support and understands these roles and responsibilities by providing the online training from Medicaid.gov for individuals who self-direct or wish to self-direct. The training series consists of six, self-guided modules, each covering a different aspect of direct service worker recruitment, training and retention and is available in multiple accessible formats. The series can be found at:
https://www.medicaid.gov/medicaid/long-term-services-supports/direct-care-workforce/online-training-for-self-directed-hcbs/index.html.

What support is chosen by the individual to assist them to self-direct their services; if no support is needed or desired, care managers and service coordinators must, at a minimum, provide training on the following:
- How the self-directed option works.
- Employer of record duties, including hiring, firing, training, and timekeeping.
- How to engage with Indiana's financial intermediary provider.
- A written copy of the person-centered service plan and individual budget is provided to all members of the individual's support team.

MCEs are contractually required to educate enrollees on the opportunity to self-direct services as an alternative to the traditional agency model. Service coordinators/care managers are responsible for assessing enrollee interest in PDCAS and providing them with information regarding the philosophy of self-direction and the availability of PDACS. The information provided must include:
- A clear explanation that participation in PDACS is voluntary;
- An overview of the supports and resources available to assist members to participate to the extent desired in PDACS;
- The benefits of self-direction; and
- An overview of member rights and responsibilities, including actions that may result in removal of participation in the PDACS, and the member's right to participate in the grievance process.

The option to self-direct is offered initially and ongoing during the normal quarterly visits by the service coordinator/care manager. Annually, the service coordinator must obtain a dated signature from the enrollee or their representative on a form that states: "My service coordinator has explained the PDACS option to me. I understand that under this option I can choose to self-direct attendant care services." Affirm one of the two statements below: "I accept the offer of PDACS and my service coordinator is helping me explore that option." "I decline PDACS at this time but understand I can choose this option at any time in the future by asking my service coordinator."

For PDHCS only, the participant and the service coordinator/care manager will create a caregiver reimbursement budget based on an algorithm determined by the FSSA. Participant will receive monthly financial budget reports detailing the funds spent and remaining for the year.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

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

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

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

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

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**
Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Enrollees are permitted to have a non-legal representative assist them in participating in PDACS when they have the ability to designate a person to serve as their representative. Representatives must meet the following minimum requirements:
- Be at least 18 years of age;
- Have a personal relationship with the member and understand his/her support needs;
- Know the member's daily schedule and routine, medical and functional status, medication regimen, likes and dislikes, and strengths and weaknesses; and
- Be physically present in the member's residence on a regular basis or at least at a frequency necessary to supervise and evaluate each worker. This frequency can be determined through the person-centered service planning process.

A member's representative will not receive payment for serving in this capacity and will not serve as the member's worker for PDACS. PDACS shall not be reimbursed when provided by the spouse of a participant, the attorney in fact (POA) of a participant, the health care representative (HCR) of a participant, or the legal guardian of a participant. PDHCS shall not be reimbursed when provided by the spouse of a participant, the attorney-in-fact (POA) of a participant, the health care representative (HCR) of a participant, or the legal guardian of a participant.

The MCE/service coordinator/care manager is required to use a representative agreement developed by OMPP to document a member's choice of a representative for PDACS, the representative's contact information, and to confirm the individual's agreement to serve as the representative and to accept the responsibilities and perform the associated duties defined therein. The representative agreement is signed by the member (or person authorized to sign on member's behalf) and the representative in the presence of the service coordinator/care manager.

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

The service coordinator/care manager has face-to-face contact with the member participating in PDACS at least every 90 days, and every 31 days for PDHCS, ore more often as the needs of the participant change to review the person-centered service plan, including self-direction, with the member for continuing use of PDACS and/or PDHCS. Representatives directing care on behalf of the participant for PDACS will be required to sign the State-developed Participant Directed 90 Day Review Checklist and verify weekly face-to-face visits between the caregiver and the participant.

The MCE/service coordinator/care manager is required to monitor enrollee participation in PDACS, including any patterns such as frequent turnover of representatives which may warrant intervention.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Waiver Service	Employer Authority	Budget Authority
Attendant Care	☒	☐
Participant Directed Home Care Service	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

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

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

☐ **Governmental entities**

☒ **Private entities**

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

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

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

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

The Bureau of Disabilities Services (BDS), through the procurement process, contracted with a fiscal intermediary for PDACS and PDHCS. The fiscal intermediary is responsible for serving as the payroll department; administering limited criminal history background checks; professional licensure checks; issuing paychecks per submitted timesheets; filing monthly, quarterly and annual tax and labor reports; issuing annual W-2 wage statements; managing service units; providing MCEs, participants, employers, and service coordinators/care managers with monthly reports of fiscal intermediary spending on participant's behalf; and responding to questions and issues concerning PDACS and PDHCS.

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

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

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

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

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

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

☒ **Other**

Specify:

Administers limited criminal history background check.

Supports furnished when the participant exercises budget authority:

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

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

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

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

☐ **Other services and supports**

Specify:

Additional functions/activities:

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

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

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

☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

DDRS, through its Bureau of Disabilities Services (BDS), is responsible for monitoring the performance of the fiscal intermediary through weekly telephonic conference calls and weekly written reports on payments to providers. The reports include the number of participants, the number of providers, dollar amounts, and which participants have service plans but are not receiving services.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

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

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

Service coordinators/care manager are an integral part of the success of participant-directed services as they are responsible for oversight and monitoring of the individual's service plan. One of the service coordinator's/care manager's responsibilities is to have face-to-face contact with the participant at least every 90 days, or every 31 days for PDHCS, or more often as the needs of the participant change. The role of the service coordinator/care manager is to empower the participant in directing care and in evaluating whether PDACS/PDHCS is appropriate for meeting the participant's needs and whether the participant or the participant's representative (PDACS only) is able to fulfill all the responsibilities to manage the participant-directed services. The participant and service coordinator/care manager will be asked to sign the Participant Directed 90 Day Review Checklist and verify weekly face-to-face visits between the caregiver and the participant. The service coordinator/care manager also helps to provide administrative guidance to the participant, or the participant's representative (PDACS only), regarding the self-directed attendant services implementation process. This process includes: training on the program; assisting with obtaining and/or completion of the employer and employee packets involved in hiring the participant-directed attendant care/home care provider; directing the employer to the fiscal intermediary's help line if assistance is needed with the completion of the fiscal intermediary forms and paperwork; and monitoring the outcomes of the participant-directed services.

☒ **Waiver Service Coverage.**

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

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Care Management	☒
Home and Community Assistance Service	☐
Nutritional Supplements	☐
Attendant Care	☐
Assisted Living	☐
Specialized Medical Equipment and Supplies	☐
Pest Control	☐
Adult Family Care	☐
Personal Emergency Response System	☐
Participant Directed Home Care Service	☐
Skilled Respite	☐
Home Modification Assessment	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Vehicle Modifications	☐
Home Delivered Meals	☐
Community Transition	☐
Transportation	☐
Caregiver Coaching	☐
Structured Family Caregiving	☐
Integrated Health Care Coordination	☐
Adult Day Service	☐
Home Modifications	☐

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

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

◉ **No. Arrangements have not been made for independent advocacy.**

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

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

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

MCEs must forward to OMPP any cases in which the MCE plans to involuntarily terminate a member from PDACS. If OMPP approves the request, the MCE notifies the member which initiates the right to appeal the determination. The service coordinator/care manager must conduct a face-to-face visit and update the service plan. The service coordinator/care manager assists the participant with accessing needed and appropriate services through the traditional waiver services option, ensuring that no lapse in necessary services occurs for which the participant is eligible. The service coordinator/care manager will provide the participant with other service options, which will be provided to meet the needs of the participant and to assure continuity of services to meet the participant's needs. The participant, or representative directing care on behalf of the participant, will be asked to sign the 90 Day Self-Directed Review Checklist along with the service coordinator/care manager. This process will not circumvent the participant's right to a fair hearing as detailed in Appendix F-1.

Paid caregivers shall be identified for involuntarily termination from participant-direction when it has been determined by the Fiscal Intermediary or service coordinator/care manager that any of the following exist: (A) An immediate health and safety risk associated with participant-direction, such as, imminent risk of death or irreversible or serious bodily injury related to the provision of waiver services; or (B) misuse of funds following notification, assistance and support from the Fiscal Intermediary and/or service coordinator/care manager; or (C) failure to follow and implement policies of participant-direction after receiving technical assistance and guidance from the Fiscal Intermediary and/or service coordinator/care manager; or (D) providing false information and/or documentation; or (E) paid caregiver is in violation of 455 IAC 2-15-2; or (F) individual abuse and/or neglect. Requests for involuntary termination must be sent by the MCE/service coordinator/care manager to OMPP for review and approval.

When a participant or paid caregiver is involuntarily terminated, they shall be ineligible to reapply for participant-directed services as either a participant or paid caregiver for 24 months following the date of termination. The service coordinator/care manager must work with the Fiscal Intermediary to ensure that the issues previously identified as reasons for termination have been adequately addressed prior to reinstatement.

Members who are determined for involuntary termination from self-direction may choose to reengage in self-direction under the following conditions:
• Designation of a representative when no representative existed at time of involuntary termination; or
• Designation of a new representative when representative at time of involuntary termination was determined to not be fulfilling duties; or
• Two years have elapsed since involuntary termination.

All members who wish to re-engage in self-direction after an involuntary termination must prior to re-engagement:
• Complete the pre-screening tool; and
• Complete the online training for Self-Directed HCBS

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		211
Year 2		211
Year 3		211
Year 4		211
Year 5		211

Appendix E: Participant Direction of Services

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

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

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

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

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

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

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

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☒ **Hire staff common law employer**

☐ **Verify staff qualifications**

☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

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

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

All direct care providers must submit a criminal background check as required by 455 IAC 2-15-2. The criminal background check must not show any evidence of acts, offenses, or crimes affecting the applicant's character or fitness to care for waiver consumers in their homes or other locations. The Fiscal Intermediary verifies receipt of documentation as a part of caregiver enrollment. OMPP providers are required to submit a policy regarding Indiana Office of the Inspector General (OIG) checks at certification and compliance review. Criminal history checks are maintained in agency files and are available upon request.

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

☐ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

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

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

☐ **Reallocate funds among services included in the budget**

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

☒ **Substitute service providers**

☒ **Schedule the provision of services**

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

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

☒ **Identify service providers and refer for provider enrollment**

☒ **Authorize payment for waiver goods and services**

☒ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

Only the PDHCS has a budget. For PDHCS, the service coordinator/care manager will assess the needs of the participant through a person-centered planning process. For waiver participants, annual cost per participant is determined by an algorithm established by FSSA. The service coordinator/care manager will develop a person-centered plan to meet those needs and service request, and a dollar amount will be assigned to the plan using the FSSA algorithm. The annual budget is determined by the number of hours assigned by the service coordinator/care manager for either or both the skilled and/or the attendant care activities during the person-centered planning process. Those hours are multiplied by the respective rate for home care skilled activities and/or attendant care activities. Even though the budget is determined during the person-centered care planning process, the participant is the one who decides what the actual rate and how many hours will actually be reimbursed within the total amount of the budget.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

The service coordinator/care manager will assess the needs and preferences of the participant through a person-centered planning process. The service coordinator/care manager will develop a person-centered plan to meet those needs and service requests, and then a dollar amount will be assigned to the plan using the FSSA algorithm. The service coordinator/care manager will explain how the budget is determined, the total amount of the budget, how a participant can request a change in the budget, and what the ramifications are if the participant exceeds the budget. The service coordinator/care manager and fiscal intermediary are responsible for monitoring the allocation of funds to the participant and the participant’s paid caregiver. Participant will receive monthly financial statement detailing the funds spend and remaining for the year.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

Service coordinators/care managers are an integral part of safeguarding participant's depletion of a self-directed budget and are responsible for the following prevention activities:
(A) discuss with participant or his/her representative the available amount in the budget;
(B) assist the participant or his/her representative with the development and modification of the participant-directed budget;
(C) submit request to the MCEs/OMPP for review and approval prior to the service coordinators/care manager's approval of the participant-directed budget;
(D) approve the participant-directed budget and modifications;
(E) assist the participant or his/her representative to develop or revise an emergency back-up plan;
(F) provide the fiscal intermediary a copy of the authorized participant budget and any modifications;
(G) monitor implementation of the plan;
(H) ensure services are initiated within required time frames;
(I) conduct ongoing monitoring of plan implementation and the participant's health and welfare;
(J) specify additional paid caregiver qualifications in the service plan based on the participant's needs and preferences when such qualifications are consistent with approved waiver qualifications.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to

offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

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

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

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

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

For Expedited Waiver Eligibility an Expedited Waiver Eligibility application facilitator (AAA) will assist individuals with the application process. Once all information has been submitted, the individual will receive an approval or pending status. Whether an individual is approved or not they will receive the following information: A notice they should maintain for future reference, an explanation of the Indiana Health Coverage Programs Privacy Rights, a copy of the Rights and Responsibilities for Health Coverage, a copy of an authorized representative agreement form, appeal rights for the financial determination, appeal rights for the functional eligibility determination and a copy of the answers that were submitted as part of the application process, which includes details of any responses that showed they were over the income or resource limits for expedited eligibility. If the individual is physically present with the Expedited Waiver Eligibility application facilitator, they will receive all physical packet documents at the time the application is submitted. If the Expedited Waiver Eligibility application facilitator completes the application over the phone the applicant will receive a physical copy within 10 business days. Regardless of if the individual is approved or receives the pending status, they will be contacted by the Division of Family Resources to conduct an interview, the individual must comply and accurately answer all questions. If additional documentation is needed to verify eligibility factors, a detailed request for documents is sent to the member, with a copy to the authorized representative. The due date to return the requested information will be 13 days after the request is mailed. Pending members sent to the Division of Family Resources can be denied at that point, common reasons for the denial are the following: failure to turn in verifications or not passing the income or asset test. For approved individuals the state would like to emphasize that they will receive the Approval Notice which informs them they have the right to change services and/or providers at any time if found to be eligible for Home and Community Based waiver services. If the individual is determined to be ineligible, they will be set for closure and given at least 13 days of advance notice. Notice will be sent to the individual and their authorized representative with appeals rights. The individual’s authorized representative can assist in filing an appeal and represent the client at the hearing.

For PathWays Waiver participants receiving services through the FFS delivery system, the following processes apply:
Waiver applicants and their legal representatives are provided written and 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 care manager.

Care managers will send formal notification to waiver applicants and participants of any action that affects the individual’s

Medicaid benefits related to waiver eligibility determination, service delivery, or participant-directed budget amount, including the following adverse actions:
• Denying new applicants entrance to the waiver (including denial of level of care);
• Not providing an individual the choice of home and community-based services as an alternative to institutional care;
• Reducing participant-directed budget allocation amount;
• Denying an individual the service(s) of their choice or the provider(s) of their choice; and
• Denying, suspending, reducing or terminating previously authorized services.

This formal notification of action will be provided in writing to the waiver applicant or participant and their legal representatives within 10 business days of the issue date specified on the formal notification and in advance of the effective date of the action. The notice will include the following information:
• Description of the decision that was made;
• Description of the 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 MCE grievance and appeals process operates in accordance with 42 CFR Part 438 Subpart F and is described in the PathWays 1915(b) Waiver.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

- ◉ **No. This Appendix does not apply**
- ○ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register**

grievances or complaints concerning the provision of services under this waiver

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

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).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

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

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

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

In accordance with 455-IAC-2, incidents are unusual occurrences affecting the health and safety of PathWays enrollees and include the following:

1. Alleged, suspected, reported, observed, or actual abuse/battery, assault, neglect, or exploitation of a member

2. The unexpected death of a member

3. Significant injuries to the member requiring emergent medical intervention, including, but not limited to, the following:(a) fracture; (b) a burn greater than first degree; (c) choking that requires intervention; or (d) contusions or lacerations.

4. Injuries of unknown origin

5. Any threat or attempt of suicide made by the member

6. Any unusual hospitalization due to significant change in health and/or mental status may require a change in service provision OR admission of an individual to a nursing facility, excluding respite stays

7. Member elopement or missing person

8. Inadequate formal or informal support for a member, including inadequate supervision which endangers the member

9. Medication errors resulting in outcomes that require medical treatment beyond an ER/physician evaluation or monitoring vital signs

10. A residence that compromises the health and safety of a member due to any of the following: (a) a significant interruption of a major utility; or (b) an environmental, structural, or other significant problem.

11. Environmental or structural problems associated with a dwelling where individuals reside that compromise the health and safety of the individuals

12. A residential fire resulting in any of the following: (a) relocation; (b) personal injury; or (c) property loss.

13. Suspected or observed criminal activity by: (a) provider’s staff when it affects or has the potential to affect the member’s care; (b) a family member of a member receiving services when it affects or has the potential to affect the member’s care or services; or (c) the member receiving services.

14. Police arrest of a member or any person responsible for the care of the member

15. A major disturbance or threat to public safety created by the member. The threat can be toward anyone, including staff, and in an internal setting, and need not be outside the individual's residence.

16. Any instance of restrictive intervention (including chemical or physical restraints, or seclusion)

17. Falls with injury, in accordance with the U.S. Center for Disease Control’s (CDC) Behavioral Risk Factor Surveillance System (BRFSS)

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

within 48 hours of the occurrence or knowledge of the occurrence (whichever is sooner).

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

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

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

All MCE materials are reviewed and approved by OMPP.

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

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

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

Incidents are reported to the FSSA web-based incident reporting system. Additionally, all cases of suspected abuse, neglect, or exploitation (ANE) are reported to an Adult Protective Services (APS) unit or law enforcement. Upon receipt of a report through the web-based system, OMPP routes it to the participant's MCE. The MCE must intake the report into its critical incident tracking system as soon as possible, but no later than four business hours after receipt. Then, the MCE must review and triage all reports within one business day of receipt to:

- Determine if ANE has occurred. If ANE is reasonably suspected, the MCE must file a critical incident report with APS if one has not already been submitted.

- Assess and address any immediate potential threats to member health, safety, and welfare. If the MCE identifies a risk of harm or potential harm, the MCE must take immediate action to ensure the safety of the member. These steps may include communication with service coordinators, other providers, family members and informal caregivers to verify or ensure that immediate threats to the individual's health and welfare are addressed and resolved. The MCE must document the actions taken as part of their weekly report to OMPP until the critical incident investigation is closed.

- Determine whether additional information is required from the provider.

- Notify the member and, as needed, other service providers about the critical incident report and related issues and concerns, about what to expect, and, as appropriate, how to mitigate future risk.

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

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

1. Conduct a full investigation. The MCE shall ensure that the investigation and resolution of critical incidents are conducted timely based on the nature and severity of each case. All investigations must be completed within 30 days, and:

a. Incidents not resolved within 21 days of the date of the initial incident must be referred to the MCE's Quality Manager or designee for additional action. The MCE must have the ability to flag such incidents in its incident management system. Follow-up reporting must continue every seven days until the incident is deemed resolved.

b. For incidents that occurred when the member was enrolled with a different MCE, the member's prior MCE must cooperate with the investigating MCE.

c. The MCE must clearly define responsibilities for implementation of its critical incident policies and procedures, to assure that a thorough investigation is completed timely. These policies are reviewed and approved by OMPP.

2. Submit to the member or the member's legal guardian as well as to the individual's care manager and service coordinator all information required by the MCE's investigator to be submitted.

3. Submit required reports to FSSA.

If a report does not meet the threshold to be a critical incident, the MCE must:

1. Respond to the reporter and route the complaint through the MCE's complaints, grievances, and appeals process.

2. Follow its quality of care and/or quality of service investigation process.

If a critical incident has been confirmed (i.e., a substantiated critical incident), the MCE is responsible for ensuring follow-up care is in place for the impacted member. The MCE must require all staff and contracted providers to

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

The MCE is responsible for implementing corrective actions to ensure that the conditions that led to the critical incident no longer exist. These may include but are not limited to:

- Enhancing provider oversight activities for a single provider, a group of providers, or all providers

- Establishing corrective action plans with network providers, within the MCE itself, or in other areas

- Modifying or terminating contracts with providers or vendors

- Transferring all or subgroups of members to be served by other providers

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

For reports of ANE, after the report is submitted to APS, it is sent to the director of the local APS unit who determines appropriate next steps. If APS conducts an investigation, an investigator may contact the MCE and/or other reporter for additional information. Once a report of an ANE critical incident has been made, the MCE must proactively provide interventions to members regarding the ANE. For cases where APS may need to be involved, the MCE must:

1. Invite APS to participate in the member-centered planning process, including plan development and updates, comprehensive assessment, and reassessment.

2. Invite APS to participate on the interdisciplinary team to the extent that the staff person makes recommendations as necessary to fulfill their APS responsibilities.

3. Designate a staff person to serve as a member advocate and liaison between APS and the member to assist in developing service options.

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

Additionally, the OMPP Mortality Review Committee will review all participant deaths that:

- Are due to alleged, suspected or known abuse or neglect

- Are from trauma or accident

- Are alleged or known suicide or homicide

- Occur unexpectedly following transition from a nursing facility

- Occurs when participant has gone missing from normal care setting

The OMPP Mortality Review Committee may:

- Request additional information and review the case a second time when the requested information is in the file;

- Close a case with recommendations for the provider(s) or service coordinator/care manager, a referral to another entity, or a systemic recommendation; or

- Close a case with no recommendation(s).

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

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

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

Oversight of reporting and response to critical incidents is the responsibility of OMPP. To assist in this oversight, MCEs are required to submit weekly critical incident reports to OMPP. These reports document data such as:

- Date the critical incident occurred

- Date the critical incident was identified

- Confirmation of report made to APS for incidents involving ANE

- Date initial action was taken

- Incident type

- Relevant provider information

- Current status of the investigation

- Closure information (e.g., date closed, final disposition, service plan updates made, provider changes initiated, education provided, other actions taken, etc.)

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

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

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

The MCEs, with oversight of OMPP, have an obligation to implement and maintain systems to prevent and mitigate critical incidents from occurring, such as:

- Conducting screenings to identify members who are at risk of experiencing a critical incident, as well as follow-up protocols to implement interventions for those members who are at risk.

- Making reasonable efforts through member interactions, education, and interventions to ensure that members are free from ANE.

- Referring members at risk to the appropriate resource including the LTC Ombudsman or other appropriate agency, such as the Area Agency on Aging.

- Processes to develop and update members' care plans and/or service plans, as needed, to balance member needs for safety, protection, physical health and freedom from harm with overall quality of life and individual choice.

- Using trend reports to identify potentially vulnerable members and develop systemic or operational interventions. This includes developing a screening or algorithm to identify individuals at higher risk of incidents. This also includes identifying areas where critical incidents are underreported.

- In cases where a participant has more than three critical incidents in a 12-month period, the MCE must perform an analysis of that participant's situation and take action as necessary to prevent or mitigate further incidents.

-Identifying, remediating, and resolving systemic issues based on a review of program data including:
o Developing and implementing initiatives to mitigate critical incident risks.
o Developing and implementing initiatives to reduce levels of underreporting.
o Imposing corrective actions with network providers, within the MCE itself, or in other areas, as needed.
o Terminating contracts with providers or vendors that, based on MCE analysis, pose risks that cannot be mitigated or that the provider has failed to mitigate.
o Other MCE actions, as needed.

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

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

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

Appendix G: Participant Safeguards

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

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

◉ **The state does not permit or prohibits the use of restraints**

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

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

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

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

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

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

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

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

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

Appendix G: Participant Safeguards

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

3)

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

◉ **The state does not permit or prohibits the use of seclusion**

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

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

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

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

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

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

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

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

◉ **Yes. This Appendix applies** *(complete the remaining items)*

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, Adult Family Care (AFC) service, the Structured Family Caregiving (SFC) 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 unpaid providers of care, families are not required to monitor and document medication consumption.

In Indiana, medication management may include reminders, cues, opening of medication containers or providing assistance to the 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, ADS, SFC, 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 OMPP rules and policies as well as the specific waiver definition which include activities that are allowed and not allowed, service standards, and documentation standards for each service. All providers must adhere to the OMPP’s Incident Reporting (IR) policies and procedures related to unusual occurrences. All approved waiver providers that are responsible for medication assistance are required to report specific medication errors as defined in OMPP’s incident reporting policy as outlined in Appendix G1-b of this application. Additionally, providers licensed by the Indiana Department of Health (IDOH) must also report medication errors to the IDOH.

The service coordinator/care manager conducts a face-to-face visit with the participant at least every ninety (90) days to assure all services, including medication assistance, are within the expectations of the waiver program. Additionally, non-licensed providers will be surveyed by the OMPP, or its designee, to assure compliance with all applicable rules and regulations.

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

Providers must demonstrate an understanding of each 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 service coordinators, MCEs, OMPP staff or their contracted representatives. Any noncompliance issues or concerns are addressed promptly, including a corrective action plan as deemed necessary and appropriate.

Monitoring of medication management is included within the person centered compliance review process for participants selected for random review. Service coordinators/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.

OMPP is responsible for monitoring and oversight of medication assistance practices and conduct analysis of medication errors and potentially harmful practices as discovered through incident reporting, provider compliance review process, mortality review, and the complaint process. Data is analyzed at the participant 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 OMPP's incident reporting policy. Licensed AL waiver service providers must also report medication errors to the Indiana Department of Health (IDOH).

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

AL waiver service providers, by IDOH regulation, 410 IAC 16.2-5-4(e)(7), are required to record any error in medication shall be noted in the resident's record. All approved waiver providers that are responsible for medication administration are required to record medication errors, including refusal to take medications, in the participants' record as per OMPP'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 licensed AL waiver providers, the facilities are required to report to IDOH any unusual occurrences if it directly threatens the welfare, safety or health of a resident as per 410 IAC 16.2-5-1.3(g)(1). The current IDOH policy on unusual occurrences includes the reporting of medication errors to IDOH that caused resident harm or require extensive monitoring for 24-48 hours. Waiver providers that are responsible for medication administration must report medication errors in accordance with the OMPP's IR policy.

Any medication error, except for refusal to take medications, must be reported to the state via the incident reporting process detailed within Appendix G-1-a of this application. Such errors including the following:

a) Medication given that was not prescribed or ordered for the 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.

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

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

Data Aggregation and Analysis:

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

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 demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

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

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

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

		Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
G.2.b Number and percentage of waiver individuals (or families/legal guardians) who

received information on how to report abuse, neglect, and/or exploitation (ANE) via the service planning process. Numerator: Number of participants, family members, or legal guardians who received information on reporting ANE as part of the service plan. Denominator: Number of service plans audited.

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

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

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

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
G.4.b Number and percentage of sampled participants who report having a complete physical exam in the past year. Numerator: Number of sampled participants who report having a complete physical exam in the past year. Denominator: Number of sampled participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
EDW 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: MCEs, EDW	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: 100% of waiver members who are eligible for the AAP HEDIS measure
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
G.4.c Number and percentage of HCBS participants who received an ambulatory or preventive health visit during the year. Numerator: Number of HCBS participants who received an ambulatory or preventive health visit during the measurement year. Denominator: Number of HCBS participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Data Warehouse (EDW)

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

Data Aggregation and Analysis:

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

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.

All HCBS providers are required to report critical incidents (CI) to the FSSA web-based incident reporting system (and APS as applicable). The MCE must include CI reporting requirements for providers in all network provider agreements. The MCEs receive CI reports from the web-based incident reporting system and are responsible for reviewing/remediating the CI. The MCEs are also responsible for logging all reported incidents on the CI report that goes to OMPP weekly. OMPP is responsible for verifying that all web-based incident reporting system reported incidents appear on the MCE reports.

The MCEs must have a system for accepting and analyzing CI reports. They are responsible for remediating the CIs and sending status updates to OMPP via the weekly CI report. In the web-based incident reporting system, there is a field for providers to indicate if an incident was reported to APS; providers are required to report to APS, but the MCE is responsible for identifying and reporting instances when the provider did not report to APS.

OMPP's CI Team reviews all CI reports and performs data analysis to identify trends and cases to send to the Mortality Review Committee. Part of the service plan review will include whether information on reporting A-N-E was included in the service planning process. Data is also monitored to ensure the MCEs are closing cases timely. Corrective action is implemented when performance or non-compliance issues are identified.

If a report meets the defined criteria to be a CI, the MCE must follow the steps identified in the CI Management section of the MCE Policy and Procedure Manual. If a CI has been confirmed (i.e., a substantiated critical incident), the MCE is responsible for ensuring follow-up care is in place for the impacted member. The MCE shall require all staff and contracted providers to document updates regarding initiated action(s) taken for the member and all follow-up activities related to the intervention(s) implemented as a result of the incident. Such follow-up may include updating the member's service plan to reflect enhanced care needs and conducting necessary follow up visits. The MCE's process must include a holistic review of the circumstances of the CI and preventing future occurrences. For example, if multiple CIs are filed for a network provider, the MCE should evaluate the implications for inclusion of that provider in its network or the application of additional oversight and reporting requirements, sanctions, or other requirements. The MCE must also report to OMPP decisions to exclude the provider from network participation based on founded allegations. The MCE should align its response with 455 IAC 2-6, Provider Qualifications, and take comparable actions with providers who have egregious or repeated violations. The MCE is also responsible for implementing corrective actions to ensure that the conditions that led to the CI no longer exist.

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

ii. Remediation Data Aggregation

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

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

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

DISCOVERY and ANALYSIS
OMPP will utilize the information gathered during the discovery and remediation efforts identified throughout this waiver application in conjunction with the information gathered through Indiana's other four 1915(c) waivers to ensure a seamless approach to system improvement. In support of these activities, FSSA will convene a quality team comprised of representatives from OMPP, BDS, each MCE, and others as appropriate. This team will assist OMPP in identifying areas requiring system improvements through the review of information gathered through the discovery and remediation processes. Systems improvement strategies used by OMPP will be tailored to address the specific issues identified through discovery and remediation data, and can include targeted technical assistance and training with the MCEs (and, as needed with their provider panels), data system improvements, or contract clarifications or adjustments.

The 1915(c) waiver data sources identified throughout the appendices in this application will form the basis of information upon which systems improvement will be undertaken. Initial analysis of discovery data is conducted by the appropriate OMPP staff as part of their day-to-day activities. This discovery data is obtained from the following activities and sources:

• Regular reporting — OMPP conducts regular reporting activities to include the collection of the following information: claims, encounters, member grievances and appeals, independent external reviews, translation and interpretation services, provider helpline performance, provider claims, credentialing, outcome measures, utilization, service authorizations, administrative, financial, network development and access, quality management and improvement, program integrity, and critical incidents.

• Electronic Database queries—OMPP utilizes several electronic database applications which provide routine reports on various performance indicators in addition to allowing for on-demand report generation. These reports provide some of the performance measurement data for the waiver sub- assurances.

• On site reviews — OMPP conducts bi-monthly onsite reviews of all PathWays MCEs. Site visits are utilized to review MCE compliance with federal, state, and contract requirements through strategies such as onsite demonstrations of operational procedures, meetings and interviews with MCE personnel, and monitoring helpline calls.

• Incident Review— OMPP requires all waiver service providers to report critical incidents via a web-based submission tool. All reports are processed by incident review staff within the time period stipulated in the MCE manual. All reports of actual or alleged ANE are designated as critical incidents and forwarded to OMPP for additional review in addition to any submission to APS.
o Mortality Review— All incident reports of waiver participants' deaths are forwarded to OMPP for review. Death events which may have been impacted by the provision or non-provision of waiver services are referred to designated Mortality Review staff for further investigation.

Reporting and management of critical incidents will be an area of heightened focus during the early implementation of the PathWays program. The state expects a high degree of collaboration to reduce the risk of critical incidents as members transition into the MCE and transition to new Service Coordinators. This period may involve activities such as increased reporting frequency and detail, ad hoc workgroups to identify trends, and required interventions to address those trends. The state may also require the submission of the MCE's methodology for identifying individuals at high risk for critical incidents.

• Provider Compliance/Licensure Monitoring —The Provider Compliance Tool (PCT) review involves a service review visit to each non-licensed/noncertified provider at least one time every three years to establish that the provider continues to meet all provider requirements contained in 455 IAC 2. If found deficient the provider will be required to submit and fulfill the requirements of an acceptable CAP. Failure to successfully complete the CAP process may result in corrective action up to and including decertification as a waiver provider. IDOH is responsible for assuring licensed providers continue to meet license requirements. If found deficient the provider will be required to submit and fulfill the requirements of an acceptable CAP. Failure to successfully complete the CAP process may result in corrective action up to and including decertification as a waiver provider.

COMPILATION and TRENDING OF PERFORMANCE MEASURES
OMPP identified key performance measures and present these in numerator/denominator format. These measures

are derived from other discovery activities but serve as both discovery and analytical tools. Each of these measures corresponds with a sub-assurance identified in the waiver application.

Data obtained from all of these sources, as well as data generated through remediation processes, is disseminated to the appropriate agency staff. Remediation of participant findings is initiated immediately at the program and service level.

OMPP will meet at least quarterly to review and evaluate the QIS performance measures, sampling strategies, and processes for remediation and improvement. The evaluation compares current performance to past or anticipated performance, analyzes trends in performance improvement/decrement, and analyzes remediation reports to identify systemic deficiencies. OMPP also reviews reports and descriptions of best-practice quality improvement approaches from other states. OMPP recommendations for system improvements will be researched and developed into proposals for consideration by the Quality Strategy Committee.

SYSTEM IMPROVEMENT and DESIGN
OMPP can include upper management personnel from MCES, other FSSA agencies, and other areas within OMPP, and it may also include legal representation. The purpose is to provide leadership and direction for quality improvement projects, policy revision or development, and actions leading to refinement of quality operations and system management.

OMPP may assign research, design or implementation activities back to appropriate agencies, MCE staff, other OMPP personnel, or contracted entities.

Prioritization of system improvement activities will be subject to several factors:
- regulatory requirements as specified by law or funding sources;
- potential to reduce risk or negative outcomes for program participants;
- potential to effect positive outcomes for a substantial number of participants;
- potential for implementation success;
- cost and feasibility of implementation activities; and
- ability to measure results and outcomes of system improvements.

OMPP is sensitive to the complexities of the service delivery system and the impact that change can have on both that system and on the participants we serve. While the scope of any given system improvement initiative will determine the implementation processes, when appropriate the state will:
- seek and consider stakeholder input;
- communicate changes and timelines to stakeholders, clearly identifying how the change may impact them;
- use beta testing and limited roll-out strategies; and
- abide by existing State protocols for approval, development and implementation of new policies, technologies and general practices.

Outcomes of all system changes and improvements will be monitored using the discovery and analysis tools and process described above. Measures obtained from these tools and processes will be compared to past and anticipated measures in continuation of the quality improvement cycle. In addition to the data and information related to the measures specifically identified in this waiver, OMPP will utilize information from the following sources to achieve a coordinated, effective system improvement strategy: external quality review (EQR) reports, managed care quality strategy, and performance improvement projects (PIPs).

ii. System Improvement Activities

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

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **Quality Improvement Committee**	☐ **Annually**
☒ **Other** Specify: MCEs	☐ **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.

OMPP is committed to making sound, data driven design changes based upon information gathered from discovery and remediation, and from the waiver monitoring activities. OMPP utilizes several electronic database applications and MCE reports which provide routine reports on various performance indicators in addition to allowing for on-demand report generation. These reports provide key data and allow OMPP to monitor and assess the outcome and effects of system design changes. OMPP identified key performance measures which are compiled in numerator/denominator format. These measures are derived from a variety of discovery activities and serve as both discovery and analytical tools. Data gathered from these discovery activities is compiled and trend lines are developed by the OMPP. This information is disseminated throughout the agency and is provided to other areas within OMPP as well as other agencies and MCE staff for review and analysis. These entities assess the outcome of system design changes through a comparison of current and past performance measure results. Findings are then used to assess the need for additional changes or refinement, in the continuation of the quality improvement cycle.

The State will use this data to inform future QIS considerations. The State will utilize formalized processes, including solicitation of input from CMS, to monitor the efficacy of the intervention to ensure that the areas targeted for improvement are positively impacted. Areas of non-compliance are addressed through a progressive sanctioning process that may include corrective action plans developed by the MCEs or by the LOC assessor contractor, as appropriate, and such interventions will further inform overall system design changes to prevent future issues. Lessons learned from these activities will be communicated internally by the OMPP, and externally to MCEs and provider entities.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

While the QIS is designed to identify opportunities for improvement in the service delivery system, the QIS itself must be monitored and improved upon. Improvements in the QIS will be necessary to keep up with changes in the regulatory and service delivery environments, and due to data or tools which the operators find to be inconsistent, incomplete or not conducive to obtaining desired measures or outcomes.

As many of the data collection and analysis tools are electronic in nature, OMPP will review opportunities to integrate new technology into the QIS. OMPP staff will also actively seek input into QIS component performance from staff and contract entities who work with the various components on a day-to- day basis. Any complaints received from service recipients regarding QIS activities will be reviewed by OMPP staff. OMPP staff will formally review the QIS at least annually and make recommendations for changes or improvements.

OMPP has engaged with stakeholders and advocates throughout the design and development phases of the waiver. In order to ensure success and maintain a truly collaborative process, the state will continue reaching out to providers, advocates, and individuals throughout the implementation and operational phases of the demonstration.

In addition to the ongoing incorporation of a continuous quality improvement process for the quality and oversight process as a whole, OMPP will, at least once during the initial term of the waiver engage in a critical assessment of the performance of both the system improvement and the QIS and revise it as necessary and appropriate. Modifications to the Quality Improvement Strategy will also be submitted annually with the 372 report.

Appendix H: Quality Improvement Strategy (3 of 3)

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

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

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ◉ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

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

Waiver services are furnished through MCEs; therefore, 1915(b) waiver financial accountability requirements apply. MCEs are contractually required to reconcile eligibility and capitation payments on a monthly basis and return overpayments within 45 days.

For services delivered via FFS, FSSA's Audit Unit is responsible for annual review of services/billing performed by AAAs with reporting to OMPP. FSSA PI has an agreement with FSSA Audit to investigate allegations of fraud, waste and abuse (FWA). PI receives allegations of provider FWA, tracks in its case management system, and forwards to FSSA Audit to begin research/audit. FSSA Audit works with PI to vet providers with the Indiana Medicaid Fraud Control Unit (MFCU). Once MFCU's clearance is determined, FSSA Audit determines means to validate the accuracy of the allegation.

FSSA Audit conduct a statistically valid random sample of consumers and then PI's Fraud & Abuse Detection System (FADS) vendor will pull a sample for their audit. The size of a random sample audit is dependent upon the universe(s) size, claim/claim line payments, and other statistical criteria. The sample size is ultimately determined utilizing a FADS contractor tool that generates a statistically valid random sample size. Depending on the concerns identified during the risk assessment FADS will recommend an approach and/or scope for the audit:
• Targeted Probe Audit Sample- A sample of sufficiently small size designed to focus on specific services, members, timeframes or other scenarios identified as higher risk for FWA to determine potential outcomes of audit findings or payment error issues. If the probe identifies material issues, statistical sampling is used to expand testing and quantify overpayments.
• Random Sample Audit - Identify potential payment errors and extrapolate those to the entire universe of claims. FSSA Audit conducts its audit activities, develops a findings report for the provider which may include a CAP and request for overpayment, and shares findings with PI. Audits are performed onsite utilizing a probe test that includes a review of:
• Providers' source documents. This includes documents that support paid claims, e.g. employee signed service notes, logs, evidence of supervisory approvals.
• Payroll records. Dates/times/locations of service per claims are compared to related time cards and payroll registers.
• Employee background and qualifications. Supporting documents, found in in HR files, are reviewed, including background checks, licenses, and search of the HHS/OIG exclusions list.

The FSSA PI section regularly utilizes random-sampling and extrapolation in conducting audits of IHCP providers. If the focus of the audit is narrow, and the number of potentially erroneous claims is manageable, the review will be conducted on all identified claims. In the event the issue involves a large number of claims, or if the review is a provider-focused, comprehensive review, PI has the ability to utilize statistically-valid random sampling and extrapolation to determine any potential overpayments from the IHCP. The frequency of utilizing this approach is fluid, based upon the providers in queue for audit as well as the proposed audits included in the yearly FADS Audit Workplans. On-going monitoring of IHCP providers is supported by utilization of Truven Health Analytic's Provider Peer Comparison Tool, J-SURS, which compares providers to peers of like specialty to identify outliers. All provider types are profiled at least yearly, while higher-risk provider types are profiled quarterly. The results of the profiles are reviewed by PI staff to determine which providers may need further investigation and these results are discussed in weekly FADS team meetings.

Provider records are reviewed to ensure compliance with applicable state and federal guidelines, as well as policies published by the IHCP. Review scope may vary depending on provider type/specialty and/or concerns identified through pre-audit activities (e.g., data mining, complaints, etc.). Review scopes typically include (at a minimum) procedures to determine provider compliance with applicable documentation requirements and review of provider credentials/qualifications to ensure they are practicing within the scope of their licensure or certification (if applicable). When appropriate, these reviews may include reconciliation of the records to timesheet and/or other payroll records, as well as vehicle insurance and/or health records of servicing providers (e.g., TB test records for waiver and home health providers). A detailed claim-level review checklist is prepared for each review that lists all claims included in the review, outlines the scope of the review, and identifies all findings or educational items noted during the review.

FADS investigations/audits can be initiated based on referrals received from different sources/agencies. PI receives information from the following sources which could potentially lead to additional action including audit action:
1. IHCP Provider and Member Concerns Line
2. Other agencies (MFCU)
3. Analyses/Analytics performed by the PI Investigations team
4. Analytics performed by FADS contractors
Depending on the allegations/information received regarding the provider(s), PI may conduct a Preliminary Investigation, utilizing the Credible Allegation of Fraud (CAF) tool developed by FADS contractors to determine next steps.

In certain instances, PI refers the provider in question to FADS contractors for additional analysis which may include

performing a Risk Assessment. The Risk Assessment tool, developed by FADS contractors, is utilized to gather information on a specific provider's background as well as billing patterns utilizing claims data and other research databases, focusing on any potential issues identified during the referral process. FADS contractors utilize this tool to assist in the decision making process when recommending the next appropriate action to be taken for the provider(s) in question.

There are differences in post-payment review methods, scope and frequency based upon audit type, provider type/specialty, background information, and state rules/regulations. PI can audit IHCP providers through either an algorithmic approach or a provider-specific full review. Algorithms processed by the PI FADS contractor, focus on specific codes, diagnoses, or program limitations to identify potentially erroneous claims across the IHCP. These reviews can involve hundreds of IHCP providers, but are limited in scope. The providers are notified of the potential errors upon receipt of the Draft Audit Findings letter, where no medical records are reviewed prior to identification of the claims. If PI decides to conduct a more comprehensive review of a provider, PI request a full medical record review. The audit can be conducted through a medical record request desk audit, or as an on-site review. The on-site audit can be announced or unannounced, based upon the circumstances.
Depending on multiple factors, risk assessments typically result in one of the following recommended actions (dependent upon the severity of the allegations and other information uncovered during the risk assessment):
• No further action: No issues uncovered warranting further action.
• Provider education: No issues identified that would result in patient harm or overpayments; however, it may be apparent that the provider as well as the Medicaid Program would benefit from additional education for the provider on proper/best billing practices.
• Provider self-audit: Specific concern(s) were identified resulting in a recommended limited-scope audit; however, the concern(s) are in an area which the State is comfortable with the provider conducting the audit to ensure compliance. FADS contractors perform validation review of the provider self-audit results. If FADS contractors determine they are not in agreement with a high percentage of the provider's self-audit results during the validation review, they will recommend the audit be escalated to a desk review and all records within the provider self- audit sample are evaluated by the contractor.
• Provider desk audit: Concern(s) were identified resulting in the need for medical record review (full or limited scope). However, the severity of the concerns do not currently warrant an on-site review. Certain provider records, including medical records, are requested for selected claims and clinical staff (if necessary) conduct a review of the services billed to ensure compliance with IHCP guidelines. Providers are allowed 30 days to submit the requested information.
• Provider on-site audit (announced or unannounced): Severity of the concern(s) has resulted in a recommendation of an on-site audit. Providers are generally given shorter notice (or no notice) of the pending on-site audit. If notice is provided, it can range from a few days to a few weeks depending on several factors (type of facility, audit concerns, etc.). Requested information is collected on-site. A facility tour as well as provider/staff interviews are also conducted during on-site reviews. FADS contractors, including clinical staff, are included in on-site reviews and assist with conducting interviews. State Program Integrity personnel often also participate in on-site reviews.
• Referral to MFCU: Payment suspension recommended as the potential intent of fraudulent behavior was identified. Depending on the allegations/information received regarding the provider(s), the SUR Unit may conduct a Preliminary Investigation, utilizing the Credible Allegation of Fraud (CAF) tool developed by FADS contractors to determine the appropriate next steps, if any.
**Audit reports containing accuracy-related issues, missing documentation, internal control deficiencies, and training issues are prepared. Providers submit corrective action plans. Any overpayments are set up for recoupment. Audit reports are distributed to provider leadership and appropriate FSSA executives. Periodically, PI is advised of any systemic issues identified. FSSA Audit Services seeks PI's advice on audit reporting and direction on technical questions. For audits performed based on referrals such as incorrect billing, the reporting varies. If the audit finds the provider made unintentional errors, the typical audit reporting process is followed. However, if the referred audit identifies potential, intentional errors that may be credible allegations of fraud, the provider is referred to Program Integrity for further action. Select analytics are periodically rerun in an attempt to identify if provider billing patterns have changed/improved based on previous audit and/or provider education. Additional audit action may be taken for providers who continue to be identified as potential issues in these algorithms. If providers are again selected for audit, a similar audit process as previously described would occur.*

The State implemented an Electronic Visit Verification (EVV) system, known as the Sandata EVV System, that complies with the requirements of the federal 21st Century Cures Act. The IHCP CoreMMIS claim-processing system has been configured to integrate with the Sandata EVV system. IHCP requires that providers use the EVV system to document the following: Date of the service; Location of service delivery; Individual providing the service; Type of service performed; Individual receiving the service; Time the service begins and ends. Providers may choose to use an EVV system other than Sandata. However, those providers will be required to export data from their alternate system to the Sandata "Aggregator" for integration with CoreMMIS.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the 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 percentage of claims paid for services that have a matching EVV record. Numerator: Number of claims paid for services that have a matching EVV record. Denominator: Number of claims submitted subject to EVV.

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
I.2.Number and percentage of claims per MCE which are not paid at the State minimum fee schedule. Numerator: Number of waiver claims which were not paid at the State minimum fee schedule. Denominator: Number of waiver claims paid.

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the 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 PM I.1: MCEs provide quarterly reports to OMPP documenting claims adjudication for services subject to EVV. This reporting allows OMPP and the MCEs to monitor the volume of claims for which an associated EVV record is not present. MCEs are expected to monitor provider compliance with EVV requirements and to conduct outreach and education as necessary to resolve claims non-compliance and ensure provider understanding of submission requirements. OMPP monitors MCE reports to identify any trends that require remediation. For example, OMPP would outreach to MCEs with high EVV denial rates to understand MCE processes for provider education and resolution. In the event of an identified deficiency in MCE remediation process, a corrective action plan, liquidated damages, or other contractually agreed upon remedy is required. OMPP provides the MCE written notice of non-compliance with expected remediation action and monitors the corrective actions implemented through to resolution. In the event remediation is not achieved in accordance with the required corrective action plan, OMPP may implement escalating corrective action.

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

For PM I.2: The Fiscal Agent runs all encounter claims through an adjudication process that calculates the amount that should be paid under the state fee schedule. The process also captures the amount paid by the MCE, and the data is placed in the Electronic Data Warehouse (EDW). OMPP will compare the two amounts to verify for each MCE the number of waiver claims that were not paid at the state minimum fee schedule. If it is determined that an MCE is paying less than the state minimum fee schedule, OMPP will investigate the root cause(s) and develop a remediation plan as appropriate. MCEs will be required to identify reasons why the minimum fee schedule was not paid and adjust their systems to correct and re-adjudicate prior claims as needed.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ ***No***

○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing

identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

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

The method of determining capitation rates for the PathWays program is subject to the 1915(b) requirements and criteria. FSSA has contracted with an actuarial firm to develop the actuarially sound capitation payment rates on an annual basis.

For FFS rate setting, a rate review occurs at least every five years.

In state fiscal year (SFY) 2023, FSSA completed a rate review (rate study) for all waiver services. FSSA conducted a provider survey to capture the current provider experience of delivering the applicable waiver services, service specific workgroups, and all provider meetings.

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

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

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

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

Methodologies: To develop prospective payment rate methodologies for this waiver's program services, FSSA selected the following approaches:
Traditional cost model build-up - This approach reflects the program-related cost per unit of providing each covered service. The foundation of this model is the labor cost per unit, which includes projected wages and benefits costs, allocated to the service unit level. Administration and program support costs are calculated as a percentage of the labor cost per unit component. Self-directed and non-agency service rates follow the cost model build-up but do not include a supervisory component. Select services also include "other" cost components for unique requirements such as food for adult day services. All services using this build-up approach have supporting rate models.

Key default rate inputs under this approach were as follows:
Direct care staff and supervisory wages: based on BLS Indiana wages and percentiles, but were also informed by provider surveys and interested party feedback
Wage inflation: based on changes in Consumer Price Index (CPI) for employment earnings of medical professionals
Training and Paid Time Off (PTO) factors: training and PTO ranges between 60 and 70 hours per employee per year
Benefits factor ("employee related expenses" or ERE): varies by wages and is based on BLS national benchmarks for insurance costs as well as federal and state taxes
Administration and program support factor: 15% combined administration and program support factor
Indirect service time: ranges between 1 minute and 3 minutes per 15-minute unit for timed individual services
Staffing ratios: group services vary by staffing ratios that align with group service standards; group services include adult day
Caseload size: case management services reflect a waiver specific caseload size
Transportation: some services include mileage for onsite staff travel or reimbursement for a fleet
Rate composite approach - This approach was used for Assisted Living only, and is based on a composite of rates for service components to reflect the value for the package of services. It includes tiered and bundled rates for Assisted Living, where the tiers are assigned based on the level of 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 webpage at: https://www.in.gov/fssa/da/medicaid-hcbs/.

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

FSSA will continue to collaborate with the community on any revisions made to the waiver rates. Their valuable input into the waiver rate reviews is necessary to ensure that rates are sufficient to continue provider participation and participant access to waiver services.

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

Waiver services are reimbursed by MCEs. Providers bill the MCE with whom a member is enrolled. Claims are reimbursed in accordance with the terms of the provider's contract with the MCE. Providers may not bill FSSA directly for services provided to MCE enrollees. MCE billings to the State are made in accordance with the provisions of the 1915(b) PathWays Waiver.

For FFS, claims for waiver services flow directly from the providers to the Indiana Medicaid Management Information System (MMIS) and payments are made via FSSA's contracted fiscal agent.

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

Appendix I: Financial Accountability

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

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

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services***

and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

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

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

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

Appendix I: Financial Accountability

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

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

Waiver services are reimbursed by MCEs. Providers bill the MCE with whom a member is enrolled. Claims are reimbursed in accordance with the terms of the provider's contract with the MCE. Providers may not bill FSSA directly for services provided to MCE enrollees. MCE billings to the State are made in accordance with the provisions of the 1915(b) PathWays Waiver. The MMIS includes system edits to ensure that prior to issuing a capitation payment, the enrollee is eligible for the PathWays 1915(c) waiver and is enrolled with the MCE. MCEs must implement system edits to ensure that claim payments are made only when the individual is eligible for 1915(c) waiver services on the date of service. FSSA monitors MCE compliance and system capability through pre-implementation readiness review and ongoing monitoring such as encounter data audit and validation. The MCEs are also responsible for program integrity functions with OMPP review and oversight.

For FFS enrollees, OMPP approves a participant's service plan within the State's case management database ensuring only services which are necessary and reimbursable under the Waiver. The service plan is sent to the 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 Waiver. The case management data system has been programmed to alert OMPP 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 Individual Service Authorization, which is sent to each authorized provider of services on the Plan. The Individual Service Authorization identifies the 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 OMPP when executing SUR activities. Additional information about these reviews can be found in the Provider and Member Utilization Review provider reference module at the following link: http://provider.indianamedicaid.com/media/155481/provider%20and%20member%20utilization%20review.pdf

RECOUPMENT
If a payment to a provider is identified as paid in error due to error, fraud, policy, system issues, etc., the State can recoup that payment by any of the ways listed below:
1. Create a non-claim specific accounts receivable
2. Claim adjustment
3. Remit payment via check

Non-Claim Specific Accounts Receivable (AR):
When this method is used to recoup payment, an AR is setup under the Medicaid Provider's identification number. Each AR is assigned a reason code. The reason code describes the purpose for the AR. The reason code also maps to various lines on the CMS 64.
Once the AR is setup, a provider's future Medicaid payments will be reduced until the AR is fully satisfied.
Claim Adjustments:
Under this process, a claim specific AR will be created when a claim is adjusted. Either the provider or the State may adjust claims. With claim specific ARs, the AR is attached to a specific claim that was previously paid.

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

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

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

In summary, the 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 PathWays waiver services that utilize EVV are all forms of attendant care, unskilled respite care, Home and Community Assistance, and specialized medical equipment.

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

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

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

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

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

Payments for PathWays Waiver services for FFS enrollees are made through the MMIS. Capitation payments to MCEs are made by the MMIS. The MMIS contains recipient eligibility and MCE assignment information. When a PathWays 1915(c) waiver recipient is enrolled in an MCE, this is reflected on the eligibility file and monthly payment flows from the MMIS to the MCE via an 837 transaction. FSSA will recover capitation payments for enrollees who were later determined to be ineligible for PathWays.

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

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

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

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

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

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

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

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

N/A - For enrollees receiving PathWays services via managed care, no 1915(c) waiver services are paid outside the MCE capitation rate.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

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

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

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

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

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

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

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

- ○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

- ○ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ◉ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

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

The capitation payment to MCEs is reduced by a performance withhold amount as outlined in the contracts between FSSA and the MCEs, and approved by CMS. The MCEs are eligible to receive some or all of the withheld funds based on their performance against contractual requirements. FSSA also recoups excess capitation paid to the MCE in the event its medical loss ratio (MLR) falls below the contractual requirement. Additionally, the MCE contracts and capitation rate certification outline applicable capitation risk mitigation strategies such as risk corridors and risk adjustments.

For FFS enrollees, providers receive and retain 100% of the amount claimed to CMS for waiver services.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

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

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

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

iii. Contracts with MCOs, PIHPs or PAHPs.

- ○ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §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:*

In accordance with 42 CFR 441.310(a)(2), FSSA does not pay the cost of room and board and did not include costs associated with room and board in the capitation rate development process. The MCEs are contractually required to comply with federal provisions regarding reimbursement prohibitions for the cost of room and board services in residential settings.

For FFS enrollees, no room and board costs are figured into allowable provider expenses. There are provider guidelines for usual and customary fee, and the provider agreement states that a provider may only provide services for which the provider is certified. Waiver service providers are paid a fee for each type of direct service provided; no room and board costs are included in these fees.

Note: The waiver does not provide services in waiver group home settings. 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

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	38250.71	9383.11	47633.82	90177.64	2879.69	93057.33	45423.51
2	35950.45	9655.22	45605.67	93604.39	2963.20	96567.59	50961.92
3	36169.56	9935.22	46104.78	97161.36	3049.14	100210.50	54105.72
4	36447.38	10223.34	46670.72	100853.49	3137.56	103991.05	57320.33
5	36448.32	10519.82	46968.14	104685.92	3228.55	107914.47	60946.33

Appendix J: Cost Neutrality Demonstration

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

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

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	39842	39842
Year 2	47868	47868
Year 3	50843	50843
Year 4	53017	53017
Year 5	54658	54658

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.*

The projected average length of stay reflects actual experience through April 2023 in WY5 of the sixth renewal of the Aged and Disabled (A&D) waiver and was modeled using the following new entrant and lapse assumptions:

Projections for the number of slots for WY 1 through WY 5 relied on actual enrollment data for those enrolled in the A&D waiver age 60 and above through the ten months of WY5 of the sixth renewal (July 2022 through April 2023 Assumptions utilized in the projections reflect updated new entrant assumptions reflective of recent experience. Total monthly new entrants for this waiver and the updated A&D (Health and Wellness) waiver have increased from the prior A&D waiver filing for WY 3- 5.

It is projected that the number of new entrants per month will be 1,081 for WY 1 through WY 5, with the number of lapses projected at the historical level of 2.31% for those A&D waiver members age 60 and over. It is assumed that approximately 67 of the projected slots in WY 1 will be for members who chose not to opt-in to the managed care program (17 for the American Indians/Alaskan Natives and 50 for waiver recipients currently receiving hospice services at home under FFS). It is further assumed that starting in waiver year 2 only those who are already receiving hospice services when they become eligible for the PathWays program will have the option to opt-in to the program or stay on FFS (1 FFS slot is assumed to account for this). The number of slots for those receiving waiver services through FFS in waiver year 2 is approximately 19. The filing assumes that FFS waiver slots will grow at the same rate as the total waiver slots from waiver year 2 through waiver year 5.

In addition, the state is choosing to limit the number of slots in WY 1 to 39,842. It is projected that there may be a waiting list starting as of April 2025. It is also assumed that those on the waiting list will be enrolled in the waiver at the beginning of WY 2 (July 2025).

Appendix J: Cost Neutrality Demonstration

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

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

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

Base Year data reflects experience for members 60 and over from the last complete waiver year of the A&D waiver, Waiver Year 4 of the sixth renewal: July 1, 2021 – June 30, 2022. The base year data was projected to WY 1 through WY 5 of the initial waiver filing in the following manner:
• The number of users of each service was adjusted proportionally, based on projected slots and assumptions about the number of slots for capitation vs FFS delivery systems as described in J-2-b above.
• Average units per user were projected to vary with average length of stay.
• In addition, for some of the services the average units per user were increased to reflect material utilization increases that have emerged during WY 5 of the A&D waiver.
• Reimbursement was adjusted for various services impacted by the change in the rate methodology effective July 1, 2023.
• The number of Structured Family Care (SFC) users was adjusted to reflect the proposal for Legally Responsible Individuals (LRIs) to be able to be reimbursed under SFC effective July 2024. This is projected to increase the number of SFC starting in WY1.
• The new Caregiving Coaching and Behavior Management service was effective January 1, 2023. Based on input from the Division of Aging, Factor D projections assume that 95% of the projected 1,500 members from the prior filing or 1,425 individuals age 60 and above will utilize the service for 2 hours every month in SFY 2023. Cost per unit is assumed to be $15.75 per quarter hour effective July 1, 2023 based on the rate developed using the updated methodology.
• It is assumed that those in the managed care program will be receiving the necessary Case Management services through integrated case management with the managed care entities (MCEs), since it will be part of administrative function performed by the MCEs under the PathWays program. Only those receiving services through the FFS delivery system will receive waiver Case Management services through the PathWays waiver.

Cost per unit trend is projected to be 0.0% per year as rates for waiver services may remain unchanged through the duration of the waiver renewal period. Estimates of Factor D for each waiver year are illustrated in the cost neutrality summary in Appendix J-1.

Decrease in FFS users from WY1 to WY2: The numbers of estimated FFS users on the PathWays waiver (those that choose not to opt-in to the managed care program) was reduced from 67 in WY1 to 19 in WY2. During WY1, recipients receiving hospice services at home as of the July 1, 2024 PathWays implementation (approximately 50 members) will have the option to remain in FFS. This is a one-time implementation effect. During WY2, only hospice recipients who become newly eligible for the PathWays program will have the option to remain FFS (a much smaller number), while those who are already enrolled in PathWays at the time they begin to need hospice services will stay in PathWays.

Decrease in average units per user from WY1 to WY2: Average units per user decreased between WY1 and WY2 for both FFS and capitated service lines due to a decrease in the average length of stay (ALOS). The ALOS is projected to decline from 297 in WY1 to 279 in WY2. As noted at the end of the ALOS narrative, the state expects to run out of slots during WY1, with a waiting list starting April 2025. Because those who would normally have been enrolled in April, May, and June 2025 would have had short lengths of stay (90 days or less), this is expected to artificially increase the ALOS during WY1. As of WY2, slots are no longer expected to limit enrollment, and the ALOS is projected to decline to 279, a level more consistent with recent historical experience.

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 4 of the sixth renewal: July 1, 2021 – June 30, 2022 for A&D waiver enrollees age 60 and above. Base year data was trended at 2.9% per year to reflect Medical CPI-U over the most recent 3 years (rounded). In addition, factor D' reflects an increase of 32% for Home Health services effective July 1, 2023 (overall increase of 16.38%). Home health expenditures represent almost half of the state plan expenditures for the A&D waiver participants age 60 and above.

Estimates of Factor D' for each waiver year are illustrated in the cost neutrality summary in Appendix J-1.

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 4 of the sixth renewal of the A&D waiver for those age 60 and above: July 1, 2021 – June 30, 2022. Factor G for WY4 also includes $1,043.6 million in Nursing Facility Upper Payment Limit (UPL) expenditures, contributing $30,842.60 to the base year Factor G. In addition, actual Nursing facility per diem increases for those age 60 and above of 9.0% for SFY 2023 are reflected. Starting with Waiver Year 1, costs are trended at 3.8% per year.

Cost per unit trend of 3.8% was estimated using the average of the Medical CPI-U and CPI-U over the most recent 3 years (rounded) as institutional costs tend to trend midway between medical and non-medical costs.

Estimates of Factor G for each waiver year are illustrated in the cost neutrality summary in Appendix J-1.

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 for those age 60 and above from Waiver Year 4 of the sixth renewal of the A&D waiver: July 1, 2021 – June 30, 2022. Base year data was trended at 2.9% per year to reflect Medical CPI-U over the recent 3 years (rounded).

Estimates of Factor G' for each waiver year are illustrated in the cost neutrality summary in Appendix J-1.

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 Service	
Attendant Care	
Care Management	
Home and Community Assistance Service	
Skilled Respite	
Adult Family Care	
Assisted Living	
Caregiver Coaching	
Community Transition	
Home Delivered Meals	
Home Modification Assessment	
Home Modifications	
Integrated Health Care Coordination	
Nutritional Supplements	
Participant Directed Home Care Service	
Personal Emergency Response System	
Pest Control	
Specialized Medical Equipment and Supplies	
Structured Family Caregiving	
Transportation	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							**9872111.41**
Adult Day Services - Capitation	☒	1/4 hour	878	3111.10	3.61	**9860880.34**	
Adult Day Services - FFS	☐	1/4 hour	1	3111.10	3.61	**11231.07**	
Attendant Care Total:							**839004235.31**
Attendant Care - Capitation	☒	1/4 hour	17906	5483.90	8.53	**837600905.30**	
Attendant Care - FFS	☐	1/4 hour	30	5483.90	8.53	**1403330.01**	
Care Management Total:							**114434.21**
Case Management - FFS	☐	monthly	63	9.60	189.21	**114434.21**	
Home and Community Assistance Service Total:							**37022015.84**
Home and Community Assistance Service - Capitation	☒	1/4 hour	5963	791.60	7.83	**36960033.56**	
Home and Community Assistance Service - FFS	☐	1/4 hour	10	791.60	7.83	**61982.28**	
Skilled Respite Total:							**6699360.53**
Respite - Capitation	☒	1/4 hour	552	1252.80	9.67	**6687245.95**	
Respite - FFS	☐	1/4 hour	1	1252.80	9.67	**12114.58**	

GRAND TOTAL:		***1523984758.95***
Total: Services included in capitation:		*1521316997.75*
Total: Services not included in capitation:		*2667761.19*
Total Estimated Unduplicated Participants:		***39842***
Factor D (Divide total by number of participants):		***38250.71***
Services included in capitation:		*38183.75*
Services not included in capitation:		*66.96*
Average Length of Stay on the Waiver:	*297*	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Family Care Total:							**957106.57**
Adult Family Care - Level 1 - Capitation	☒	day	11	128.30	66.21	**93442.17**	
Adult Family Care - Level 2 - Capitation	☒	day	15	246.00	72.30	**266787.00**	
Adult Family Care - Level 3 - Capitation	☒	day	27	236.20	90.25	**575560.35**	
Adult Family Care - Level 1 - FFS	☐	day	0	128.30	66.21	**0.00**	
Adult Family Care - Level 2 - FFS	☐	day	0	246.00	72.30	**0.00**	
Adult Family Care - Level 3 - FFS	☐	day	1	236.20	90.25	**21317.05**	
Assisted Living Total:							**283878286.62**
Assisted Living - Daily - Capitation	☒	day	5603	107.60	112.76	**67981064.53**	
Assisted Living - Daily - FFS	☐	day	9	107.60	112.76	**109196.78**	
Assisted Living - Monthly - Capitation	☒	monthly	7322	8.70	3381.95	**215434949.73**	
Assisted Living - Monthly - FFS	☐	monthly	12	8.70	3381.95	**353075.58**	
Caregiver Coaching Total:							**2375744.17**
Caregiver Coaching - Capitation	☒	1/4 hour	1447	104.10	15.75	**2372465.02**	
Caregiver Coaching - FFS	☐	1/4 hour	2	104.10	15.75	**3279.15**	
Community Transition Total:							**203602.85**
Community Transition - Capitation	☒	unit	160	1.30	972.78	**202338.24**	
Community Transition - FFS	☐	unit	1	1.30	972.78	**1264.61**	
Home Delivered Meals Total:							**39563487.56**
Home Delivered	☒					**39496342.28**	

GRAND TOTAL:	**1523984758.95**
Total: Services included in capitation:	1521316997.75
Total: Services not included in capitation:	2667761.19
Total Estimated Unduplicated Participants:	**39842**
Factor D (Divide total by number of participants):	**38250.71**
Services included in capitation:	38183.75
Services not included in capitation:	66.96
Average Length of Stay on the Waiver:	297

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Meals - Capitation		meal	15882	321.30	7.74		
Home Delivered Meals - FFS	☐	meal	27	321.30	7.74	67145.27	
Home Modification Assessment Total:							992409.03
Home Modifications - Assessment - Capitation	☒	unit	1959	1.50	337.21	990891.58	
Home Modifications - Assessment - FFS	☐	unit	3	1.50	337.21	1517.44	
Home Modifications Total:							11712498.84
Home Modifications - Capitation	☒	unit	1378	1.40	6062.37	11695524.20	
Home Modifications - FFS	☐	unit	2	1.40	6062.37	16974.64	
Integrated Health Care Coordination Total:							30792565.12
Integrated Health Care Coordination - Capitation	☒	1/4 hour	5435	400.30	14.13	30741658.96	
Integrated Health Care Coordination - FFS	☐	1/4 hour	9	400.30	14.13	50906.15	
Nutritional Supplements Total:							638558.46
Nutritional Supplements - Capitation	☒	unit	949	28.50	23.56	637215.54	
Nutritional Supplements - FFS	☐	unit	2	28.50	23.56	1342.92	
Participant Directed Home Care Service Total:							478818.25
Participant-Directed Attendant Care Service - Capitation	☒	1/4 hour	1	32113.90	14.91	478818.25	
Personal							7247557.14

GRAND TOTAL:	**1523984758.95**
Total: Services included in capitation:	1521316997.75
Total: Services not included in capitation:	2667761.19
Total Estimated Unduplicated Participants:	**39842**
Factor D (Divide total by number of participants):	**38250.71**
Services included in capitation:	38183.75
Services not included in capitation:	66.96
Average Length of Stay on the Waiver:	297

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Emergency Response System Total:							
Personal Emergency Response System - Capitation	☒	unit	16687	9.20	47.13	**7235416.45**	
Personal Emergency Response System - FFS	☐	unit	28	9.20	47.13	**12140.69**	
Pest Control Total:							**937095.34**
Pest Control - Capitation	☒	unit	979	4.30	222.15	**935184.86**	
Pest Control - FFS	☐	unit	2	4.30	222.15	**1910.49**	
Specialized Medical Equipment and Supplies Total:							**1635896.39**
Specialized Medical Equipment and Supplies - Capitation	☒	unit	2128	3.70	207.38	**1632827.17**	
Specialized Medical Equipment and Supplies - FFS	☐	unit	4	3.70	207.38	**3069.22**	
Structured Family Caregiving Total:							**241606218.26**
Structured Family Caregiving - Level 1 - Capitation	☒	day	4084	260.00	77.40	**82186416.00**	
Structured Family Caregiving - Level 2 - Capitation	☒	day	3128	251.90	99.57	**78455504.42**	
Structured Family Caregiving - Level 3 - Capitation	☒	day	2415	251.30	132.75	**80564581.12**	
Structured Family Caregiving - Level 1 - FFS	☐	day	7	260.00	77.40	**140868.00**	
Structured Family	☐	day	5	251.90	99.57	**125408.42**	

GRAND TOTAL:	**1523984758.95**
Total: Services included in capitation:	1521316997.75
Total: Services not included in capitation:	2667761.19
Total Estimated Unduplicated Participants:	**39842**
Factor D (Divide total by number of participants):	**38250.71**
Services included in capitation:	38183.75
Services not included in capitation:	66.96
Average Length of Stay on the Waiver:	297

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Caregiving - Level 2 - FFS							
Structured Family Caregiving - Level 3 - FFS	☐	day	4	251.30	132.75	**133440.30**	
Transportation Total:							**7647152.04**
Transportation - Capitation	☒	trip/mileage	965	2196.70	3.60	**7631335.80**	
Transportation - FFS	☐	trip/mileage	2	2196.70	3.60	**15816.24**	
Vehicle Modifications Total:							**605604.99**
Vehicle Modifications - Capitation	☒	unit	100	1.10	5450.99	**599608.90**	
Vehicle Modifications - FFS	☐	unit	1	1.10	5450.99	**5996.09**	

GRAND TOTAL:	**1523984758.95**
Total: Services included in capitation:	1521316997.75
Total: Services not included in capitation:	2667761.19
Total Estimated Unduplicated Participants:	**39842**
Factor D (Divide total by number of participants):	**38250.71**
Services included in capitation:	38183.75
Services not included in capitation:	66.96
Average Length of Stay on the Waiver:	297

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							**11151969.40**
Adult Day Services - Capitation	☒	1/4 hour	1056	2922.60	3.61	**11141418.82**	

GRAND TOTAL:	**1720875963.00**
Total: Services included in capitation:	1720014340.36
Total: Services not included in capitation:	861622.64
Total Estimated Unduplicated Participants:	**47868**
Factor D (Divide total by number of participants):	**35950.45**
Services included in capitation:	35932.45
Services not included in capitation:	18.00
Average Length of Stay on the Waiver:	279

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services - FFS	☐	1/4 hour	1	2922.60	3.61	**10550.59**	
Attendant Care Total:							**946930896.25**
Attendant Care - Capitation	☒	1/4 hour	21539	5151.60	8.53	**946491464.77**	
Attendant Care - FFS	☐	1/4 hour	10	5151.60	8.53	**439431.48**	
Care Management Total:							**34057.80**
Case Management - FFS	☐	monthly	20	9.00	189.21	**34057.80**	
Home and Community Assistance Service Total:							**41781456.29**
Home and Community Assistance Service - Capitation	☒	1/4 hour	7173	743.60	7.83	**41763989.12**	
Home and Community Assistance Service - FFS	☐	1/4 hour	3	743.60	7.83	**17467.16**	
Skilled Respite Total:							**7567471.24**
Respite - Capitation	☒	1/4 hour	664	1176.80	9.67	**7556091.58**	
Respite - FFS	☐	1/4 hour	1	1176.80	9.67	**11379.66**	
Adult Family Care Total:							**1085064.80**
Adult Family Care - Level 1 - Capitation	☒	day	13	120.50	66.21	**103717.96**	
Adult Family Care - Level 2 - Capitation	☒	day	18	231.10	72.30	**300753.54**	
Adult Family Care - Level 3 - Capitation	☒	day	33	221.80	90.25	**660575.85**	
Adult Family Care - Level 1 - FFS	☐	day	0	120.50	66.21	**0.00**	
Adult Family Care - Level 2 - FFS	☐	day	0	231.10	72.30	**0.00**	
Adult Family Care - Level 3	☐	day	1	221.80	90.25	**20017.45**	

GRAND TOTAL:	**1720875963.00**
Total: Services included in capitation:	1720014340.36
Total: Services not included in capitation:	861622.64
Total Estimated Unduplicated Participants:	**47868**
Factor D (Divide total by number of participants):	**35950.45**
Services included in capitation:	35932.45
Services not included in capitation:	18.00
Average Length of Stay on the Waiver:	279

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
- FFS							
Assisted Living Total:							**321217006.64**
Assisted Living - Daily - Capitation	☒	day	6740	101.10	112.76	**76836242.64**	
Assisted Living - Daily - FFS	☐	day	3	101.10	112.76	**34200.11**	
Assisted Living - Monthly - Capitation	☒	monthly	8807	8.20	3381.95	**244235635.93**	
Assisted Living - Monthly - FFS	☐	monthly	4	8.20	3381.95	**110927.96**	
Caregiver Coaching Total:							**2681749.35**
Caregiver Coaching - Capitation	☒	1/4 hour	1740	97.80	15.75	**2680209.00**	
Caregiver Coaching - FFS	☐	1/4 hour	1	97.80	15.75	**1540.35**	
Community Transition Total:							**225295.85**
Community Transition - Capitation	☒	unit	192	1.20	972.78	**224128.51**	
Community Transition - FFS	☐	unit	1	1.20	972.78	**1167.34**	
Home Delivered Meals Total:							**44646668.32**
Home Delivered Meals - Capitation	☒	meal	19104	301.80	7.74	**44625644.93**	
Home Delivered Meals - FFS	☐	meal	9	301.80	7.74	**21023.39**	
Home Modification Assessment Total:							**1112725.56**
Home Modifications - Assessment - Capitation	☒	unit	2356	1.40	337.21	**1112253.46**	
Home Modifications - Assessment - FFS	☐	unit	1	1.40	337.21	**472.09**	
Home Modifications Total:							**13074713.38**

GRAND TOTAL:	**1720875963.00**
Total: Services included in capitation:	1720014340.36
Total: Services not included in capitation:	861622.64
Total Estimated Unduplicated Participants:	**47868**
Factor D (Divide total by number of participants):	**35950.45**
Services included in capitation:	35932.45
Services not included in capitation:	18.00
Average Length of Stay on the Waiver:	279

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Modifications - Capitation	☒	unit	1658	1.30	6062.37	13066832.30	
Home Modifications - FFS	☐	unit	1	1.30	6062.37	7881.08	
Integrated Health Care Coordination Total:							34751548.08
Integrated Health Care Coordination - Capitation	☒	1/4 hour	6538	376.00	14.13	34735609.44	
Integrated Health Care Coordination - FFS	☐	1/4 hour	3	376.00	14.13	15938.64	
Nutritional Supplements Total:							721067.94
Nutritional Supplements - Capitation	☒	unit	1141	26.80	23.56	720436.53	
Nutritional Supplements - FFS	☐	unit	1	26.80	23.56	631.41	
Participant Directed Home Care Service Total:							899597.83
Participant-Directed Attendant Care Service - Capitation	☒	1/4 hour	2	30167.60	14.91	899597.83	
Personal Emergency Response System Total:							8139596.08
Personal Emergency Response System - Capitation	☒	unit	20073	8.60	47.13	8135948.21	
Personal Emergency Response System - FFS	☐	unit	9	8.60	47.13	3647.86	
Pest Control Total:							1072940.07
Pest Control - Capitation	☒	unit	1177	4.10	222.15	1072029.26	
Pest Control - FFS	☐	unit	1	4.10	222.15	910.82	

GRAND TOTAL:	**1720875963.00**
Total: Services included in capitation:	1720014340.36
Total: Services not included in capitation:	861622.64
Total Estimated Unduplicated Participants:	**47868**
Factor D (Divide total by number of participants):	**35950.45**
Services included in capitation:	35932.45
Services not included in capitation:	18.00
Average Length of Stay on the Waiver:	279

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies Total:							**1805740.61**
Specialized Medical Equipment and Supplies - Capitation	☒	unit	2560	3.40	207.38	**1805035.52**	
Specialized Medical Equipment and Supplies - FFS	☐	unit	1	3.40	207.38	**705.09**	
Structured Family Caregiving Total:							**272618837.55**
Structured Family Caregiving - Level 1 - Capitation	☒	day	4912	244.20	77.40	**92842104.96**	
Structured Family Caregiving - Level 2 - Capitation	☒	day	3763	236.60	99.57	**88649739.91**	
Structured Family Caregiving - Level 3 - Capitation	☒	day	2905	236.00	132.75	**91010745.00**	
Structured Family Caregiving - Level 1 - FFS	☐	day	2	244.20	77.40	**37802.16**	
Structured Family Caregiving - Level 2 - FFS	☐	day	2	236.60	99.57	**47116.52**	
Structured Family Caregiving - Level 3 - FFS	☐	day	1	236.00	132.75	**31329.00**	
Transportation Total:							**8632033.20**
Transportation - Capitation	☒	trip/mileage	1161	2063.50	3.60	**8624604.60**	
Transportation - FFS	☐	trip/mileage	1	2063.50	3.60	**7428.60**	
Vehicle Modifications Total:							**725526.77**
Vehicle Modifications - Capitation	☒	unit	120	1.10	5450.99	**719530.68**	

GRAND TOTAL:	**1720875963.00**
Total: Services included in capitation:	1720014340.36
Total: Services not included in capitation:	861622.64
Total Estimated Unduplicated Participants:	**47868**
Factor D (Divide total by number of participants):	**35950.45**
Services included in capitation:	35932.45
Services not included in capitation:	18.00
Average Length of Stay on the Waiver:	279

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Vehicle Modifications - FFS	☐	unit	1	1.10	5450.99	5996.09	

GRAND TOTAL:	**1720875963.00**
Total: Services included in capitation:	1720014340.36
Total: Services not included in capitation:	861622.64
Total Estimated Unduplicated Participants:	**47868**
Factor D (Divide total by number of participants):	**35950.45**
Services included in capitation:	35932.45
Services not included in capitation:	18.00
Average Length of Stay on the Waiver:	279

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							**11922411.27**
Adult Day Services - Capitation	☒	1/4 hour	1121	2943.50	3.61	11911785.24	
Adult Day Services - FFS	☐	1/4 hour	1	2943.50	3.61	10626.04	
Attendant Care Total:							**1012974929.64**
Attendant Care - Capitation	☒	1/4 hour	22878	5188.50	8.53	1012532350.59	
Attendant Care - FFS	☐	1/4 hour	10	5188.50	8.53	442579.05	
Care Management Total:							**36158.03**
Case Management - FFS	☐	monthly	21	9.10	189.21	36158.03	
Home and Community Assistance Service Total:							**44700514.74**

GRAND TOTAL:	**1838968975.33**
Total: Services included in capitation:	1838099786.44
Total: Services not included in capitation:	869188.89
Total Estimated Unduplicated Participants:	**50843**
Factor D (Divide total by number of participants):	**36169.56**
Services included in capitation:	36152.47
Services not included in capitation:	17.10
Average Length of Stay on the Waiver:	281

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home and Community Assistance Service - Capitation	☒	1/4 hour	7619	749.00	7.83	**44682920.73**	
Home and Community Assistance Service - FFS	☐	1/4 hour	3	749.00	7.83	**17594.01**	
Skilled Respite Total:							**8103528.66**
Respite - Capitation	☒	1/4 hour	706	1185.30	9.67	**8092066.81**	
Respite - FFS	☐	1/4 hour	1	1185.30	9.67	**11461.85**	
Adult Family Care Total:							**1158154.48**
Adult Family Care - Level 1 - Capitation	☒	day	14	121.40	66.21	**112530.52**	
Adult Family Care - Level 2 - Capitation	☒	day	19	232.80	72.30	**319797.36**	
Adult Family Care - Level 3 - Capitation	☒	day	35	223.40	90.25	**705664.75**	
Adult Family Care - Level 1 - FFS	☐	day	0	121.40	66.21	**0.00**	
Adult Family Care - Level 2 - FFS	☐	day	0	232.80	72.30	**0.00**	
Adult Family Care - Level 3 - FFS	☐	day	1	223.40	90.25	**20161.85**	
Assisted Living Total:							**341756063.23**
Assisted Living - Daily - Capitation	☒	day	7159	101.80	112.76	**82177931.91**	
Assisted Living - Daily - FFS	☐	day	3	101.80	112.76	**34436.90**	
Assisted Living - Monthly - Capitation	☒	monthly	9355	8.20	3381.95	**259432766.45**	
Assisted Living - Monthly - FFS	☐	monthly	4	8.20	3381.95	**110927.96**	
Caregiver Coaching Total:							**2868492.38**
Caregiver Coaching -	☒	1/4 hour	1848	98.50	15.75	**2866941.00**	

GRAND TOTAL:	**1838968975.33**
Total: Services included in capitation:	1838099786.44
Total: Services not included in capitation:	869188.89
Total Estimated Unduplicated Participants:	**50843**
Factor D (Divide total by number of participants):	**36169.56**
Services included in capitation:	36152.47
Services not included in capitation:	17.10
Average Length of Stay on the Waiver:	281

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Capitation							
Caregiver Coaching - FFS	☐	1/4 hour	1	98.50	15.75	1551.38	
Community Transition Total:							239303.88
Community Transition - Capitation	☒	unit	204	1.20	972.78	238136.54	
Community Transition - FFS	☐	unit	1	1.20	972.78	1167.34	
Home Delivered Meals Total:							47767440.96
Home Delivered Meals - Capitation	☒	meal	20292	304.00	7.74	47746264.32	
Home Delivered Meals - FFS	☐	meal	9	304.00	7.74	21176.64	
Home Modification Assessment Total:							1182123.38
Home Modifications - Assessment - Capitation	☒	unit	2503	1.40	337.21	1181651.28	
Home Modifications - Assessment - FFS	☐	unit	1	1.40	337.21	472.09	
Home Modifications Total:							13886464.72
Home Modifications - Capitation	☒	unit	1761	1.30	6062.37	13878583.64	
Home Modifications - FFS	☐	unit	1	1.30	6062.37	7881.08	
Integrated Health Care Coordination Total:							37173612.36
Integrated Health Care Coordination - Capitation	☒	1/4 hour	6944	378.70	14.13	37157559.26	
Integrated Health Care Coordination - FFS	☐	1/4 hour	3	378.70	14.13	16053.09	
Nutritional Supplements Total:							771613.56

GRAND TOTAL:	**1838968975.33**
Total: Services included in capitation:	1838099786.44
Total: Services not included in capitation:	869188.89
Total Estimated Unduplicated Participants:	**50843**
Factor D (Divide total by number of participants):	**36169.56**
Services included in capitation:	36152.47
Services not included in capitation:	17.10
Average Length of Stay on the Waiver:	281

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nutritional Supplements - Capitation	☒	unit	1212	27.00	23.56	770977.44	
Nutritional Supplements - FFS	☐	unit	1	27.00	23.56	636.12	
Participant Directed Home Care Service Total:							906047.90
Participant-Directed Attendant Care Service - Capitation	☒	1/4 hour	2	30383.90	14.91	906047.90	
Personal Emergency Response System Total:							8746371.26
Personal Emergency Response System - Capitation	☒	unit	21321	8.70	47.13	8742270.95	
Personal Emergency Response System - FFS	☐	unit	10	8.70	47.13	4100.31	
Pest Control Total:							1140340.38
Pest Control - Capitation	☒	unit	1251	4.10	222.15	1139429.56	
Pest Control - FFS	☐	unit	1	4.10	222.15	910.82	
Specialized Medical Equipment and Supplies Total:							1974257.60
Specialized Medical Equipment and Supplies - Capitation	☒	unit	2719	3.50	207.38	1973531.77	
Specialized Medical Equipment and Supplies - FFS	☐	unit	1	3.50	207.38	725.83	
Structured Family Caregiving Total:							291655011.52
Structured Family Caregiving - Level 1 - Capitation	☒	day	5218	246.00	77.40	99352807.20	

GRAND TOTAL:	**1838968975.33**
Total: Services included in capitation:	1838099786.44
Total: Services not included in capitation:	869188.89
Total Estimated Unduplicated Participants:	**50843**
Factor D (Divide total by number of participants):	**36169.56**
Services included in capitation:	36152.47
Services not included in capitation:	17.10
Average Length of Stay on the Waiver:	281

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Structured Family Caregiving - Level 2 - Capitation	☒	day	3997	238.30	99.57	**94838941.41**	
Structured Family Caregiving - Level 3 - Capitation	☒	day	3085	237.70	132.75	**97346172.38**	
Structured Family Caregiving - Level 1 - FFS	☐	day	2	246.00	77.40	**38080.80**	
Structured Family Caregiving - Level 2 - FFS	☐	day	2	238.30	99.57	**47455.06**	
Structured Family Caregiving - Level 3 - FFS	☐	day	1	237.70	132.75	**31554.68**	
Transportation Total:							**9232639.92**
Transportation - Capitation	☒	trip/mileage	1233	2078.30	3.60	**9225158.04**	
Transportation - FFS	☐	trip/mileage	1	2078.30	3.60	**7481.88**	
Vehicle Modifications Total:							**773495.48**
Vehicle Modifications - Capitation	☒	unit	128	1.10	5450.99	**767499.39**	
Vehicle Modifications - FFS	☐	unit	1	1.10	5450.99	**5996.09**	

GRAND TOTAL:	**1838968975.33**
Total: Services included in capitation:	1838099786.44
Total: Services not included in capitation:	869188.89
Total Estimated Unduplicated Participants:	**50843**
Factor D (Divide total by number of participants):	**36169.56**
Services included in capitation:	36152.47
Services not included in capitation:	17.10
Average Length of Stay on the Waiver:	281

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							**12521158.65**
Adult Day Services - Capitation	☒	1/4 hour	1169	2964.50	3.61	**12510456.80**	
Adult Day Services - FFS	☐	1/4 hour	1	2964.50	3.61	**10701.84**	
Attendant Care Total:							**1063815723.95**
Attendant Care - Capitation	☒	1/4 hour	23856	5225.40	8.53	**1063325424.67**	
Attendant Care - FFS	☐	1/4 hour	11	5225.40	8.53	**490299.28**	
Care Management Total:							**37879.84**
Case Management - FFS	☐	monthly	22	9.10	189.21	**37879.84**	
Home and Community Assistance Service Total:							**46942231.21**
Home and Community Assistance Service - Capitation	☒	1/4 hour	7944	754.30	7.83	**46918606.54**	
Home and Community Assistance Service - FFS	☐	1/4 hour	4	754.30	7.83	**23624.68**	
Skilled Respite Total:							**8507249.22**
Respite - Capitation	☒	1/4 hour	736	1193.70	9.67	**8495706.14**	
Respite - FFS	☐	1/4 hour	1	1193.70	9.67	**11543.08**	
Adult Family Care Total:							**1211636.58**
Adult Family Care - Level 1 - Capitation	☒	day	15	122.20	66.21	**121362.93**	
Adult Family Care - Level 2 - Capitation	☒	day	20	234.40	72.30	**338942.40**	
Adult Family Care - Level 3 - Capitation	☒	day	36	225.00	90.25	**731025.00**	
Adult Family Care - Level 1 - FFS	☐	day	0	122.20	66.21	**0.00**	

GRAND TOTAL:	**1932330639.34**
Total: Services included in capitation:	1931402922.63
Total: Services not included in capitation:	927716.71
Total Estimated Unduplicated Participants:	**53017**
Factor D (Divide total by number of participants):	**36447.38**
Services included in capitation:	36429.88
Services not included in capitation:	17.50
Average Length of Stay on the Waiver:	283

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Family Care - Level 2 - FFS	☐	day	0	234.40	72.30	**0.00**	
Adult Family Care - Level 3 - FFS	☐	day	1	225.00	90.25	**20306.25**	
Assisted Living Total:							**360251332.62**
Assisted Living - Daily - Capitation	☒	day	7465	102.50	112.76	**86279723.50**	
Assisted Living - Daily - FFS	☐	day	3	102.50	112.76	**34673.70**	
Assisted Living - Monthly - Capitation	☒	monthly	9755	8.30	3381.95	**273824654.68**	
Assisted Living - Monthly - FFS	☐	monthly	4	8.30	3381.95	**112280.74**	
Caregiver Coaching Total:							**3012307.20**
Caregiver Coaching - Capitation	☒	1/4 hour	1927	99.20	15.75	**3010744.80**	
Caregiver Coaching - FFS	☐	1/4 hour	1	99.20	15.75	**1562.40**	
Community Transition Total:							**249809.90**
Community Transition - Capitation	☒	unit	213	1.20	972.78	**248642.57**	
Community Transition - FFS	☐	unit	1	1.20	972.78	**1167.34**	
Home Delivered Meals Total:							**50167905.98**
Home Delivered Meals - Capitation	☒	meal	21159	306.20	7.74	**50146576.09**	
Home Delivered Meals - FFS	☐	meal	9	306.20	7.74	**21329.89**	
Home Modification Assessment Total:							**1232637.43**
Home Modifications - Assessment - Capitation	☒	unit	2610	1.40	337.21	**1232165.34**	
Home Modifications	☐	unit	1	1.40	337.21	**472.09**	

GRAND TOTAL:	**1932330639.34**
Total: Services included in capitation:	1931402922.63
Total: Services not included in capitation:	927716.71
Total Estimated Unduplicated Participants:	**53017**
Factor D (Divide total by number of participants):	**36447.38**
Services included in capitation:	36429.88
Services not included in capitation:	17.50
Average Length of Stay on the Waiver:	283

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
- Assessment - FFS							
Home Modifications Total:							**14477545.80**
Home Modifications - Capitation	☒	unit	1836	1.30	6062.37	**14469664.72**	
Home Modifications - FFS	☐	unit	1	1.30	6062.37	**7881.08**	
Integrated Health Care Coordination Total:							**39039234.41**
Integrated Health Care Coordination - Capitation	☒	1/4 hour	7241	381.40	14.13	**39023066.86**	
Integrated Health Care Coordination - FFS	☐	1/4 hour	3	381.40	14.13	**16167.55**	
Nutritional Supplements Total:							**810652.48**
Nutritional Supplements - Capitation	☒	unit	1264	27.20	23.56	**810011.65**	
Nutritional Supplements - FFS	☐	unit	1	27.20	23.56	**640.83**	
Participant Directed Home Care Service Total:							**912494.98**
Participant-Directed Attendant Care Service - Capitation	☒	1/4 hour	2	30600.10	14.91	**912494.98**	
Personal Emergency Response System Total:							**9119909.50**
Personal Emergency Response System - Capitation	☒	unit	22232	8.70	47.13	**9115809.19**	
Personal Emergency Response System - FFS	☐	unit	10	8.70	47.13	**4100.31**	
Pest Control Total:							**1188613.57**

GRAND TOTAL:	**1932330639.34**
Total: Services included in capitation:	1931402922.63
Total: Services not included in capitation:	927716.71
Total Estimated Unduplicated Participants:	**53017**
Factor D (Divide total by number of participants):	**36447.38**
Services included in capitation:	36429.88
Services not included in capitation:	17.50
Average Length of Stay on the Waiver:	283

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Pest Control - Capitation	☒	unit	1304	4.10	222.15	1187702.76	
Pest Control - FFS	☐	unit	1	4.10	222.15	910.82	
Specialized Medical Equipment and Supplies Total:							2059179.71
Specialized Medical Equipment and Supplies - Capitation	☒	unit	2836	3.50	207.38	2058453.88	
Specialized Medical Equipment and Supplies - FFS	☐	unit	1	3.50	207.38	725.83	
Structured Family Caregiving Total:							306271909.44
Structured Family Caregiving - Level 1 - Capitation	☒	day	5441	247.70	77.40	104314743.18	
Structured Family Caregiving - Level 2 - Capitation	☒	day	4168	240.00	99.57	99601862.40	
Structured Family Caregiving - Level 3 - Capitation	☒	day	3217	239.40	132.75	102237385.95	
Structured Family Caregiving - Level 1 - FFS	☐	day	2	247.70	77.40	38343.96	
Structured Family Caregiving - Level 2 - FFS	☐	day	2	240.00	99.57	47793.60	
Structured Family Caregiving - Level 3 - FFS	☐	day	1	239.40	132.75	31780.35	
Transportation Total:							9697750.92
Transportation - Capitation	☒	trip/mileage	1286	2093.10	3.60	9690215.76	
Transportation - FFS	☐	trip/mileage	1	2093.10	3.60	7535.16	

GRAND TOTAL:	**1932330639.34**
Total: Services included in capitation:	1931402922.63
Total: Services not included in capitation:	927716.71
Total Estimated Unduplicated Participants:	**53017**
Factor D (Divide total by number of participants):	**36447.38**
Services included in capitation:	36429.88
Services not included in capitation:	17.50
Average Length of Stay on the Waiver:	283

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Vehicle Modifications Total:							**803475.93**
Vehicle Modifications - Capitation	☒	unit	133	1.10	5450.99	**797479.84**	
Vehicle Modifications - FFS	☐	unit	1	1.10	5450.99	**5996.09**	

GRAND TOTAL:	**1932330639.34**
Total: Services included in capitation:	1931402922.63
Total: Services not included in capitation:	927716.71
Total Estimated Unduplicated Participants:	**53017**
Factor D (Divide total by number of participants):	**36447.38**
Services included in capitation:	36429.88
Services not included in capitation:	17.50
Average Length of Stay on the Waiver:	283

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							**12906425.07**
Adult Day Services - Capitation	☒	1/4 hour	1205	2964.50	3.61	**12895723.22**	
Adult Day Services - FFS	☐	1/4 hour	1	2964.50	3.61	**10701.84**	
Attendant Care Total:							**1096754921.17**
Attendant Care - Capitation	☒	1/4 hour	24595	5225.40	8.53	**1096264621.89**	
Attendant Care - FFS	☐	1/4 hour	11	5225.40	8.53	**490299.28**	
Care Management Total:							**39601.65**

GRAND TOTAL:	**1992192050.39**
Total: Services included in capitation:	1991212999.72
Total: Services not included in capitation:	979050.67
Total Estimated Unduplicated Participants:	**54658**
Factor D (Divide total by number of participants):	**36448.32**
Services included in capitation:	36430.40
Services not included in capitation:	17.91
Average Length of Stay on the Waiver:	283

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management - FFS	☐	monthly	23	9.10	189.21	**39601.65**	
Home and Community Assistance Service Total:							**48395148.79**
Home and Community Assistance Service - Capitation	☒	1/4 hour	8190	754.30	7.83	**48371524.11**	
Home and Community Assistance Service - FFS	☐	1/4 hour	4	754.30	7.83	**23624.68**	
Skilled Respite Total:							**8772740.04**
Respite - Capitation	☒	1/4 hour	759	1193.70	9.67	**8761196.96**	
Respite - FFS	☐	1/4 hour	1	1193.70	9.67	**11543.08**	
Adult Family Care Total:							**1269196.20**
Adult Family Care - Level 1 - Capitation	☒	day	15	122.20	66.21	**121362.93**	
Adult Family Care - Level 2 - Capitation	☒	day	21	234.40	72.30	**355889.52**	
Adult Family Care - Level 3 - Capitation	☒	day	38	225.00	90.25	**771637.50**	
Adult Family Care - Level 1 - FFS	☐	day	0	122.20	66.21	**0.00**	
Adult Family Care - Level 2 - FFS	☐	day	0	234.40	72.30	**0.00**	
Adult Family Care - Level 3 - FFS	☐	day	1	225.00	90.25	**20306.25**	
Assisted Living Total:							**371426473.57**
Assisted Living - Daily - Capitation	☒	day	7696	102.50	112.76	**88949598.40**	
Assisted Living - Daily - FFS	☐	day	3	102.50	112.76	**34673.70**	
Assisted Living - Monthly - Capitation	☒	monthly	10057	8.30	3381.95	**282301850.54**	

GRAND TOTAL:	**1992192050.39**
Total: Services included in capitation:	1991212999.72
Total: Services not included in capitation:	979050.67
Total Estimated Unduplicated Participants:	**54658**
Factor D (Divide total by number of participants):	**36448.32**
Services included in capitation:	36430.40
Services not included in capitation:	17.91
Average Length of Stay on the Waiver:	283

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living - Monthly - FFS	☐	monthly	5	8.30	3381.95	140350.92	
Caregiver Coaching Total:							3106051.20
Caregiver Coaching - Capitation	☒	1/4 hour	1987	99.20	15.75	3104488.80	
Caregiver Coaching - FFS	☐	1/4 hour	1	99.20	15.75	1562.40	
Community Transition Total:							257981.26
Community Transition - Capitation	☒	unit	220	1.20	972.78	256813.92	
Community Transition - FFS	☐	unit	1	1.20	972.78	1167.34	
Home Delivered Meals Total:							51722618.11
Home Delivered Meals - Capitation	☒	meal	21814	306.20	7.74	51698918.23	
Home Delivered Meals - FFS	☐	meal	10	306.20	7.74	23699.88	
Home Modification Assessment Total:							1270877.05
Home Modifications - Assessment - Capitation	☒	unit	2691	1.40	337.21	1270404.95	
Home Modifications - Assessment - FFS	☐	unit	1	1.40	337.21	472.09	
Home Modifications Total:							14926767.41
Home Modifications - Capitation	☒	unit	1893	1.30	6062.37	14918886.33	
Home Modifications - FFS	☐	unit	1	1.30	6062.37	7881.08	
Integrated Health Care Coordination Total:							40246411.18
Integrated Health Care Coordination - Capitation	☒	1/4 hour	7465	381.40	14.13	40230243.63	

GRAND TOTAL:	**1992192050.39**
Total: Services included in capitation:	1991212999.72
Total: Services not included in capitation:	979050.67
Total Estimated Unduplicated Participants:	**54658**
Factor D (Divide total by number of participants):	**36448.32**
Services included in capitation:	36430.40
Services not included in capitation:	17.91
Average Length of Stay on the Waiver:	283

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Integrated Health Care Coordination - FFS	☐	1/4 hour	3	381.40	14.13	**16167.55**	
Nutritional Supplements Total:							**835644.93**
Nutritional Supplements - Capitation	☒	unit	1303	27.20	23.56	**835004.10**	
Nutritional Supplements - FFS	☐	unit	1	27.20	23.56	**640.83**	
Participant Directed Home Care Service Total:							**912494.98**
Participant-Directed Attendant Care Service - Capitation	☒	1/4 hour	2	30600.10	14.91	**912494.98**	
Personal Emergency Response System Total:							**9402010.83**
Personal Emergency Response System - Capitation	☒	unit	22920	8.70	47.13	**9397910.52**	
Personal Emergency Response System - FFS	☐	unit	10	8.70	47.13	**4100.31**	
Pest Control Total:							**1225046.18**
Pest Control - Capitation	☒	unit	1344	4.10	222.15	**1224135.36**	
Pest Control - FFS	☐	unit	1	4.10	222.15	**910.82**	
Specialized Medical Equipment and Supplies Total:							**2122326.92**
Specialized Medical Equipment and Supplies - Capitation	☒	unit	2923	3.50	207.38	**2121601.09**	
Specialized Medical Equipment and Supplies - FFS	☐	unit	1	3.50	207.38	**725.83**	

GRAND TOTAL:	**1992192050.39**
Total: Services included in capitation:	1991212999.72
Total: Services not included in capitation:	979050.67
Total Estimated Unduplicated Participants:	**54658**
Factor D (Divide total by number of participants):	**36448.32**
Services included in capitation:	36430.40
Services not included in capitation:	17.91
Average Length of Stay on the Waiver:	283

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Structured Family Caregiving Total:							**315772696.26**
Structured Family Caregiving - Level 1 - Capitation	☒	day	5609	247.70	77.40	**107535635.82**	
Structured Family Caregiving - Level 2 - Capitation	☒	day	4297	240.00	99.57	**102684549.60**	
Structured Family Caregiving - Level 3 - Capitation	☒	day	3317	239.40	132.75	**105415420.95**	
Structured Family Caregiving - Level 1 - FFS	☐	day	3	247.70	77.40	**57515.94**	
Structured Family Caregiving - Level 2 - FFS	☐	day	2	240.00	99.57	**47793.60**	
Structured Family Caregiving - Level 3 - FFS	☐	day	1	239.40	132.75	**31780.35**	
Transportation Total:							**9999157.32**
Transportation - Capitation	☒	trip/mileage	1326	2093.10	3.60	**9991622.16**	
Transportation - FFS	☐	trip/mileage	1	2093.10	3.60	**7535.16**	
Vehicle Modifications Total:							**827460.28**
Vehicle Modifications - Capitation	☒	unit	137	1.10	5450.99	**821464.19**	
Vehicle Modifications - FFS	☐	unit	1	1.10	5450.99	**5996.09**	

GRAND TOTAL:	**1992192050.39**
Total: Services included in capitation:	1991212999.72
Total: Services not included in capitation:	979050.67
Total Estimated Unduplicated Participants:	**54658**
Factor D (Divide total by number of participants):	**36448.32**
Services included in capitation:	36430.40
Services not included in capitation:	17.91
Average Length of Stay on the Waiver:	283