

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 waiver s target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

Request for a Renewal to a 1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

GENERAL CHANGES:

- Throughout the renewal, references to Cost Comparison Budget/Plan of Care (CCB/POC) have been changed to service plan to more accurately reflect the focus on person centered planning that meets the needs of the participant.
- Updated all references to the Aging Rule (previously 460 IAC 1.2) to 455 IAC 2 throughout the renewal
- Updated Quality Improvement Strategy for each Appendix

The following details all amendment changes by appendix and section:

MAIN APPLICATION for 1915(c) HCBS AMENDMENT APPLICATION:

- 1-H Dual Eligibility- Checked as applicable
- 2 Brief Waiver Description- Removed duplicate paragraph
- 6-I Additional Requirements -Public Input- Updated to include public input specific to the renewal
- 7-B Contact Person(s)- Completed contact information
- 8 Authorizing Signature-Completed authorizing signature information
- Attachment #1: Transition Plan Updated to reflect waiver changes that are included in this renewal

APPENDIX A: WAIVER ADMINISTRATION AND OPERATION:

- A-3 Use of Contracted Entities- Updated description of Utilization Management Functions to reflect current practice; added new section for Quality Assurance Function to reflect administrative functions completed by contracted entity.
- A-4 Local/Regional Non-Governmental Non-state Component- Language changed to service plan
- A-5 Responsibility for Assessment of Performance- Spelling error corrected
- A-6 Assessment Methods and Frequency- Updated language regarding Surveillance Utilization Review (SUR) functions under Program Integrity and the recently formed Benefit Integrity Team
- A-7 Distribution of Waiver Operational and Administrative Functions- Updated table for current functions; Medicaid Agency is indicated for each function

APPENDIX B: PARTICIPANT ACCESS and ELIGIBILITY:

- B-1-b Additional Criteria- Punctuation corrected
- B-3-a Unduplicated Number of Participants- Updated to reflect projections for the 5 year renewal
- B-3-f Selection of Entrants to Waiver- Updated policies regarding selection of entrants to the waiver.
- B-6-i Timely Reevaluations- Grammar corrected
- B-6-j Maintenance of Evaluation/Reevaluation Records- Grammar corrected
- B-7-a Procedures-Language changed to service plan

APPENDIX C: PARTICIPANT SERVICES:

APPENDIX C-1/C-3 Service Specification

Clarification has been added to Adult Family Care, Attendant Care, Behavior Management/Behavior Program and Counseling, Case Management, Environmental Modification, Homemaker, and Respite, that services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, 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.

Documentation Standards have been updated for consistency.

Provider Qualifications- Other Standards have been updated to reflect Indiana Code and Indiana Administrative Code citations that pertain to individual providers of services.

The base service definitions and provider qualifications have not been changed except as noted:

- ADULT DAY SERVICE

Clarified staffing expectations for each level of service

- ADULT FOSTER CARE

Changed to "Adult Family Care" throughout Waiver and in the following service definitions: Attendant Care, Homemaker, Respite, Adult Family Care, Assisted Living, Community Transition, Environmental Modifications, Home Delivered Meals, Nutritional Supplements, Personal Emergency Response System, Pest Control, Transportation, Vehicle Modifications. Also removed reference to Occupational, Physical and Speech Therapies in the service definition.

- ASSISTED LIVING

New service added to the waiver.

- ATTENDANT CARE

Provider Specifications- Provider Type updated to remove the provider type FSSA/DA Approved Agency due to Indiana licensing requirements for these services. This change does not impact any existing providers or waiver participants.

- BEHAVIOR MANAGEMENT

Provider Qualifications- Other Standards have been updated to allow supervision by a Certified Brain Injury Specialist (CBIS)

- ENVIRONMENTAL MODIFICATIONS

Removed language stating permanent ramps "must be a wooden structure"

- HOME DELIVERED MEALS

Service standards revised to state 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. Removed the requirement for all meals and menus to be approved by a licensed dietician.

- HOMEMAKER

Allowable activities clarified to allow clearing primary walkway

Activities not allowed clarified to not allow Cleaning up of the yard, defined as lawn mowing, raking leaves

Provider Specifications- Provider Type updated to remove the provider type FSSA/DA Approved Agency due to Indiana licensing requirements for these services. This change does not impact any existing providers or waiver participants.

- OCCUPATIONAL THERAPY

Service removed from waiver. Participants are able to access therapy through Medicaid State Plan if needed.

- PHYSICAL THERAPY

Service removed from waiver. Participants are able to access therapy through Medicaid State Plan if needed.

- RESIDENTIAL BASED HABILITATION

Service specification clarified to stress that this service provides training to regain skills that were lost secondary to the traumatic brain injury. Provider Qualifications- Other Standards have been updated to allow supervision by a Certified Brain Injury Specialist (CBIS)

- RESPITE

Removed nursing facility as a location where waiver respite service may be provided. This change does not impact any existing providers or waiver participants.

- SPEECH-LANGUAGE THERAPY

Service removed from waiver. Participants are able to access therapy through Medicaid State Plan if needed.

- STRUCTURED DAY PROGRAM

Provider Qualifications- Other Standards have been updated to allow supervision by a Certified Brain Injury Specialist (CBIS)

C-2 GENERAL SERVICE SPECIFICATIONS:

C-2-a Criminal History/ Background Investigations- Updated IAC citation, removed on-going verification language however no change in actual process.

C-2-b Abuse Registry Screening- Updated IAC citation, removed on-going verification language however no change in actual process.

C-2-c Open Enrollment of Providers- Services in Facilities Subject to §1616(e) of the Social Security Act changed to Yes due to addition of Assisted Living. Tables completed.

C-2-e Payment for Waiver Services Furnished by Relatives/Legal Guardians- Revised language to remove physical therapy, occupational therapy, and speech therapy and to add the legal guardian of a participant as an excluded entity: services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, 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.

APPENDIX D: PARTICIPANT-CENTERED PLANNING and SERVICE DELIVERY

D-1 State Participant-Centered Service Plan Title- Changed to Service Plan

D-1-c Supporting Participant in Service Plan Development- Removed text The Division of Aging (DA) reviews the plan of care (POC) and the cost comparison budget (CCB) and has final authority regarding the amount of service that will be approved for the waiver participant.

D-1-d Service Plan Development Process- Removed language about 90 day review as this section is about service plan development

D-1-e Risk Assessment/Mitigation- Description re-written but no change in process

D-1-f Informed Choice of Providers- Description re-written but no change in process

D-1-g Making Plan Subject to Medicaid Agency Approval- Description re-written but no change in process

D-2-a Service Plan Implementation/Monitoring- Description re-written but no change in process

APPENDIX F: PARTICIPANT RIGHTS:

F-1 Opportunity to Request Fair hearing- Updated appeal time frame from 30 to 33 days

F-3-b Operational Responsibility- Description re-written but no change in process

F-3-c Description of Grievance/Complaint System: Description re-written but no change in process

APPENDIX G: PARTICIPANT SAFEGUARDS

G-1-b State Critical Event/Incident Reporting- Description re-written but no change in process

G-1-c Participant Training/Education- Language changed to service plan

G-1-d Review/Response to Critical Events or Incidents- Description re-written but no change in process

G-1-e Oversight of Critical Incidents/Events- Description re-written but no change in process

G-2-a Use of Restraints/Seclusion- Removed sentence regarding seclusion for services delivered outside of the home since all restraints and/or seclusion are prohibited on the waiver

G-2-b Use of Restrictive Interventions- Removed text The prohibition of the use of restrictive interventions will be addressed in the care plan. since restrictive interventions are prohibited on the waiver.

G-3-b Medication Management Responsibility- Updated to include services provided to participants utilizing Assisted Living

G-3-c Medication Administration State Policy- Updated to include services provided to participants utilizing Assisted Living

APPENDIX H: QUALITY IMPROVEMENT STRATEGY

H-1-a-i System Improvements- Description re-written but no change in process

H-1-a-ii System Improvement Activities- Updated to include State Medicaid Agency

H-1-b-i Process for Monitoring/Analyzing Design- Description re-written but no change in process

H-1-b-ii Process to Evaluate QIS- Description re-written but no change in process

APPENDIX I: FINANCIAL ACCOUNTABILITY

I-1 Financial Integrity- Updated SUR language

I-2-d Billing Validation Process- Description re-written but no change in process

I-5-b Excluding Room/Board Costs- Removed text except for the provision of respite care (for 24-hour respite care provided out of the home) and (except when the participant is receiving respite care in a 24-hour respite care setting out of the participant's home) due to removal of nursing facility as a location where waiver respite service may be provided.

APPENDIX J: COST NEUTRALITY DEMONSTRATION

J-1 Composite Overview Cost-Neutrality Formula- Updated table for the 5-year Renewal estimates

J-2-a Number of Unduplicated Participants Served- Updated table for the 5-year Renewal

J-2-b Average Length of Stay- Updated length of stay explanation for the Renewal

J-2-c Derivation of Estimates for Each Factor- Updated explanation of projections for the Renewal.

J-2-d Estimate of Factor D- Updated tables for each year of the Renewal, Case Management service changed to monthly rate

Application for a 1915(c) Home and Community-Based Services Waiver**1. Request Information (1 of 3)**

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

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

Traumatic Brain Injury Waiver

C. Type of Request:renewal

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

3 years 5 years

Original Base Waiver Number: IN.40197

Waiver Number:IN.4197.R03.00

Draft ID: IN.02.03.00

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

Regular Waiver

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

01/01/13

Approved Effective Date: 01/01/13

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 in 42 CFR §440.160

Nursing Facility

Select applicable level of care

Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155

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

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

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

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

Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)

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

Waiver participants must meet the minimal LOC requirements for that of an intermediate care facility for the mentally retarded (ICF/MR) and have a diagnosis of Traumatic Brain Injury.

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

1. Request Information (3 of 3)

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

- Not applicable**

- Applicable**

Check the applicable authority or authorities:

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

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

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

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

- §1915(b)(1) (mandated enrollment to managed care)
- §1915(b)(2) (central broker)
- §1915(b)(3) (employ cost savings to furnish additional services)
- §1915(b)(4) (selective contracting/limit number of providers)

- A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

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

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

- A program authorized under §1115 of the Act.**

Specify the program:

- H. Dual Eligibility for Medicaid and Medicare.**

Check if applicable:

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

2. Brief Waiver Description

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

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

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

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

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

Year 1 (2013)	200
Year 2 (2014)	200
Year 3 (2015)	200
Year 4 (2016)	200
Year 5 (2017)	200

Organizational Structure. The Indiana Division of Aging has been given the authority by the Office of Medicaid Policy and Planning (Single State Agency) to administer the Traumatic Brain Injury Waiver via a memorandum of understanding. The Indiana Division of Aging performs the daily operational tasks of the waiver and the Office of Medicaid Policy and Planning oversees all executive decisions and activities related to the waiver.

Service Delivery Methods. A written service plan will be developed by qualified case managers for each participant under this waiver. The service plan will describe the medical and other services (regardless of funding sources) to be furnished, their frequency, and the type of provider who will furnish each service. The service plan will be subject to the approval of the Division of Aging and the Office of Medicaid Policy and Planning. Traditional service delivery methods are used.

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. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in 1902(a)(1) of the Act (*select one*):
- No**
- Yes**

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

- Geographic Limitation.** A waiver of statewide requirements 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 statewide requirements is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR 440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.
- 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:
In preparation for this renewal in February 2012 the Division of Aging in partnership with the Office of Medicaid Policy and Planning met with the following stakeholders; Arc of IN, AARP, Back Home IN Alliance, Generations Project; Assisted Living Providers; Leading Age IN; IN Assisted Living Association; Area Agency on Aging Executive Directors; Brain Injury Association of IN Board, Aging & Disability Resource Centers and Area Agency on Aging Medicaid Waiver Liaisons.

A Draft proposal for the TBI Renewal was e-mailed to all of the stakeholders from the February 2012 meetings and posted on the Division of Aging website on May 17, 2012 for 30 days with an e-mail link to submit comments. All

comments received were reviewed by Division of Aging staff and the Office of Medicaid Policy and Planning staff; with responses sent directly to those submitting the comments. In addition to the February 2012 stakeholder meetings and posting the renewal on the website Division of Aging staff held Regional Case Manager Trainings in June 2012 in Ft. Wayne, Vincennes and Indianapolis where the TBI renewal and proposed changes were reviewed with the 318 attendees.

Staff from the Division of Aging continues to participate as active members of the TBI Grant workgroup dedicated to identifying goals, objectives and service barriers to Hoosiers diagnosed with traumatic brain injuries. This workgroup is comprised of physicians, caregivers, providers, state agencies and advocates to ensure equal representation. The Indiana TBI Grant workgroup meets on a monthly basis and has sub-workgroups committees consisting of: Statewide Systems of Support; Education; and Information and Referral.

- 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:

Amos

First Name:

Angela

Title:

Waiver Manager

Agency:

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

Address:

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

Address 2:

City:

Indianapolis

State:

Indiana

Zip:

46204

Phone:

(317) 234-6340

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Fax:

E-mail:

- 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:

State Medicaid Director or Designee

Submission Date:

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

Last Name:**First Name:****Title:****Agency:****Address:****Address 2:****City:****State:****Indiana****Zip:****Phone:**Ext: TTY**Fax:****E-mail:**

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

The waiver renewal removes the services of Physical Therapy, Occupational Therapy and Speech Therapy as these services are available via the Indiana State Plan.

The transition plan for the one person that has utilized PT and OT from the TBI Waiver: They may access those services through Medicaid State Plan as there is not a cap on therapies through the Medicaid State Plan. The case manager will work with the participant prior to January 1, 2013 to assure a smooth transition. If for some reason therapy is denied through PA due to the lack of medical necessity the participant may appeal that decision.

The waiver renewal also removes a nursing facility as an approved Respite service location as participants are able to enter a nursing facility for short term care under the State Plan. There are no waiver participants utilizing this service.

Upon approval of this waiver renewal, the Division of Aging website will be updated to include the waiver renewal notice along with the approved renewal. The following stakeholder/ advocacy groups have agreed to publish the waiver renewal notice:

- Area Agency on Aging websites
- The Arc of Indiana newsletter
- Division of Aging website

The waiver case managers will be instructed to deliver the waiver renewal notice to the waiver participant at the next scheduled 90 day review and document its delivery within the electronic case management system in the client's case note.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

- The waiver is operated by the State Medicaid agency.**

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

- The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

(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:

Indiana Family & Social Services Administration, Division of Aging

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:
 The Office of Medicaid Policy and Planning and the Division of Aging have a Memorandum of Understanding that outlines the duties and responsibilities of each agency regarding the services provided under the waiver.

Staff members from the Office of Medicaid Policy and Planning also participate in monthly staff meetings to discuss issues relevant to the delivery of waiver services.

The Office of Medicaid Policy and Planning exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver.

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.:*

There is a contract between the Medicaid agency (OMPP) and each contracted entity listed below that sets forth the responsibilities and performance requirements of the contracted entity. The contract(s) under which these entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency.

Specific to this waiver's operational and administrative functions, the following activities will be conducted by these contracted entities.

UTILIZATION MANAGEMENT FUNCTIONS:

The waiver auditing function is incorporated into the Surveillance Utilization Review (SUR) functions of the contract between the Medicaid agency and SUR Contractor, as detailed in Appendix I-1.

The Office of Medicaid Policy and Planning (OMPP) has expanded its Program Integrity (PI) activities using a multi-faceted approach to SUR activity that includes provider self-audits, desk audits and on-site audits. The Fraud and Abuse Detection System (FADS) team analyzes claims data allowing them to identify providers and/or claims that indicate aberrant billing patterns and/or other risk factors.

The PI audit process utilizes data mining, research, identification of outliers, problematic billing patterns,

aberrant providers and issues that are referred by other divisions and State agencies. In 2011, the State of Indiana formed a Benefit Integrity Team comprised of key stakeholders that meets bi-weekly to review and approve audit plans, provider communications and make policy/system recommendations to affected program areas. The SUR Unit also meets with all waiver divisions on a quarterly basis, at a minimum, and receives referrals on an ongoing basis to maintain open lines of communication and aid in understanding specific areas of concern such as policy clarification.

The SUR Unit offers education regarding key program initiatives and audit issues at waiver provider meetings to promote ongoing compliance with Federal and State guidelines, including all Indiana Health Coverage Programs (IHCP) and waiver requirements.

QUALIFIED PROVIDER ENROLLMENT FUNCTION:

The OMPP has a fiscal agent under contract which is obligated to assist the OMPP in processing approved Medicaid Provider Agreements to enroll approved eligible providers in the Medicaid Management Information System for claims processing. This includes the enrollment of approved waiver providers. The fiscal agent also conducts provider training and provides technical assistance concerning claims processing. The contract defines the roles and responsibilities of the Medicaid fiscal contractor.

QUALITY ASSURANCE FUNCTION:

Provides initial processing of incident reports. The quality assurance contractor administers the Person-Centered Compliance Tool (PCCT) and the Provider Compliance Tool (PCT).

- 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 through their qualified case managers are responsible for preparing a written service plan for each individual waiver participant. The service plan will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each service. All services will be furnished pursuant to a written service plan. The service plan will be subject to the approval of the Division of Aging and/or the Office of Medicaid Policy and Planning. Federal Financial Participation (FFP) will not be claimed for waiver services furnished prior to the development of the service plan. FFP will not be claimed for waiver services which are not included in the individual written service plan.

Each of the sixteen (16) Area Agencies on Aging are responsible for disseminating information regarding

the waiver to potential enrollees, assisting individuals in the waiver enrollment application process, conducting level of care evaluation activities, recruiting providers to perform waiver services, and conducting training and technical assistance concerning waiver requirements.

Independent case managers are also responsible for preparing a written service plan for each individual waiver participant. The service plan will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each service. All services will be furnished pursuant to a written service plan. The service plan will be subject to the approval of the Division of Aging and/or the Office of Medicaid Policy and Planning. Federal Financial Participation (FFP) will not be claimed for waiver services furnished prior to the development of the service plan. FFP will not be claimed for waiver services which are not included in the individual written service plan.

Appendix A: Waiver Administration and Operation

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

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

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

The OMPP is responsible for oversight of waiver audit functions performed by the Surveillance and Utilization Review contractor.

OMPP, in collaboration with DA, is responsible for assessment of the Medicaid Fiscal Agent's enrollment into the Medicaid Management Information System (MMIS) of providers that have been approved by DA for the waiver and fully executed Medicaid Provider Agreements.

The OMPP, in collaboration with DA is responsible for the performance of the Medicaid Fiscal Agent's provision of training and technical assistance concerning waiver requirements. OMPP has developed a contract monitoring report to measure the audit contractor's adherence to the contract and quality of work being performed. OMPP reviews monthly, quarterly and annual reports summarizing audit activities.

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:

Performance based contracts are written with the Area Agencies on Aging and are audited by the Indiana State Board of Accounts and the Family and Social Services Administration's Audit Unit. These audits are performed on a yearly basis.

The DA provider relations specialist oversees and assures that providers are appropriately enrolled through the Medicaid Fiscal Agent. The required Waiver Enrollments and Updates Weekly Report is sent by the Fiscal Agent to the DA provider relations specialist. Providers are to be enrolled by the dedicated Fiscal Agent provider enrollment specialist within an average of thirty (30) days from receipt of the completed provider agreement paperwork. The DA provider relations specialist forwards complaints about the timeliness or performance of the Fiscal Agent to the OMPP Director of Operations and Systems.

The Quality Assurance Contractor meets monthly with representatives from the Division of Aging to review survey results of waiver participants and providers. Written reports are submitted to the Division of Aging on a quarterly basis that specify the participants and providers that have been surveyed, the issues found at the time of survey, and the corrective action plans required of the providers to ensure compliance with the Division of Aging's rules and regulations. These reports are reviewed in the quarterly Quality Assurance meetings that include representatives of

OMPP.

The State of Indiana employs a hybrid Program Integrity (PI) approach to oversight of the waiver programs, incorporating oversight and coordination by a dedicated waiver specialist position within the Surveillance and Utilization Review (SUR) Unit, as well as engaging the full array of technology and analytic tools available through the Fraud and Abuse Detection System (FADS) Contractor arrangements. The Office of Medicaid Policy and Planning (OMPP) has expanded its PI activities using a multi-faceted approach to SUR activity that includes provider self-audits, desk audits and on-site audits. The FADS team analyzes claims data allowing them to identify providers and/or claims that indicate aberrant billing patterns and/or other risk factors.

In 2011, the State of Indiana formed a Benefit Integrity Team comprised of key stakeholders that meets bi-weekly to review and approve audit plans, provider communications and make policy/system recommendations to affected program areas.

Throughout the entire Program Integrity process, oversight is maintained by OMPP. While the FADS Contractor may be incorporated in the audit process, no audit is performed without the authorization of OMPP. OMPP'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.

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	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

A.1 Number and percent of waiver participants enrolled by the operating agency in accordance with state established criteria. Numerator: Total number of participants enrolled by the operating agency in accordance with state criteria. Denominator: Total number of waiver participants enrolled.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:

A.2 Number and percent of active waiver participants compared to the approved waiver capacity. Numerator: Total number of active waiver participants. Denominator: Total number of CMS approved waiver slots.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

A.3 Number and percent of quarterly LOC reports submitted to the Medicaid Agency by the operating agency within the required time period. Numerator: Total number of quarterly LOC reports submitted within the required time period. Denominator: Total number of quarterly LOC reports due.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

A.4 Number and percent of service plan reports submitted to the Medicaid Agency by the operating agency within the required time period. Numerator: Total number of service plan reports submitted within the required time period. Denominator: Total number of service plan reports due.

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other	

Specify: <input style="width: 100%; height: 20px;" type="text"/>

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

A.5 Number and percent of provider reviews completed by the operating agency within specified timeframe outlined in the waiver. Numerator: Total number of provider reviews completed by the operating agency within specified timeframe. Denominator: Total number of provider reviews due.

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%; height: 20px;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

A.6 Number and percent of waiver policies and procedures developed by the operating agency that were approved by OMPP prior to implementation. Numerator: Total number of waiver policies and procedures developed by the operating agency that were approved by OMPP prior to implementation. Denominator: Total number of waiver policies and procedures implemented.

Data Source (Select one):

Presentation of policies or procedures

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	

		<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

A.7 Number and percent of enrolled waiver service providers who met all provider enrollment requirements corresponding to the executed contract. Numerator: The total number of enrolled waiver service providers who met all provider enrollment requirements. Denominator: The total number of waiver service providers who were enrolled by the fiscal contractor.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:

A.8 Number and percent of providers assigned a Medicaid provider number according to the required timeframe specified in the contract with the fiscal contractor.

Numerator: The number of providers assigned a Medicaid provider number by the fiscal contractor 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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Fiscal Intermediary	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Continuously and Ongoing
<input type="checkbox"/>	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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 State's 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.

A.1- A.6 Medicaid staff (OMPP) meet at least monthly with the operating agency to review and aggregate data, respond to questions, identify areas of concern and resolve issues to ensure the successful implementation of the waiver program. The Medicaid agency exercises oversight over the performance of the waiver function by the operating agency, contractors and providers through on-going review and approval of the waiver, revisions to the plan, policies, as well as participation in numerous councils and committees. Medicaid staff also participates with the operating agency in all conference calls with CMS pertaining to the Waiver.

OMPP works with the operating agency to ensure that problems are addressed and corrected. OMPP participates in the data aggregation and analysis of individual performance measures throughout the waiver application. Between scheduled meetings, problems are regularly addressed through written and/or verbal communications to ensure timely remediation. The operating agency and the OMPP discuss the circumstances surrounding an issue or event and what remediation actions should be taken.

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

A.7-A.8 Medicaid staff (OMPP) meet at least monthly with the fiscal contractor to review reports, respond to questions, identify areas of concern and resolve issues to ensure contractual compliance. Corrective actions vary according to the scope and severity of the identified problem. In some cases, informal actions, such as obtaining an explanation of the circumstances surrounding the event, or verification that remediation actions have been taken, may be sufficient to deem the problem resolved. In other situations, more formal actions may be taken. This may consist of a written corrective action plan (CAP).

- 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 a group 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 waiver target group, check each of the subgroups in the selected target group 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
<input checked="" type="radio"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<input checked="" type="radio"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input checked="" type="checkbox"/>	Brain Injury	0		<input checked="" type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="radio"/> Mental Retardation or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Mental Retardation			<input type="checkbox"/>
<input type="radio"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

Waiver participants must meet the minimal LOC requirements for that of a nursing facility (NF) or intermediate care facility for the mentally retarded (ICF/MR) and have a diagnosis of Traumatic Brain Injury.

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

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Specify the percentage:

- Other**

Specify:

- Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based

services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver.
Complete Items B-2-b and B-2-c.

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

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

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

- The following dollar amount:**

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

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

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

Specify percent:

- Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

- The participant is referred to another waiver that can accommodate the individual's needs.**
 Additional services in excess of the individual cost limit may be authorized.

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

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	<input type="text" value="200"/>
Year 2	<input type="text" value="200"/>
Year 3	<input type="text" value="200"/>
Year 4	<input type="text" value="200"/>
Year 5	<input type="text" value="200"/>

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	<input type="text"/>
Year 2	<input type="text"/>
Year 3	<input type="text"/>
Year 4	<input type="text"/>
Year 5	<input type="text"/>

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	
Community transition of institutionalized person due to <input type="checkbox"/> Money Follows the Person <input type="checkbox"/> 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*):

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

Purpose (*describe*):

The State reserves capacity within the TBI 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 waiver, Money Follows the Person .

Describe how the amount of reserved capacity was determined:

The State reviewed the number of TBI patients currently receiving institutional care and determined, based upon the number of TBI waiver slots, the realistic number of individuals that could be transitioned in year 1 through 5. It was determined that we could move two (2) individuals in each of the waiver years 1 through 5 onto the TBI waiver.

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

Waiver Year	Capacity Reserved
Year 1	2
Year 2	2
Year 3	2
Year 4 (renewal only)	2
Year 5 (renewal only)	2

Appendix B: Participant Access and Eligibility

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

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

- The waiver is not subject to a phase-in or a phase-out schedule.

- The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

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

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

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

Applicants will enter the waiver on the following basis:

1. Eligible individuals transitioning off 100% state funded budgets to the waiver, transitioning from nursing facilities to the waiver, or discharging from in-patient hospital settings to the waiver, by date of application; followed by
2. Other eligible individuals applying to the waiver on a first come first serve basis by date of application.

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

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

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

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

2. Miller Trust State.

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

- No
- Yes

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

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

- Low income families with children as provided in §1931 of the Act
- 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:

Children receiving Adoption Assistance or Children receiving Federal Foster Care Payments under Title IV E - Sec. 1902(a)(10)(A)(i)(I) of the Act

Children receiving adoption assistance under a state adoption agreement - Sec 1902(a)(10)(A)(ii)(VIII)

Independent Foster Care Adolescents Sec 1902(a)(10)(A)(ii)(XVII)

Children Under Age 1 Sec 1902(a)(10)(A)(i)(IV)

Children Age 1-5 - Sec 1902(a)(10)(A)(i)(VI)

Children Age 1 through 18 - Sec 1902(a)(10)(A)(i)(VII)

Transitional Medical Assistance Sec 1925 of the Act

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 spenddown 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 4)

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 State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

- 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 (*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-c (209b 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-c (209b 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-c (209b State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

- b. Regular Post-Eligibility Treatment of Income: SSI 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 (3 of 4)

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

The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR 435.735 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 amounts 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):

- The following standard under 42 CFR §435.121

Specify:

- 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 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*):

The following standard under 42 CFR §435.121

Specify:

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 (4 of 4)

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-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:

- 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 an entity under contract with the Medicaid agency.

Specify the entity:

- Other**
Specify:

All initial level of care approvals are reviewed by the operating Agency Division of Aging (DA) staff. Re-evaluations completed by AAA case managers are approved or denied by AAA management staff. Re-evaluations completed by non-AAA case managers are approved or denied by DA Staff.

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:

All initial evaluations are completed by the Area Agency on Aging (AAA) case manager and determinations are rendered by the case manager supervisor.

Case managers performing level of care evaluations and case management supervisors must meet all case management qualifications as detailed in Appendix C.

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 TBI Waiver are first screened for nursing facility (NF) level of care. Any individuals identified to have suffered the brain injury prior to age 22 may meet intermediate care facility for the mentally retarded (ICF/MR) level of care. Screening for ICF/MR level of care will then be completed for these individuals.

Nursing Facility (NF)

Indiana has established the Eligibility Screen (E-Screen), a tool that is used to determine basic level of care criteria that identifies nursing facility level of care (405 IAC 1-3). The Eligibility Screen along with the additional TBI specific information (Explain what happened; When did it happen; Specific quantifiable dysfunctions; How does dysfunction differ from pre-injury; Level of care comments) is required to be completed by the case manager as part of the LOC packet. An E-screen will not be accepted by the computer system, if not all of the pages of the E-screen have been addressed or if the participant does not have a diagnosis of Traumatic Brain Injury (TBI). Initially, the individual's physician must complete the Physician Certification for Long Term Care (450B). The 450B includes the physician recommendation regarding the safety and feasibility of the individual to receive home and community-based services.

Intermediate Care Facility for the Mentally Retarded (ICF/MR)

Any individuals identified to have suffered the brain injury prior to age 22 may meet ICF/MR level of care, which is assessed using the Level of Care Screening Tool. To complete an ICF/MR waiver level of care determination, operating agency staff, or the provider of Case Management must obtain and review the following:

- 1) Psychological records including I.Q. score;
- 2) Social assessment records;
- 3) Medical records;
- 4) Additional records necessary to have a current and valid reflection of the individual; and
- 5) A completed 450B Confirmation of Diagnosis form, signed and dated by a physician within the past year.

If collateral records are not available or are not a valid reflection of the individual, additional assessments may be

obtained from psychologists, physicians, nurses and licensed social workers.

The BDDS Central Office or Case Manager (re-evaluations) reviews the LOC Screening Tool and collateral material, applicable to individuals with intellectual disability*, developmental disability and other related conditions, in order to ascertain if the individual meets ICF/MR LOC.

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

The substantial functional limitation categories, as defined in 42 CFR 435.1010, are: 1)self-care, 2)learning, 3)self-direction, 4)capacity for independent living, 5)receptive and expressive language, and 6)mobility.

The basic conditions are: 1)intellectual disability*, cerebral palsy, epilepsy, autism, or condition similar to intellectual disability*, 2)the condition identified in #1 is expected to continue, 3)the condition identified in #1 had an age of onset prior to age 22, and 4)the applicant needs a combination or sequence of services.

*Intellectual disability is also known as mental retardation.

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 applicants to the TBI Waiver are first screened for nursing facility (NF) level of care. Any individuals identified to have suffered the brain injury prior to age 22 may meet intermediate care facility for the mentally retarded (ICF/MR) level of care. Screening for ICF/MR level of care will then be completed for these individuals.

All applicants for the Waiver are evaluated to assure that level of care (LOC) is met prior to receiving services. Waiver participants must meet the minimal LOC requirements for that of a nursing facility (NF) or intermediate care facility for the mentally retarded (ICF/MR) and have a diagnosis of Traumatic Brain Injury. All initial evaluations are completed by the Area Agency on Aging (AAA) case manager and determinations are rendered by the case manager supervisor. Indiana has established the Eligibility Screen, a tool that is used to determine basic level of care criteria that identifies nursing facility level of care (405 IAC 1-3). The Eligibility Screen along with the additional TBI specific information (Explain what happened; When did it happen; Specific quantifiable dysfunctions; How does dysfunction differ from pre-injury; Level of care comments) is required to be completed by the case manager as part of the LOC packet. Initially, the individual's physician must complete the Physician Certification for Long Term Care (450B). The 450B includes the physician recommendation regarding the safety and feasibility of the individual to receive home and community-based services.

Any individuals identified to have suffered the brain injury prior to age 22 may meet ICF/MR level of care, which is assessed using the Level of Care Screening Tool.

LOC evaluations are structured and monitored to assure that decisions are appropriately rendered. The waiver database contains certain edits and audits that prevent submission of an initial plan of care until all LOC requirements are met. The Waiver Operations Unit investigates and resolves plan of care and level of care issues prior to making final decision.

RE-EVALUATIONS

LOC evaluations are made as part of the individual's annual waiver renewal process or more often if there is a significant change in the individual's condition which impacts LOC.

The above mentioned documents are the same for LOC re-evaluation process, except the 450B is not required. In addition, all LOC re-evaluations for clients managed by the Area Agency on Aging (AAA) are completed by the Area Agency on Aging (AAA) case manager and determinations are rendered by the case manager supervisor. All case management supervisors meet all case management qualifications as detailed in Appendix C and have received training in the nursing facility (NF) and intermediate care facility for the mentally retarded (ICF/MR) level of care process by the Division of Aging or designee.

For those participants who have chosen to be case managed by non-AAA case managers the LOC re-evaluation decisions are required to be reviewed by and a decision rendered by designated staff members within the Division of Aging (DA). Designated staff members within the DA meet all case management qualifications as detailed in Appendix C and have received training in the nursing facility (NF) and intermediate care facility for the mentally retarded (ICF/MR) level of care process by the Division of Aging or designee.

- 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*):

The Division of Aging is using a reporting tool that generates a report at least sixty (60) days prior to the annual level of care (LOC) reevaluation to advise case managers that reviews are due. The report was designed to establish trends and needed education regarding annual level of care. The reports are monitored by the Supervisor of the Waiver Operations Unit and coordinated with the Assistant Director of the Waiver Operations Unit.

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

The DA runs a monthly report that identifies participants whose reevaluation are due within sixty (60) days and sends the listing to case managers. After the due date, the DA re-runs the report that identifies the case managers who are late in submitting the LOC reevaluation and notifies the case managers that the reevaluation is due within fifteen (15) days. If the reevaluation is not received by the DA within fifteen (15) days of notification, the DA submits the listing of delinquent case managers to the Quality Assurance/Quality Improvement (QA/QI) Unit within the DA 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 evaluations and reevaluation documentation is maintained for a minimum of three years within the electronic case management database within the Division of Aging.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

- a. **Methods for Discovery: Level of Care Assurance/Sub-assurances**
 - 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 new enrollees who received a Level of Care (LOC) evaluation prior to enrollment. Numerator: Number of new enrollees who received a LOC evaluation prior to enrollment. Denominator: Number of new enrollees.

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 enrolled participants who are reevaluated annually.

Numerator: Number of enrolled participants who are reevaluated annually.

Denominator: Number of participants with annual LOC reevaluations due.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic Case Management Database System

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
	Specify: <input type="text"/>

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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.3 Number and percent of LOC determinations made where the LOC criteria was accurately applied. Numerator: Number of waiver LOC determinations made where the LOC criteria was accurately applied. Denominator: Number of waiver LOC determinations.

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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 State's 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.

LOC determinations are facilitated through a module in the electronic case management application referred to as the "E-Screen". This tool is structured to assure that LOC criteria is consistently applied and other automated features prevent service plan approval prior to LOC approval, and provide prompts to assure redeterminations are conducted timely. Additionally, discovery reports are monitored by the Division of Aging (DA) Quality Assurance Unit to identify any individual instances of non-compliance, which are remediated individually and analyzed for systemic issues. Specific remediation processes are identified for instances of non-compliance for each performance measure. All documentation of resolution activities will be maintained within the electronic case management database.

B.1: If the DA, or any other entity, identifies any instance of a new applicant not having received a level of care evaluation prior to enrollment the DA will ascertain if any related claims had been made and deny these. The waiver case manager will be required to immediately conduct a proper evaluation and re-enter this into the system. If it is identified that the individual does not meet the criteria for either of the approved

levels of care, the case manager will be advised to refer the individual for any other services which may be available. The DA 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.

B.2: Findings of overdue redeterminations are individually reviewed to determine cause and circumstance. The case manager will be required to immediately conduct a redetermination and enter this in the electronic case management system. Any systemic failure to complete LOC redeterminations can result in referral for handling as a formal complaint through which the responsible entity may be sanctioned, up to and including termination as a case management provider. If redetermination reveals that the individual does not meet one of the approved LOC categories, any claims submitted will be denied back to the date of expiration of the prior LOC period. The case manager will be advised to refer the individual for any other services which may be available. The individual will also be informed in writing of their rights to appeal and have a Medicaid Fair Hearing.

B.3: In any discovery finding where a participant received an evaluation where LOC criteria was not accurately applied, the DA will require that a reevaluation be conducted with findings verified by supervisory or DA personnel. If there is any evidence that the evaluation was intentionally inaccurate, the individual completing the evaluation will be referred to the DA for handling as a formal complaint with potential sanctions up to and including termination as a waiver provider. Instances attributable to lack of knowledge of LOC criteria, either individually or on the part of a business entity, will require re-training as specified by the DA.

If redetermination reveals that the individual does not meet one of the approved LOC categories, any claims submitted will be denied back to the date of expiration of the prior LOC period. The case manager will be advised to refer the individual for any other services which may be available and the individual participant 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.

ii. Remediation Data Aggregation

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

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

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 case manager is responsible for explaining the waiver services available to the individual requesting services. The case manager assesses the individual and completes a service plan. On the service plan there is a section regarding freedom of choice. The freedom of choice language is as follows and is required to be signed by the individual.

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

In addition, the applicant/participant is informed that participants in the waiver can not receive traditional Medicaid services through Medicaid's risk-based managed care system.

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

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

Appendix B: Participant Access and Eligibility

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

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

The Office of Medicaid Policy and Planning and the Division of Aging address the needs of individuals with limited English in a variety of ways:

- Public informational materials regarding TBI waiver services will be available in Spanish and English.
- The case manager identifies the individual's preferred language of communication.
- Case managers and service providers are expected to have oral interpretation available for most common languages in their service areas. Bilingual providers are preferred. Oral interpretation is achieved either through:
 - (a) bilingual staff, contractual interpreters, telephone interpreters; or
 - (b) the use of family/friends as interpreters only when/if the person needing service is aware of the option of one provided at no cost. An individual needing services will not be required to use a family member as an interpreter.

Appendix C: Participant Services

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

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Adult Day Service (ADS) are community-based group programs designed to meet the needs of adults with impairments through individual service plans. These structured, comprehensive, non-residential programs provide health, social, recreational, and therapeutic activities, supervision, support services, and personal care. Meals and/or nutritious snacks are required. The meals cannot constitute the full daily nutritional regimen. However, each meal must meet 1/3 of the daily Recommended Dietary Allowance. These services must be provided in a congregate, protective setting.

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

Enhanced, and Intensive.

ALLOWABLE ACTIVITIES

BASIC ADULT DAY SERVICES (Level 1) includes:

- Monitor and/or supervise 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
- Health assessment and intermittent monitoring of health status
- Monitor medication or medication administration
- Appropriate structure and supervision for those with mild cognitive impairment
- 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
- Health assessment with regular monitoring or intervention with health status
- Dispense or supervise the dispensing of medication to individuals
- Psychosocial needs assessed and addressed, including counseling as needed for individuals and caregivers
- Therapeutic structure, supervision, and intervention for those with mild to moderate cognitive impairments
- 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 supervision 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 deal with participants' psycho-social needs

SERVICE STANDARDS

- Adult Day Services must follow a written service plan addressing specific needs determined by the client's assessment

DOCUMENTATION STANDARDS

- Identified need in the service plan
 - Services outlined in the service plan
 - Evidence that level of service provided is required by the individual
 - Attendance record documenting the date of service and the number of units of service delivered that day
 - Completed Adult Day Service Level of Service Evaluation form
- Case manager must give the completed Adult Day Service Level of Service Evaluation to the 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:

- Any activity that is not described in allowable activities is not included in this service

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/ DA approved Adult Day Service Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Services

Provider Category:

Agency

Provider Type:

FSSA/ DA 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:

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

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Attendant Care

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Attendant Care Services primarily involve hands-on assistance for aging adults and persons with disabilities. These services are provided in order to allow aging adults or persons with disabilities to remain in their own homes and to carry out functions of daily living, self-care, and mobility.

ALLOWABLE ACTIVITIES

Homemaker activities that are essential to the individual's health care needs in order to prevent or postpone institutionalization when provided during the provision of other attendant care services.

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

Provides assistance with mobility which includes:

- Proper body mechanics
- Transfers
- Ambulation
- Use of assistive devices

Provides assistance with elimination which includes:

- Assists with bedpan, bedside commode, toilet
- Incontinent or involuntary care
- Emptying urine collection and colostomy bags

Provides assistance with nutrition which includes:

- Meal planning, preparation, clean-up

Provides assistance with safety which includes:

- Use of the principles of health and safety in relation to self and individual

- Identify and eliminate safety hazards
- Practice health protection and cleanliness by appropriate techniques of hand washing
- Waste disposal, and household tasks
- Reminds individual to self-administer medications
- Provides assistance with correspondence and bill paying
- Escorts individuals to community activities that are therapeutic in nature or that assist with developing and maintaining natural supports

SERVICE STANDARDS

- Attendant Care services must follow a written service plan addressing specific needs determined by the individual's assessment
- If direct care or supervision of care is not provided to the client and the documentation of services rendered for the units billed reflects homemaker 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 homemaker duties, the case manager must be contacted to amend the service plan to a) add Homemaker Services and eliminate Attendant Care Services or b) reduce attendant care hours and replace with the appropriate number of hours of homemaker services

DOCUMENTATION STANDARDS

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

- Attendant Care services will not be provided to medically unstable individuals as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician, or other health professional
- Attendant Care services will not be provided to household members other than to the participant
- Attendant Care services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, 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
- Attendant Care services to participants receiving Adult Family Care 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/DA 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):**

DA approved

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Attendant Care****Provider Category:**Agency **Provider Type:**

Licensed Home Health Agency

Provider Qualifications**License (specify):**

IC 16-27-1

IC 16-27-4

Certificate (specify):**Other Standard (specify):**

DA approved

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Attendant Care**

Provider Category:Individual **Provider Type:**

FSSA/DA approved Attendant Care Individual

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

DA approved

455 IAC 2 Provider Qualifications; General requirements

455 IAC 2 General requirements for direct care staff

455 IAC 2 Liability insurance

455 IAC 2 Professional qualifications and requirements

455 IAC 2 Personnel Records

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:Statutory Service **Service:**Case Management **Alternate Service Title (if any):**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Case Management is a comprehensive service comprised of a variety of specific tasks and activities designed to coordinate and integrate all other services required in the individual's service plan.

ALLOWABLE ACTIVITIES

- Assessments of eligible individuals to determine eligibility for services, functional impairment level, and corresponding in-home and community services needed by the individual
- Development of service plans to meet the individual's needs
- Implementation of the service plans, linking individual with needed services, regardless of the funding source

- Assessment and service planning for discharge from institutionalization
- Annual reassessments of individual's needs
- Periodic updates of service plans
- Monitoring of the quality of home care community services provided to the individual
- Determination of and monitoring the provisions of in-home and community services
- Information and assistance services
- Enhancement or termination of services based on need

SERVICE STANDARDS

- Case Management Services must be reflected in the service plan of the individual
- Services must address needs identified in the service plan

DOCUMENTATION STANDARDS**Documentation for Billing:**

- Approved provider
- Must provide documentation identifying them as the case manager of record for the individual (the pick list is appropriate documentation)

Clinical/Progress Documentation:

- Services must be outlined in the service plan
- Evidence that individual requires the level of service provided
- Documentation to support services rendered

Specify applicable (if any) limits on the amount, frequency, or duration of this service:**ACTIVITIES NOT ALLOWED**

- Case Management may not be conducted by any organization, entity, or individual that also delivers other in-home and community-based services, or by any organization, entity, or individual related by common ownership or control to any other organization, entity, or individual who also delivers other in-home and community-based services, unless the organization is an Area Agency on Aging that has been granted permission by the Family and Social Services Administration Division of Aging to provide direct services to individuals

Note: Common ownership exists when an individual, individuals, 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 an individual or organization has the power or the ability, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not actually exercised. Related means associated or affiliated with, or having the ability to control, or be controlled by.

- Independent case managers and independent case management companies may not provide initial applications for Medicaid Waiver services
- Reimbursement of case management under Medicaid Waivers may not be made unless and until the individual becomes eligible for Medicaid Waiver services. Case management provided to individuals who are not eligible for Medicaid Waiver services will not be reimbursed as a Medicaid Waiver service
- Case management services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, 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

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/DA approved Case Management Agency
Individual	FSSA/ DA approved Case Management Individual

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

FSSA/DA approved Case Management Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

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

Education and work experience

-a qualified mental retardation professional (QMRP) who meets the QMRP requirements at 42 CFR 483.430

-a registered nurse with one year's experience in human services; or

-a Bachelor's degree in Social Work, Psychology, Sociology, Counseling, Gerontology, or Nursing; or

-a Bachelor's degree in any field with a minimum of two years full-time, direct service experience with the elderly or disabled (this experience includes assessment, care plan development, and monitoring); or

-a Master's degree in a related field may substitute for the required experience

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Case Management****Provider Category:**Individual **Provider Type:**

FSSA/ DA approved Case Management Individual

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

DA, or its designee, approved
 455 IAC 2 Documentation of qualifications
 455 IAC 2 Case Management
 Liability Insurance

Education and work experience

-a qualified mental retardation professional (QMRP) who meets the QMRP requirements at 42 CFR 483.430

-a registered nurse with one year's experience in human services; or

-a Bachelor's degree in Social Work, Psychology, Sociology, Counseling, Gerontology, or Nursing; or

-a Bachelor's degree in any field with a minimum of two years full-time, direct service experience with the elderly or disabled (this experience includes assessment, care plan development, and monitoring); or

-a Master's degree in a related field may substitute for the required experience

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:Statutory Service **Service:**Homemaker **Alternate Service Title (if any):**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Homemaker services offer direct and practical assistance consisting of household tasks and related activities. Homemaker services assist the individual to remain in a clean, safe, healthy home environment. Homemaker services are provided when the individual is unable to meet these needs or when an informal caregiver is unable to meet these needs for the individual.

ALLOWABLE ACTIVITIES

1. Provides housekeeping tasks which include:

- 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
- choosing appropriate procedures, equipment, and supplies; improvising when there are limited supplies, keeping equipment clean and in its proper place
- clearing primary walkway

2. Provides assistance with meals or nutrition which includes:

- shopping, including planning and putting food away
- making meals, including special diets under the supervision of a registered dietitian or health professional

3. Runs the following essential errands:

- grocery shopping
- household supply shopping
- prescription pick up

4. Provides assistance with correspondence and bill paying

SERVICE STANDARDS

- Homemaker services must follow a written service plan addressing specific needs determined by the client's assessment

DOCUMENTATION STANDARDS

- Identified need in the service plan
- Services outlined in the service plan
- Data record of services provided, including:
 - complete date and time of service (in and out)
 - specific services/tasks provided
 - signature of employee providing the service (minimally the last name and first initial) If the person providing the service is required to be a professional, the title of the individual must also be included.
- Each staff member providing direct care or supervision of care to the individual must make at least one entry on each day of service. All entries should describe an issue or circumstance concerning the individual.
- 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 hands on services such as eating, bathing, dressing, personal hygiene, and activities of daily living
- Escort or transport individuals to community activities or errands
- Homemaker services provided to household members other than to the participant
- Cleaning up of the yard, defined as lawn mowing, raking leaves
- Homemaker services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, the health care representative (HCR) of a participant, the legal guardian of the participant, or by any member of the participant's household
- Services to participants receiving Adult Family Care waiver service

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Home Health Agency
Agency	Licensed Personal Services Agency
Individual	FSSA/DA approved Homemaker Individual

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Homemaker****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):

DA approved

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Licensed Personal Services Agency

Provider Qualifications

License (specify):

IC 16-27-4

Certificate (specify):

Other Standard (specify):

DA approved

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Homemaker

Provider Category:

Individual

Provider Type:

FSSA/DA approved Homemaker Individual

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

DA approved

455 IAC 2 Provider qualifications: becoming an approved provider; maintaining approval

455 IAC 2 Provider qualifications: general requirements

455 IAC 2 Liability insurance

455 IAC 2 Professional qualifications and requirements

455 IAC 2 Personnel Records

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Residential Based Habilitation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

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

ALLOWABLE ACTIVITIES

Goal oriented training and demonstration with:

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

SERVICE STANDARDS

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

DOCUMENTATION STANDARDS

- Identified need in the service plan
- Services outlined in the service plan
- Data record of services provided, including:
 - complete date and time of service (in and out)
 - specific services/tasks provided
 - monthly documentation of progress toward identified goals
 - signature of employee providing the service (minimally the last name and first initial) If the person providing the service is required to be a professional, the title of the individual must also be included.
- Each staff member providing direct care or supervision of care to the individual must make at least one entry

on each day of service. All entries should describe an issue or circumstance concerning the individual.

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

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

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

ACTIVITIES NOT ALLOWED

Payments for residential based habilitation are not made for room and board

Payment for residential based habilitation does not include payments made directly or indirectly when provided as an individual provider by a parent of a minor child participant, 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

Payments will not be made for the routine care and supervision

Residential Based Habilitation services to participants receiving Adult Family Care waiver service

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Residential Based Habilitation

Provider Category:

Agency

Provider Type:

FSSA/DA approved Residential Based Habilitation Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

DA approved

455 IAC 2 Provider Qualifications; General requirements

455 IAC 2 General requirements for direct care staff

455 IAC 2 Liability insurance

455 IAC 2 Professional qualifications and requirements

455 IAC 2 Personnel Records

Habilitation services must be performed by persons who are supervised by a Certified Brain Injury Specialist (CBIS) or Qualified Mental Retardation Professional (QMRP) or a physical, occupational,

or speech therapist licensed by the state of Indiana and have successfully completed training or have experience in conducting habilitation programs.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Respite services are those services that are provided temporarily or periodically in the absence of the usual caregiver. Service may be provided in the following locations: in an individual's home or in the private home of the caregiver.

The level of professional care provided under respite services depends on the needs of the individual.

An individual requiring assistance with bathing, meal preparation and planning, specialized feeding, such as an individual who has difficulty swallowing, refuses to eat, or does not eat enough; dressing or undressing; hair and oral care; and weight bearing transfer assistance should be considered for respite home health aide under the supervision of a registered nurse

An individual requiring infusion therapy; venipuncture; injection; wound care for surgical, decubitus, incision; ostomy care; and tube feedings should be considered for respite nursing services

ALLOWABLE ACTIVITIES

- Home health aide services
- Skilled nursing services

SERVICE STANDARDS

Respite services must follow a written service plan addressing specific needs determined by the individual's assessment

The level of care and type of respite will not exceed the requirements of the service plan- therefore, skilled nursing services will only be provided when the needs of the individual warrant skilled care

If an individual's needs can be met with an LPN, but an RN provides the service, the service may only be billed at the LPN rate

DOCUMENTATION STANDARDS

- Identified need in the service plan
- Services outlined in the service plan

- Documentation must include the following elements: the reason for the respite, the location where the service was rendered and the type of respite rendered
- Data Record of staff to individual 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 individual makes at least one entry on each day of service describing an issue or circumstance concerning the individual
- 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, the title of the individual 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 individual requiring intervention by a health care professional, or case manager that involved the individual also needs to be documented

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

ACTIVITIES NOT ALLOWED

- Respite shall not be used as day/child care to allow the persons normally providing care to go to work
- Respite shall not be used as day/child care to allow the persons normally providing care to attend school
- Respite shall not be used to provide service to a participant while participant is attending school
- Respite may not be used to replace services that should be provided under the Medicaid State Plan
- Respite will not be reimbursed when provided as an individual provider by a parent of a minor child participant, 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
- Respite must not duplicate any other service being provided under the participant's service plan
- Respite service to participants receiving Adult Family Care 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: Respite

Provider Category:

Agency

Provider Type:

Licensed Home Health Agency

Provider Qualifications

License (specify):

IC 16-27-1

Certificate (specify):

Other Standard (specify):

DA approved

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:Statutory Service **Service:**Day Habilitation **Alternate Service Title (if any):**

Structured Day Program

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

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

SERVICE STANDARDS

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

DOCUMENTATION STANDARDS

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

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

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

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/DA approved Structured Day Program Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Structured Day Program

Provider Category:

Agency

Provider Type:

FSSA/DA approved Structured Day Program Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

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

SERVICE STANDARDS

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

DOCUMENTATION STANDARDS

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

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

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

ACTIVITIES NOT ALLOWED

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

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/DA approved Supported Employment Agency
Agency	Community Mental Health Center

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

FSSA/DA approved Supported Employment Agency

Provider Qualifications

License (specify):

Certificate (specify):

CARF

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Community Mental Health Center

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

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

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:Other Service

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

Service Title:

Adult Family Care

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Adult Family Care (AFC) is a comprehensive service in which a participant resides with an unrelated caregiver in order for the participant to receive personal assistance designed to provide options for alternative long term care to individuals who meet NF or ICF/MR level of care and whose needs can be met in a home-like environment. The participant and up to three (3) other participants who are elderly or have physical and/or cognitive disabilities who are not members of the provider's or primary caregiver's family, reside in a home that is owned, rented, or managed by the AFC provider.

The goal of the service is to provide necessary care while emphasizing the participant's independence. This goal is reached through a cooperative relationship between the participant (or the participant's legal guardian), the participant's HCBS Medicaid Waiver case manager, and the AFC provider. 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. The service is designed to provide options for alternative long-term care to persons who meet NF or ICF/MR level of care, and whose needs can be met in an AFC setting.

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

Participants selecting Adult Family Care service may also receive Case Management service, Adult Day Service, Specialized Medical Equipment and Supplies, Health Care Coordination, Behavior Management, Structured Day Program-individual, Structured Day Program- group, and Supported Employment through the waiver.

ALLOWABLE ACTIVITIES:

The following are included in the daily per diem for Adult Family Care:

- Attendant care
- Chores
- Companion services
- Homemaker
- Medication oversight (to the extent permitted under State law)
- Personal care and services
- Transportation for necessary appointments that include transporting individuals to doctor appointments and community activities that are therapeutic in nature or assists with maintaining natural supports
- Consumer focused activities that are appropriate to the needs, preferences, age, and condition of the individual participant
- Assistance with correspondence and bill paying if requested by participant.

SERVICE STANDARDS

- Adult Family Care services must follow a written service plan addressing specific needs determined by the individual's assessment
- 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 individual familiar with the individual'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, comfortable surroundings that include furnishings as specified in the Adult Family Care Survey Tool, and the opportunity to modify one's living area to suit one's individual 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 individual 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
- Consumer-focused activity plans are developed by the provider with the participant or their representative
- AFC emphasizes the participant's independence in a setting that protects and encourages participant dignity, choice and decision-making while preserving self-respect
- 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:

- Identified need in the service plan
- Services outlined in the service plan
- Requires completed Adult Family Care Level of Service Evaluation form. (Case manager must give the completed Adult Family Care Level of Service Evaluation form to the provider)
- Daily documentation to support services rendered by the AFC to address needs identified in the Level of Service Evaluation form:
 - participant's status
 - updates
 - participation in consumer focused activities
 - medication management records, if applicable
- Maintenance of participant's personal records to include:
 1. social security number
 2. medical insurance number

3. birth date
4. all medical information available including all prescription and non-prescription drug medication currently in use
5. most recent prior residence
6. hospital preference
7. mortuary (if known)
8. religious affiliation and place of worship, if applicable

Participant's personal records must contain copies of all applicable documents:

1. advance directive
2. living will
3. power of attorney
4. health care representative
5. do not resuscitate (DNR) order
6. letters of guardianship

NOTE: if applicable, copies must be:

- placed in a prominent place in the consumer file; and
- sent with the consumer when transferred for medical care

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
- Adult Family Care services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, 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
- Payments for room and board or the costs of facility maintenance, upkeep or improvement
- Personal care services provided to medically unstable or medically complex participants as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician or other health professional

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

Separate payment will not be made for Homemaker, Respite, Environmental Modifications, Vehicle Modifications, Personal Emergency Response System, Attendant Care, Home Delivered Meals, Nutritional Supplements, Pest Control, Community Transition Services and Residential Based Habilitation furnished to a participant selecting Adult Family Care Services as these activities are integral to and inherent in the provision of Adult Family Care Services.

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Adult Family Care

Provider Category:Individual **Provider Type:**

FSSA/DA approved Adult Family Care Individual

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

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

DA approved

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

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service**

Service Name: Adult Family Care

Provider Category:Agency **Provider Type:**

FSSA/DA approved Adult Family Care Agency

Provider Qualifications**License (specify):****Certificate (specify):**

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Other Standard (*specify*):

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

DA approved

- 455 IAC 2 Becoming an approved provider; maintaining approval
- 455 IAC 2 Provider Qualifications: General Requirements
- 455 IAC 2 General requirements for direct care staff
- 455 IAC 2 Procedures for protecting individuals
- 455 IAC 2 Unusual occurrence; reporting
- 455 IAC 2 Transfer of individual's record upon change of provider
- 455 IAC 2 Notice of termination of services
- 455 IAC 2 Provider organizational chart
- 455 IAC 2 Collaboration and quality control
- 455 IAC 2 Data collection and reporting standards
- 455 IAC 2 Quality assurance and quality improvement system
- 455 IAC 2 Financial information
- 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:**

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assisted Living

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (*Scope*):

Assisted living service is defined as personal care and services, homemaker, chore, attendant care and companion services, medication oversight (to the extent permitted under State law), therapeutic social and

recreational programming, provided in a home-like environment in a residential facility which is licensed by the Indiana State Department of Health (ISDH), in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the assisted living facility, but the care provided by these other entities supplements that provided by the assisted living facility and does not supplant it.

Participants reside in their own living units (which may include dually occupied units when both occupants request the arrangement) which include kitchenette, toilet facilities, and a sleeping area, not necessarily designated as a separate bedroom from the living area. The individual has a right to privacy. Living units may be locked at the discretion of the individual. Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The individual retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each individual to facilitate aging in place. Routines of care provision and service delivery must be individual-driven to the maximum extent possible, and treat each person with dignity and respect.

Participants selecting Assisted Living service may also receive Case Management, Specialized Medical Equipment and Supplies, Behavior Management, Structured Day Program, Supported Employment, and Community Transition services through the waiver.

ALLOWABLE ACTIVITIES

The following are included in the daily per diem for Assisted Living Services:

- Attendant care
- Chores
- Companion services
- Homemaker
- Medication oversight (to the extent permitted under State law)
- Personal care and services
- Therapeutic social and recreational programming

SERVICE STANDARDS

- Assisted Living services must follow a written service plan addressing specific needs determined by the client's assessment.

DOCUMENTATION STANDARDS

- Services outlined in the service plan
- Evidence that individual requires the level of service provided
- Documentation to support service rendered
- Negotiated risk agreement, if applicable
- Requires completed Assisted Living Level of Service Evaluation form
- Case manager must give the completed Assisted Living Level of Service Evaluation form to the provider.

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

ACTIVITIES NOT ALLOWED

- The Assisted Living service per diem does not include room and board.
- Personal care services provided to medically unstable or medically complex participants as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician or other health professional

Separate payment will not be made for Homemaker, Respite, Environmental Modifications, Vehicle Modifications, Transportation, Personal Emergency Response System, Attendant Care, Adult Family Care, Adult Day Services, Home Delivered Meals, Nutritional Supplements, and Pest Control 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):

DA approved

410 IAC 16.2-5

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:Other Service

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

Service Title:

Behavior Management/ Behavior Program and Counseling

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
 Service is included in approved waiver. The service specifications have been modified.
 Service is not included in the approved waiver.

Service Definition (Scope):

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

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

ALLOWABLE ACTIVITIES

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

SERVICE STANDARDS

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

DOCUMENTATION STANDARDS

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

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

ACTIVITIES NOT ALLOWED

- Aversive techniques
- Any techniques not approved by the individual's person centered planning team and the Division of Aging
- Behavior Management/ Behavior Program and Counseling services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, 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

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/ DA approved Behavior Management/ Behavior Program and Counseling Individual
Agency	FSSA/ DA approved Behavior Management/ Behavioral Program and Counseling Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavior Management/ Behavior Program and Counseling

Provider Category:

Individual

Provider Type:

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

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

DA approved

455 IAC 2 Provider Qualifications; General requirements

455 IAC 2 General requirements for direct care staff

455 IAC 2 Liability insurance

455 IAC 2 Professional qualifications and requirements

455 IAC 2 Personnel Records

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavior Management/ Behavior Program and Counseling

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

DA approved

455 IAC 2 Provider Qualifications; General requirements

455 IAC 2 General requirements for direct care staff
 455 IAC 2 Liability insurance
 455 IAC 2 Professional qualifications and requirements
 455 IAC 2 Personnel Records

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transition

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

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

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

Items purchased through Community Transition are the property of the individual receiving the service, and the individual takes the property with him or her in the event of a move to another residence, even if the residence from which he or she is moving is owned by a provider agency. Nursing Facilities are not reimbursed for Community Transition because those services are part of the per diem. For those receiving this service under the waiver, reimbursement for approved Community Transition expenditures are reimbursed through the local Area Agency on Aging (AAA) or DA approved provider who maintains all applicable receipts and verifies the delivery of services. Providers can directly relate to the State Medicaid Agency at their election.

ALLOWABLE ACTIVITIES

- Security deposits that are required to obtain a lease on an apartment or home
- Essential furnishings and moving expenses required to occupy and use a community domicile including a bed, table or chairs, window coverings, eating utensils, food preparation items, bed or bath linens
- Set-up fees or deposits for utility or service access including telephone, electricity, heating, and water
- Health and safety assurances including pest eradication, allergen control, or one time cleaning prior to occupancy

SERVICE STANDARDS

Community Transition services must follow a written service plan addressing specific needs determined by the individual's assessment

DOCUMENTATION STANDARDS

- Identified need in the service plan
- Services outlined in the service plan
- Documentation requirements include maintaining receipts for all expenditures, showing the amount and what item or deposit was covered

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

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

ACTIVITIES NOT ALLOWED

- Apartment or housing rental or mortgage expenses
- Food
- Appliances
- Diversional or recreational items such as hobby supplies
- Television
- Cable TV access
- VCRs
- Regular utility charges
- Services to participants receiving Adult Family Care waiver service

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

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

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

DA approved

455 IAC 2 Becoming an approved provider; maintaining approval

455 IAC 2 Provider qualifications: General requirements

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Modifications

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Environmental modifications are minor physical adaptations to the home, as required by the individual's service plan, which are necessary to ensure the health, welfare and safety of the individual, which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

Home Ownership

Environmental modifications shall be approved for the individual's own home or family owned home. Rented homes or apartments are allowed to be modified only when a signed agreement from the landlord is obtained. The signed agreement must be submitted along with all other required waiver documentation.

Choice of Provider

The individual chooses which approved/certified providers will submit bids or estimates for this service. The provider with the lowest bid will be chosen, unless there is a strong written justification from the case manager detailing why a provider with a higher bid should be selected.

Requirements

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

A. Environmental modification requests must be provided in accordance with applicable State and/or local building codes and should be guided by Americans with Disability Act (ADA) or ADA Accessibility Guidelines

(ADAAG) requirements when in the best interest of the individual and his/her specific situation.

B. Environmental modifications shall be authorized only when it is determined to be medically necessary and shall have direct medical or remedial benefit for the waiver individual. This determination includes the following considerations:

1. The modification is the most cost effective or conservative means to meet the individual's need(s) for accessibility within the home;
2. The environmental modification is individualized, specific, and consistent with, but not in excess of, the individual's need(s);

C. Requests for modifications at two or more locations may only be approved at the discretion of the Division of Aging director or designee.

D. Requests for modifications may be denied if the State division director or State agency designee determines the documentation does not support residential stability and/or the service requested.

ALLOWABLE ACTIVITIES

Justification and documentation is required to demonstrate that the modification is necessary in order to meet the individual's identified need (s).

A. Adaptive door openers and locks - limited to one (1) per individual primary residence for an individual living alone or who is alone without a caregiver for substantial periods of time but has a need to open, close or lock the doors and cannot do so without special adaptation.

B. Bathroom Modification - limited to one (1) existing bathroom per individual primary residence when no other accessible bathroom is available. The bathroom modification may include:

1. removal of existing bathtub, toilet and/or sink;
2. installation of roll in shower, grab bars, ADA toilet and wall mounted sink;
3. installation of replacement flooring, if necessary due to bath modification.

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

D. Environmental safety devices limited to:

1. door alarms;
2. anti-scald devices;
3. hand held shower head;
4. grab bars for the bathroom.

E. Fence - limited to 200 linear feet (individual must have a documented history of elopement);

F. Ramp - limited to one per individual primary residence, and only when no other accessible ramp exists:

1. In accordance with the Americans with Disabilities Act (ADA) or ADA Accessibility Guidelines (ADAAG), unless this is not in the best interest of the client;
2. Portable - considered for rental property only;
3. Permanent;
4. Vertical lift - may be considered in lieu of a ramp if there is photographic and written documentation that shows it is not possible for a ramp to be used.

G. Stair lift if required for access to areas of the home necessary to meet the direct medical or remedial benefit of the individual per service plan;

H. Single room air conditioner (s) / single room air purifier (s) if required for access to areas of the home necessary to meet the direct medical or remedial benefit of the individual per service plan:

1. There is a documented medical reason for the individual's need to maintain a constant external temperature. The documentation necessary for this equipment includes a prescription from the primary care physician.
2. The room air conditioner size is consistent with the room size (square feet) capacity to be cooled.

I. Widen doorway - to allow safe egress:

1. Exterior - modification limited to one per individual primary residence when no other accessible door exists;
2. Interior - modification of bedroom, bathroom, and/or kitchen door/doorway as needed to allow for access. (A pocket door may be appropriate when there is insufficient room to allow for the door swing).

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

K. Upon the completion of the modification, painting, wall coverings, doors, trim, flooring etc. will be matched (to the degree possible) to the previous color/style/design;

L. Maintenance - limited to \$500.00 annually for the repair and service of environmental modifications that have been provided through a HCBS waiver:

1. Requests for service must detail parts cost and labor cost;
2. If the need for maintenance exceeds \$500.00, the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor funded through a non-waiver funding source.

M. Items requested which are not listed above, must be reviewed and decision rendered by the State division director or State agency designee.

SERVICE STANDARDS

A. Environmental Modification must be of direct medical or remedial benefit to the individual;

B. To ensure that environmental modifications meet the needs of the individual and abide by established federal, state, local and FSSA standards, as well as ADA requirements, when applicable, approved environmental modifications will include:

1. Assessment of the individual's specific needs, conducted by an approved, qualified individual who is independent of the entity providing the environmental modifications;
2. Independent inspections during, as well as at the completion of, the modification process, prior to authorization for reimbursement;
3. Modifications must meet applicable standards of manufacture, design and installation;
4. Modifications must be compliant with applicable building codes.

DOCUMENTATION STANDARDS

A. The identified direct benefit or need must be documented within:

1. Service plan; and
2. Physician prescription and/or clinical evaluation as deemed appropriate; and

B. Documentation/explanation of the service within the Request for Approval to Authorize Services (RFA) including the following:

1. Property owner of the residence where the requested modification is proposed;
2. Property owner's relationship to the individual;
3. What, if any, relationship the property owner has to the waiver program;
4. Length of time the individual has lived at this residence;
5. If a rental property - length of lease;
6. Written agreement of landlord for modification;
7. Verification of individual's intent to remain in the setting; and
8. Land survey may be required when exterior modification(s) approach property line.

C. Signed and approved RFA;

D. Signed and approved service plan;

E. Provider of services must maintain receipts for all incurred expenses related to the modification;

F. Must be in compliance with FSSA and Division specific guidelines and/or policies.

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

A lifetime cap of \$15,000 is available for environmental modifications. The cap represents a cost for basic modification of an individual's home for accessibility and safety and accommodates the individual's needs for

housing modifications. The cost of an environmental modification includes all materials, equipment, labor, and permits to complete the project. No parts of an environmental modification may be billed separately as part of any other service category (e.g. Specialized Medical Equipment). In addition to the \$15,000 lifetime cap, \$500 is allowable annually for the repair, replacement, or an adjustment to an existing environmental 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 are not of direct medical or remedial benefit to the individual:
1. central heating and air conditioning;
 2. routine home maintenance;
 3. installation of standard (non-ADA or ADAAG) home fixtures (e.g., sinks, commodes, tub, wall, window and door coverings, etc.) which replace existing standard (non-ADA or ADAAG) home fixtures;
 4. roof repair;
 5. structural repair;
 6. garage doors;
 7. elevators;
 8. ceiling track lift systems;
 9. driveways, decks, patios, sidewalks, household furnishings;
 10. replacement of carpeting and other floor coverings;
 11. storage (e.g., cabinets, shelving, closets), sheds;
 12. swimming pools, spas or hot tubs;
 13. video monitoring system;
 14. adaptive switches or buttons to control devices intended for entertainment, employment, or education;
 15. 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. Modifications that duplicate existing accessibility (e.g., second accessible bathroom, a second means of egress from home, etc.);
- D. Modifications that will add square footage to the home;
- E. Individuals 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 environmental modifications rests with the facility owner or operator);
- G. Individuals living in a provider owned residence are not eligible to receive this service. (Note: The responsibility for environmental modifications rests with the facility owner or operator);
- H. Completion of, or modifications to, new construction or significant remodeling/reconstruction are excluded unless there is documented evidence of a significant change in the individual's medical or remedial needs that now require the requested modification.
- I. Services to participants receiving Adult Family Care.
- J. Environmental modification services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, 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.

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/ DA approved Environmental Modification Individual
Individual	Plumber
Individual	Evaluator
Agency	FSSA/ DA approved Environmental Modification Agency/ Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Individual

Provider Type:

Architect

Provider Qualifications

License (specify):

Certificate (specify):

IC 25-4

Other Standard (specify):

DA approved

455 IAC 2 Becoming an approved provider; maintaining approval

455 IAC 2 Provider qualifications: General requirements

455 IAC 2 Financial information

455 IAC 2 Liability insurance

455 IAC 2 Professional qualifications and requirements; documentation of qualifications

455 IAC 2 Warranty required

Compliance with applicable building codes and permits

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Individual

Provider Type:

FSSA/ DA approved Environmental Modification Individual

Provider Qualifications

License (specify):

Any applicable licensure must be in place

Certificate (specify):

Other Standard (specify):

DA approved

455 IAC 2 Becoming an approved provider; maintaining approval

455 IAC 2 Provider qualifications: General requirements

455 IAC 2 Maintenance of Records of services provided

455 IAC 2 Liability insurance

455 IAC 2 Professional qualifications and requirements; documentation of qualifications

455 IAC 2 Warranty required

Compliance with applicable building codes/ permits.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Environmental Modifications****Provider Category:**Individual **Provider Type:**

Plumber

Provider Qualifications**License (specify):**

IC 25-28.5

Certificate (specify):

Other Standard (specify):

DA approved

455 IAC 2 Becoming an approved provider; maintaining approval

455 IAC 2 Provider qualifications: General requirements

455 IAC 2 Financial information

455 IAC 2 Liability insurance

455 IAC 2 Professional qualifications and requirements; documentation of qualifications

455 IAC 2 Warranty required

Compliance with applicable building codes and permits

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Environmental Modifications****Provider Category:**Individual

Provider Type:

Evaluator

Provider Qualifications**License (specify):**

IC 25-20.2 Home Inspector

IC 25-27-1 Physical Therapist

IC 25-23.5 Occupational Therapist

Certificate (specify):

Other Standard (specify):

DA approved

455 IAC 2 Becoming an approved provider; maintaining approval

455 IAC 2 Provider qualifications: General requirements

455 IAC 2 Financial information

455 IAC 2 Liability insurance

455 IAC 2 Professional qualifications and requirements; documentation of qualifications

455 IAC 2 Warranty required

Compliance with applicable building codes and permits

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Environmental Modifications****Provider Category:**Agency **Provider Type:**

FSSA/ DA approved Environmental Modification Agency/ Contractor

Provider Qualifications**License (specify):**

Any applicable licensure

IC 25-20.2 Home inspector

IC 25-28.5 Plumber

Evaluator

IC 25-23.5 Occupational Therapy

IC 25-27 Physical Therapy

Certificate (specify):

IC 25-4 Architect

Other Standard (specify):

DA approved

455 IAC 2 Becoming an approved provider; maintaining approval

455 IAC 2 Provider qualifications: General requirements

455 IAC 2 Maintenance of Records of services provided

455 IAC 2 Liability insurance

455 IAC 2 Professional qualifications and requirements; documentation of qualifications

455 IAC 2 Warranty required

Compliance with applicable building codes and permits

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:Other Service

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

Service Title:

Health Care Coordination

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

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

Because of the different benefits provided under Skilled Nursing and Health Care Coordination, Medicaid Prior Authorization for skilled nursing services is not necessary prior to the provision of Health Care Coordination.

The appropriate level of Health Care Coordination service should be determined by a healthcare professional (RN, doctor).

ALLOWABLE ACTIVITIES

- Physician consults
- Medication ordering
- Development and oversight of a healthcare support plan

SERVICE STANDARDS

- Health Care Coordination services must follow a written service plan addressing specific needs determined by the individual's assessment
- Weekly consultations or reviews
- Face to face visits with the individual
- Other activities, as appropriate
- Services must address needs identified in the service plan
- The provider of home health care coordination will provide a written report to pertinent parties at least quarterly. Pertinent parties includes the individual, guardian, waiver case manager, all service providers, and other entities.

DOCUMENTATION STANDARDS

- Identified need in the service plan
- Services outlined in the service plan

- Current Indiana RN license for each nurse
- Evidence of a consultation including complete date and signature; consultation can be with the individual, other staff, other professionals, as well as health care professionals
- Evidence of a face-to-face visit with the individual, including complete date and signature

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.

Health care coordination services are:

- a minimum of one (1) face to face visit per month
- not to exceed eight (8) hours of Health Care Coordination per month

ACTIVITIES NOT ALLOWED

- Skilled nursing services that are available under the Medicaid State plan
- Case management services provided under a 1915(b) managed care waiver, 1915(c) HCBS waiver, or 1915 (g) targeted case management waiver
- Services to participants receiving Assisted Living waiver service
- Any other service otherwise provided by the waiver

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Home Health Agencies

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Health Care Coordination

Provider Category:

Agency

Provider Type:

Licensed Home Health Agencies

Provider Qualifications

License (specify):

IC 16-27-1 Home Health Agency

IC 25-23-1 RN

Certificate (specify):

Other Standard (specify):

DA approved

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Delivered Meals

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

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

ALLOWABLE ACTIVITIES

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

SERVICE STANDARDS

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

DOCUMENTATION STANDARDS

- Identified need in the service plan
- Services outlined in the service plan
- Date of service and units of service documented

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 and Assisted Living waiver service

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

- Participant-directed as specified in Appendix E
 Provider managed

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

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DA 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/DA approved Home Delivered Meals Agency

Provider Qualifications**License** (*specify*):
Certificate (*specify*):
Other Standard (*specify*):

DA approved

455 IAC 2 Becoming an approved provider; maintaining approval

455 IAC 2 Provider qualifications: General requirements

455 IAC 2 Maintenance of Records of services provided

455 IAC 2 Liability insurance

455 IAC 2 Maintenance of records of services provided

Must comply with all State and local health laws and ordinances concerning preparation, handling, and serving of food.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Nutritional Supplements

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Nutritional (Dietary) supplements include liquid supplements, such as Boost or Ensure to maintain an individual's health in order to remain in the community.

Supplements should be ordered by a physician based on specific life stage, gender, and/ or lifestyle.

Reimbursement for approved Nutritional Supplement expenditures are reimbursed through the local Area Agency on Aging (AAA) who maintains all applicable receipts and verifies the delivery of services. Providers can directly relate to the State Medicaid Agency at their election.

ALLOWABLE ACTIVITIES

- Enteral Formulae, category 1 such as "Boost" or "Ensure"

SERVICE STANDARDS

- Nutritional Supplement services must follow a written service plan addressing specific needs determined by the individual's assessment

DOCUMENTATION STANDARDS

- Identified need in the service plan
- Services outlined in the service plan
- Documentation to support services rendered

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

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

ACTIVITIES NOT ALLOWED

- Services available through the Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before reimbursement is available through the Medicaid waiver for this service)
- Services to participants receiving Adult Family Care waiver service

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/DA 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/DA approved Nutritional Supplements Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

DA approved
 455 IAC 2 Becoming an approved provider; maintaining approval
 455 IAC 2 Provider qualifications: General requirements
 455 IAC 2 Transfer of individual's record upon change of provider
 455 IAC 2 Maintenance of Records of services provided
 455 IAC 2 Liability insurance
 455 IAC 2 Individual's personal file; site of service delivery

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Personal Emergency Response System(PERS) is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual 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 help button is activated. The response center is staffed 24 hours daily/ 7 days per week by trained professionals.

ALLOWABLE ACTIVITIES

- PERS is limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive supervision
- Device Installation service
- Ongoing monthly maintenance of device

SERVICE STANDARDS

- Personal Emergency Response services must follow a written service plan addressing specific needs determined by the individual's assessment

DOCUMENTATION STANDARDS

- Identified need in the service plan
- Services outlined in the service plan
- Documentation of expense for installation
- Documentation of monthly rental fee

Specify applicable (if any) limits on the amount, frequency, or duration of this service:**ACTIVITIES NOT ALLOWED**

- The replacement cost of lost or damaged equipment
- Reimbursement is not available for Personal Emergency Response System Supports when the individual requires constant supervision to maintain health and safety
- Services to participants receiving Adult Family Care waiver service
- Services to participants receiving Assisted Living waiver service

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/ DA approved Personal Emergency Response Sytem 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/ DA approved Personal Emergency Response Sytem Agency

Provider Qualifications**License (specify):**

Certificate (*specify*):

Other Standard (*specify*):

DA approved

455 IAC 2 Becoming an approved provider; maintaining approval

455 IAC 2 Provider qualifications: General requirements

455 IAC 2 Maintenance of Records of services provided

455 IAC 2 Liability insurance

455 IAC 2 Professional qualifications and requirements; documentation of qualifications

455 IAC 2 Warranty required

Compliance with applicable building codes and permits

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Pest Control

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

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 insects such as roaches, mosquitoes, and fleas; insect-like organisms, such as mites and ticks; and vertebrates, such as rats and mice.

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

Reimbursement for approved Pest Control expenditures are reimbursed through the local Area Agency on Aging (AAA) 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

- Pest Control services are added to the service plan when the Case Manager determines-either through direct observation or client 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 by the individual's assessment

DOCUMENTATION STANDARDS

- Identified need in the service plan
- Services outlined in the service plan
- Receipts of specific service, date of service, and cost of service completed

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

An annual cap of \$600 is available for pest control services.

ACTIVITIES NOT ALLOWED

- Pest Control services may not be used solely as a preventative measure, there must be documentation of a need for this service either through Care Manager direct observation or individual report that a pest is causing or is expected to cause more harm than is reasonable to accept
- Services to participants receiving Adult Family Care waiver service or Assisted Living waiver service

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/DA 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/DA approved Pest Control Agency

Provider Qualifications**License** (*specify*):

IC 15-3-3.6

Certificate (*specify*):
Other Standard (*specify*):

DA approved

455 IAC 2 Becoming an approved provider; maintaining approval

455 IAC 2 Provider qualifications: General requirements

455 IAC 2 Maintenance of Records of services provided

455 IAC 2 Liability insurance

455 IAC 2 Professional qualifications and requirements; documentation of qualifications

455 IAC 2 Warranty required

Pesticide applicators must be certified or licensed through the Purdue University Extension Service and the Office of the Indiana State Chemist.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging
Area Agencies on Aging verify license number.

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment and Supplies

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Specialized Medical Equipment and Supplies are medically prescribed items required by the individual's service plan which are necessary to assure the health, welfare and safety of the individual, which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

All Specialized Medical Equipment and Supplies must be approved by the waiver program prior to the service being rendered.

A. Individuals 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).

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

B. Specialized Medical Equipment and Supplies shall be authorized only when it is determined to be medically necessary and shall have direct medical or remedial benefit for the waiver individual. This determination includes the following considerations:

1. The request is the most cost effective or conservative means to meet the individual's specific need(s);
2. The request is individualized, specific, and consistent with, but not in excess of, the individual's need(s);

C. Requests will be denied if the Division of Aging director or designee determines the documentation does not support the service requested.

ALLOWABLE ACTIVITIES

Justification and documentation is required to demonstrate that the request is necessary in order to meet the individual's identified need(s).

A. Communication Devices - computer adaptations for keyboard, picture boards, etc. RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan;

B. Generators (portable) - when either ventilator, daily use of oxygen via a concentrator, continuous infusion of nutrition (tube feeding), or medication through an electric pump are medical requirements of the individual. The generator is limited to the kilo-wattage necessary to provide power to the essential life-sustaining equipment, and is limited to one (1) generator per individual per ten (10) year period;

C. 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;

D. Self help devices - including over the bed tables, reachers, adaptive plates, bowls, cups, drinking glasses and eating utensils that are prescribed by a physical therapist or occupational therapist;

E. Strollers - when needed because individual's primary mobility device does not fit into the individual's vehicle/mode of transportation, or when the individual does not require the full time use of a mobility device, but a stroller is needed to meet the mobility needs of the individual outside of the home setting. RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan;

F. Manual wheelchairs - when required to facilitate safe mobility. RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan;

G. Maintenance - limited to \$500.00 annually for the repair and service of items that have been provided through a HCBS waiver. Items that were previously purchased through the waiver, but not listed in allowable activities, will continue to be maintained according to the definition.

1. Requests for service must detail parts cost and labor cost;

2. If the need for maintenance exceeds \$500.00, the case 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. Posture chairs and feeding chairs - as prescribed by physician, occupational therapist, or physical therapist. RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan;

SERVICE STANDARDS

A. Specialized Medical Equipment and Supplies must be of direct medical or remedial benefit to the individual;

B. All items shall meet applicable standards of manufacture, design and service specifications;

DOCUMENTATION STANDARDS

Documentation standards include the following:

A. The identified direct benefit or need must be documented within:

1. service plan; and

2. Physician prescription and/or clinical evaluation as deemed appropriate.

B. Medicaid State Plan Prior Authorization request and the decision rendered, if applicable;

- C. Signed and approved Request for Approval to Authorize Services (RFA);
- D. Signed and approved service plan;
- E. Provider of services must maintain receipts for all incurred expenses related to this service;
- F. Must be in compliance with FSSA and Division specific guidelines and/or policies.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
 Maintenance - limited to \$500.00 annually for the repair and service of items that have been provided through a HCBS waiver. Items that were previously purchased through the waiver, but not listed in allowable activities, will continue to be maintained according to the definition.
1. Requests for service must detail parts cost and labor cost;
 2. If the need for maintenance exceeds \$500.00, the case 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. The following items and equipment:
1. hospital beds, air fluidized suspension mattresses/beds;
 2. therapy mats;
 3. parallel bars;
 4. scales;
 5. activity streamers;
 6. paraffin machines or baths;
 7. therapy balls;
 8. books, games, toys;
 9. electronics such as CD players, radios, cassette players, tape recorders, television, VCR/DVDs, cameras or film, videotapes and other similar items;
 10. computers and software;
 11. adaptive switches and buttons;
 12. exercise equipment such as treadmills or exercise bikes;
 13. furniture;
 14. appliances - such as refrigerator, stove, hot water heater;
 15. indoor and outdoor play equipment such as swing sets, swings, slides, bicycles adaptive tricycles, trampolines, play houses, merry-go-rounds;
 16. swimming pools, spas, hot tubs, portable whirlpool pumps;
 17. temperpedic mattresses, positioning devices, pillows;
 18. bathtub lifts;
 19. motorized scooters;
 20. barrier creams, lotions, personal cleaning cloths;
 21. totally enclosed cribs and barred enclosures used for restraint purposes;
 22. medication dispensers;
 23. 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 individual, his/her family members, or other non-waiver providers.

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/ DA approved Specialized Medical Equipment and Supplies Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Licensed Home Health Agency

Provider Qualifications

License (specify):

IC 16-27-1

Certificate (specify):

Other Standard (specify):

DA approved

455 IAC 2 Warranty required

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

FSSA/ DA 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):

DA approved

455 IAC 2 Becoming an approved provider; maintaining approval

455 IAC 2 Provider qualifications: General requirements

455 IAC 2 Maintenance of Records of services provided

455 IAC 2 Liability insurance

455 IAC 2 Professional qualifications and requirements; documentation of qualifications

455 IAC 2 Warranty required

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

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

Service Title:

Transportation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Services offered in order to enable individuals served under the waiver to gain access to waiver and other community services, activities and resources, specified by the service plan

SERVICE STANDARDS

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

Transportation services are reimbursed at three (3) types of service:

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

DOCUMENTATION STANDARDS

- Identified need in the service plan
- Services outlined in the service plan
- A provider or its agent shall maintain documentation that the provider meets and maintains the requirements for providing services under 455 IAC 2

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

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

ACTIVITIES NOT ALLOWED

- Services available through the Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before reimbursement is available through the Medicaid waiver for this service)
- Services to participants receiving Adult Family Care waiver service or Assisted Living waiver service

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/DA 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):

DA approved

Compliance with applicable vehicle/driver licensure for vehicle being utilized

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

FSSA/DA approved Transportation Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

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

Compliance with applicable vehicle/driver licensure for vehicle being utilized

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Vehicle Modifications

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Vehicle Modifications (VMOD) are the addition of adaptive equipment or structural changes to a motor vehicle that permit an individual with a disability to safely transport in a motor vehicle. Vehicle modifications, as specified in the service plan, may be authorized when necessary to increase an individual's ability to function in a home and community based setting to ensure accessibility of the individual with mobility impairments. These services must be necessary to prevent or delay institutionalization. The necessity of such items must be documented in the plan of care by a physician's order. Vehicles necessary for an individual to attend post secondary education or job related services should be referred to Vocational Rehabilitation Services.

The vehicle to be modified must meet all of the following:

1. The individual 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 individual's sole or primary means of transportation;
5. The vehicle is not registered to or titled by a Family and Social Services Administration (FSSA) approved provider.

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

A. Vehicle modification requests must meet and abide by the following:

1. The vehicle modification is based on, and designed to meet, the individual's specific need(s);
2. Only one vehicle per an individual's household may be modified;
3. The vehicle is less than ten (10) years old and has less than 100,000 miles on the odometer;
4. If the vehicle is more than five years old, the individual must provide a signed statement from a qualified mechanic verifying that the vehicle is in sound condition.

B. All vehicle modification shall be authorized only when it is determined to be medically necessary and/or shall have direct medical or remedial benefit for the waiver individual. This determination includes the following considerations:

1. The modification is the most cost effective or conservative means to meet the individual's specific need (s);
2. The modification is individualized, specific, and consistent with, but not in excess of, the individual's need (s);
3. All bids must be itemized.

C. Many automobile manufacturers offer a rebate of up to \$1,000.00 for individuals purchasing a new vehicle requiring modifications for accessibility. To obtain the rebate the individual 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.

D. Requests for modifications may be denied if the Division of Aging director or designee determines the documentation does not support the service requested.

ALLOWABLE ACTIVITIES

Justification and documentation is required to demonstrate that the modification is necessary in order to meet the individual'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 (Excludes mobility base);

G. Maintenance is limited to \$500.00 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 \$500.00, the case 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 decision rendered by the State division director or State agency designee.

SERVICE STANDARDS

- A. Vehicle Modification must be of direct medical or remedial benefit to the individual;
- B. All items must meet applicable manufacturer, design and service standards.

DOCUMENTATION STANDARDS

- A. The identified direct benefit or need must be documented within:
 - 1. Service plan; and
 - 2. Physician prescription and/or clinical evaluation as deemed appropriate.
- B. Documentation/explanation of service within the Request for Approval to Authorize Services (RFA) must include:
 - 1. ownership of vehicle to be modified; or
 - 2. vehicle owner's relationship to the individual; and
 - 3. make, model, mileage, and year of vehicle to be modified.
- C. Signed and approved RFA;
- D. Signed and approved service plan;
- E. Provider of services must maintain receipts for all incurred expenses related to the modification;
- F. Must be in compliance with FSSA and Division specific guidelines and/or policies.

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

A lifetime cap of \$15,000.00 is available for vehicle modifications. In addition to the applicable lifetime cap, \$500.00 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

Examples/descriptions of modifications/items Not Covered include, but are not limited to the following:

- A. Lowered floor van conversions;
- B. Purchase, installation, or maintenance of CB radios, cellular phones, global positioning/tracking devices, or other mobile communication devices;
- C. Repair or replacement of modified equipment damaged or destroyed in an accident;
- D. Alarm systems;
- E. Auto loan payments;
- F. Insurance coverage;
- G. Drivers license, title registration, or license plates;
- H. Emergency road service;
- I. Routine maintenance and repairs related to the vehicle itself.
- J. Services to participants receiving Adult Family Care waiver service.

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/ DA 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/ DA approved Vehicle Modification Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

DA approved

455 IAC 2 Becoming an approved provider; maintaining approval

455 IAC 2 Provider qualifications: General requirements

455 IAC 2 Liability insurance

455 IAC 2 Professional qualifications and requirements; documentation of qualifications

455 IAC 2 Maintenance of records of services provided

455 IAC 2 Warranty required

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging

Frequency of Verification:

up to 3 years

Appendix C: Participant Services

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

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

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

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

As a waiver service defined in Appendix C-3. Do not complete item C-1-c.

As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). Complete item C-1-c.

As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). Complete item C-1-c.

As an administrative activity. Complete item C-1-c.

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

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

- a. Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

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

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

All providers must submit a criminal background check as required by 455 IAC 2. The criminal background check must not show any evidence of acts, offenses, or crimes affecting the applicant's character or fitness to care for waiver consumers in their homes or other locations. Additionally, Licensed professionals are checked for findings through the Indiana Professional Licensing Agency. The Division of Aging also requires that a current limited criminal history be obtained from the Indiana State Police central repository as prescribed in 455 IAC 2 Adoption of personnel policies, for each employee or agent involved in the direct management, administration, or provision of services in order to qualify to provide direct care to individuals receiving services at the time of provider certification. Direct care staff is also checked against the nurse aide registry at the Indiana Professional Licensing Agency verifying that each unlicensed employee or agent involved in the direct provision of services has no finding entered into the registry in order to qualify to provide direct care to individuals receiving services. The Division of Aging provider relations waiver specialist verifies receipt of documentation as a part of provider enrollment.

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

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

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

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Indiana Professional Licensing Agency is responsible for maintaining the nurse aide registry. Pursuant to Indiana Administrative Code 455 IAC 2 General Requirements: the provider must obtain and submit a current document from the nurse aide registry of the Indiana Professional Licensing Agency verifying that each unlicensed employee involved in the direct provision of services has no finding entered into the registry before providing direct care to individuals receiving services. The Division of Aging provider relations waiver specialist 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)

- c. Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

i. **Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Indiana State Licensed Residential Care Facilities	

ii. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants request the arrangement) which include kitchenette, toilet facilities, and a sleeping area, not necessarily designated as a separate bedroom from the living area. Individuals may choose to utilize their own furnishings. The individual has a right to privacy. Living units may be locked at the discretion of the individual. Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The individual retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each individual to facilitate aging in place. Routines of care provision and service delivery must be individual-driven to the maximum extent possible, and treat each person with dignity and respect.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Indiana State Licensed Residential Care Facilities

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Residential Based Habilitation	<input type="checkbox"/>
Vehicle Modifications	<input type="checkbox"/>
Personal Emergency Response System	<input type="checkbox"/>
Supported Employment	<input type="checkbox"/>
Behavior Management/ Behavior Program and Counseling	<input type="checkbox"/>
Specialized Medical Equipment and Supplies	<input checked="" type="checkbox"/>
Case Management	<input checked="" type="checkbox"/>
Structured Day Program	<input type="checkbox"/>
Home Delivered Meals	<input type="checkbox"/>
Homemaker	<input type="checkbox"/>
Environmental Modifications	<input type="checkbox"/>

Waiver Service	Provided in Facility
Pest Control	<input type="checkbox"/>
Attendant Care	<input type="checkbox"/>
Nutritional Supplements	<input type="checkbox"/>
Transportation	<input type="checkbox"/>
Adult Family Care	<input type="checkbox"/>
Assisted Living	<input checked="" type="checkbox"/>
Community Transition	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Health Care Coordination	<input type="checkbox"/>
Adult Day Services	<input type="checkbox"/>

Facility Capacity Limit:

no limit

Scope of Facility Standards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

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.*

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.

- Other policy.**

Specify:

Adult Family Care, Attendant Care, Behavior Management/Behavior Program and Counseling, Case Management, Homemaker and Respite waiver services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, 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.

Relatives who receive payment for waiver services 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.

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The Office of Medicaid Policy and Planning and the Division of Aging are dedicated to increasing home and community-based providers for the waiver. The Division of Aging is promoting home and community-based

services by using new marketing tools and personal visits to potential providers. The Division of Aging is dedicated to focusing on recruitment, certification, timely enrollment of providers by the fiscal agent contractor, and retention of waiver providers. Information regarding home and community-based services is posted on the Family and Social Services Administration's website. The Division of Aging has open enrollment meaning any provider can apply at any time.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

C.1 Number and percent of newly enrolled licensed providers that met the provider qualifications prior to providing waiver services. Numerator: Number of newly enrolled licensed providers that met the provider qualifications prior to providing waiver services. Denominator: Number of newly enrolled licensed providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider Relations Tracking Sheet

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 50px; height: 20px;" type="text"/>

<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

C.2 Number and percent of existing enrolled licensed providers that continue to meet provider qualifications. Numerator: Number of existing enrolled licensed providers continuing to meet provider qualifications. Denominator: Number of existing enrolled licensed enrolled waiver providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Indiana State Department of Health (ISDH) Notice

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):
	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input type="checkbox"/> State Medicaid Agency		
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Indiana State Department of Health (ISDH)	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- b. **Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 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 Sheet

Responsible Party for data	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):

collection/generation <i>(check each that applies):</i>		
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Performance Measure:

C.4 Number and percent of non-licensed/non-certified providers that continue to meet waiver requirements. Numerator: Number of existing non-licensed/non-certified providers reviewed that continue to meet waiver requirements.

Denominator: Number of existing non-licensed/non-certified providers reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider Compliance Tool

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: QA Contractor	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 100% over a 3 year period.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> Other Specify: QA Contractor	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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.5 Number and percent of newly enrolled case managers who completed initial case management training. Numerator: Number of newly enrolled case managers who completed initial case management training. Denominator: Number of newly enrolled case managers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider Relations Training Record

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

		Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

C.6 Number and percent of case management providers who continue to meet training requirements. Numerator: Number of case management providers who meet training requirements. Denominator: Number case management providers reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider Compliance Tool

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: QA Contractor	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 100% review over a 3 year period
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QA Contractor	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

C.7 Number and percent of providers who meet staff training requirements.

Numerator: Number of providers who meet staff training requirements.

Denominator: Total number of providers reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider Compliance Tool

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: QA Contractor	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 100% review over a 3 year period
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify: <input type="text"/>

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

The Division of Aging QA/QI Unit reviews daily incident reports, complaints, and other data sources, such as Adult Protective Services records, to determine on an on-going basis if specific provider trends exist. Additionally, the DA utilizes various electronic reports, generated on a monthly basis, which directly relate to the performance measures identified in the approved waiver. Each negative finding is individually researched by the DA QA/QI unit to determine if the problem or issue has been resolved.

b. Methods for Remediation/Fixing Individual Problems

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

Various discovery activities conducted by the Division of Aging (DA) may lead to the identification of areas of non-compliance with the waiver provider agreement. The DA utilizes various electronic reports, generated on a monthly basis, which directly relate to the performance measures identified in the approved waiver. Each negative finding is individually researched by the DA QA/QI unit to determine if the problem or issue has been resolved. If existing documentation does not indicate resolution, QA/QI unit personnel initiate corrective actions. Corrective actions vary according to the scope and severity of the identified problem. In some cases, informal actions, such as verifying that remediation actions have been taken, may be sufficient to deem the problem resolved. In other situations more formal actions may be taken. This may consist of a written corrective action plan (CAP), or a referral to the State Department of Health. The QA/QI unit is responsible for verifying that corrective actions are completed. 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 their right to appeal. Documentation of all corrective actions taken with providers will be maintained in the operating agency's Provider Database. Prior to taking action to suspend or terminate a provider alternative service options will be provided to any affected participants through their case manager.

C.1 and C.3: Indiana requires all new waiver provider-applicants to submit documentation verifying that they meet the criteria and qualifications to provide services prior to allowing them to enroll with the fiscal intermediary (FI). The process in place effectively prevents provider-applicants from providing waiver services prior to approval and enrollment. In the event a provider became enrolled and initiated delivery of waiver services prior to approval by the DA, the DA would instruct the fiscal intermediary (FI) to deny any claim relating to waiver service provision, and disenroll the provider-applicant until such time as provider-applicant fully documents they meet all qualifications. The DA will initiate an investigation of both internal and FI processes to identify deficiencies or vulnerabilities within the enrollment and approval processes and undertake appropriate improvements.

C.2 and C.4: To assure existing providers continue to meet provider qualifications, providers undergo a formal service review at least every three (3) years. For licensed providers, this review is conducted by the Indiana State Department of Health (ISDH). Non-licensed providers are reviewed by a quality assurance (QA) team contracted through the operating agency. Both ISDH and the contracted entity have formal review and remediation procedures which utilize CAPs submitted by the provider with approval or denial by the reviewing entity. If denied, the provider is required to re-submit the CAP. Once approved, the reviewing entity verifies successful implementation of the CAP. Any provider not successfully completing the remediation process to document qualifications is decertified as a provider.

C.5: The DA requires all new waiver case managers to undergo training conducted by State personnel prior to being entered into the electronic case management database system as an approved provider of case management services. In the event a case manager (CM) is identified as providing services prior to completing the required training, the operating agency will instruct the FI to deny any claim for services and disenroll that individual as a provider of case management services. The CM-applicant will be required to

complete the required training before being re-enrolled. The DA will implement an investigation of internal and FI practices to identify deficiencies or vulnerabilities in the enrollment and approval processes and undertake improvements. The DA will also initiate formal complaint proceedings against the case manager's sponsoring provider agency, if applicable, with possible formal sanctions up to and including termination as a waiver provider.

C.6: To assure a high level of service delivery by case managers (CMs), service reviews are conducted on all case management entities by the contracted QA team. This review includes verification of documentation of individual CM training. Any finding of non-compliance with training requirements will result in formal remediation utilizing a CAP, submitted by the provider, with approval or denial by the QA Reviewer. If denied, the provider is required to re-submit the CAP within a two-week time frame. Once approved, the reviewing entity verifies successful implementation of the CAP. Any provider not successfully completing remediation to meet case manager training requirements is decertified as a CM provider.

C.7: To assure service delivery standards are met by provider personnel, service reviews are conducted on approved waiver providers by the contracted QA team. Included in each participant's service review is verification of documentation of training of each individual caregiver or service delivery personnel as required in the provider agreement. Any finding of non-compliance with training requirements will result in a formal remediation process utilizing a CAP submitted by the provider, with approval or denial by the QA Reviewer. If denied, the provider is required to re-submit the CAP within a two-week time frame. Once approved, the reviewing entity verifies successful implementation of the CAP. Any provider not successfully completing remediation to assure required personnel training is decertified as a provider.

ii. Remediation Data Aggregation

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

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

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 D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Service Plan

- a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):
- Registered nurse, licensed to practice in the State**
- Licensed practical or vocational nurse, acting within the scope of practice under State law**
- Licensed physician (M.D. or D.O)**
- Case Manager** (qualifications specified in Appendix C-1/C-3)
- Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Social Worker.

Specify qualifications:

Other

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. *Specify:* (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The case manager works closely with the participant, or the participant's legal guardian, and other persons the participant chooses to include in the service plan development process. The participant or legal guardian has sole authority to determine who is included in the service plan development process. The participant is provided with a "pick-list" of all approved service providers in his or her area and has freedom of choice to select among these providers for each service addressed in the service plan. The case manager encourages the participant to actively self-advocate by communicating needs and preferences to potential and selected providers and other plan development participants.

Appendix D: Participant-Centered Planning and Service Delivery

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

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs

change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Persons involved in the service plan development are the participant or the participant's legal guardian, and other persons the participant chooses to include and the case manager. The case manager, in collaboration with the participant, develops the service plan and submits it to the DA for approval.

All applicants for the waiver are evaluated to assure that level of care (LOC) is met prior to receiving services. All applicants are first screened for nursing facility (NF) level of care. Any individuals identified to have suffered the brain injury prior to age 22 may meet intermediate care facility for the mentally retarded (ICF/MR) level of care. Screening for ICF/MR level of care will be completed for these individuals.

Individuals must meet the minimal LOC requirements for that of a nursing facility (NF) or intermediate care facility for the mentally retarded (ICF/MR) and have a diagnosis of Traumatic Brain Injury to meet the qualifications for the waiver. Indiana has established the Eligibility Screen, a tool that is used to determine basic NF LOC. The Eligibility Screen along with the additional TBI specific information (Explain what happened; When did it happen; Specific quantifiable dysfunctions; How does dysfunction differ from pre-injury; Level of care comments) is required to be completed by the case manager as part of the LOC packet. Initially, the individual's physician must complete the Physician Certification for Long Term Care (450B). This medical document lists the diagnosis, medications, abilities, disabilities and prognosis. The 450B also includes the physician recommendation regarding the safety and feasibility of the individual to receive home and community-based services.

Any individuals identified to have suffered the brain injury prior to age 22 may meet ICF/MR level of care, which is assessed using the Developmental Disabilities Profile (DDP). To meet ICF/MR level of care, an applicant/participant must receive a score of 28 or higher on the DDP. In addition to the basic requirements found in IC 12-7-2-61, Indiana also requires that waiver participants have at least three of the six substantial limitations as defined in 42 CFR 435.1009, in the areas of: 1) self-care; 2) learning; 3) self-direction; 4) capacity for independent living; 5) receptive and expressive language; and 6) mobility. These criteria are considered along with the DDP and an array of collateral materials when considering eligibility for waiver services.

The case manager informs the individual of the services available under the waiver. If the individual meets NF or ICF/MR LOC and has a diagnosis of Traumatic Brain Injury, the individual will be provided with a pick list of all Medicaid Waiver approved providers in the individual's geographic area that provide home and community-based services. It is the individual's choice to choose their services and service providers to meet their identified medical needs and goals.

The case manager in collaboration with the individual and providers completes an initial, ninety (90) day, and annual re-determination assessment to evaluate the individual's strengths, capacities, needs, preferences and desired outcomes, health status, and risk factors. Assessments can be conducted more often if needed. Based on the outcomes of the assessments, a comprehensive service plan is developed. The case manager assures the service plan meets the medical needs and goals of the individual and includes the individual's preferences of services, if available through the waiver, and assigns specific responsibilities for completion of the various components of the plan. The Service Plan is signed by the case manager and the individual or the individual's legal guardian. The DA waiver specialist provides a second level of review of the service plan to assure that the participant's goals, needs (including healthcare needs), and preferences are met.

The individual signs a release form that allows the case manager to contact service providers once the client has selected the providers of choice. The case manager is responsible for the coordination of all services and to assure that needs are met. The case manager is responsible for the implementation and monitoring of the service plan.

The participant receives a copy of the service plan so they are aware of the services that are being provided and the frequency of the services by the service providers. The service plan development process affords a checks and balance approach regarding the assignment of responsibilities to implement and monitor the service plan by input from the participant, case manager, physician, provider of service, and the DA.

The case manager is required to conduct a face-to-face visit with the participant at least every ninety (90) days to ensure the health and welfare of the participant and to determine if the previously approved services continue to meet the medical needs and goals of the waiver participant. The service plan is also reviewed every ninety (90) days, or more often as necessary. Updates to the service plan can be made as often as necessary to reflect the participant's medical needs and goals.

All individuals must be Medicaid eligible prior to receiving waiver services, therefore, the State does not use temporary or interim service plans to get services initiated until a more detailed service plan can be finalized.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Risks are assessed both during the LOC and service planning processes. During the initial and renewal LOC processes, the Eligibility Screen tool is used to identify potential risks and vulnerabilities. When ICF/MR LOC is determined, the ICF/ID Provisional Level of Care Screening Instrument Revised is used. Service plan development takes into account risks identified from the 90 Day Review tool, which is used to develop the initial service plan and then at least every ninety (90) days thereafter. Appropriate interventions may be initiated immediately through the usual service system to address emergent needs.

Formal and informal back-up supports are identified early in the service planning process to address contingencies which could pose a threat to the participant's health or welfare. These contingency plans may address medical emergencies, failure of a support worker to appear when scheduled, or any other potential risk which can be identified by assessment tools, the participant, or members of their support system. Informal supports including friends, family, and neighbors may be used to assist in providing services in a crisis situation. The State also requires that all participants have easy access to emergency contact information and monitors for this in provider compliance reviews.

The State recognizes that risk tolerance varies greatly from participant to participant and encourages case managers to recognize and respect the participant's individual desires and preferences when formulating risk mitigation strategies.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

As a service is identified, a pick list of approved Medicaid Waiver providers is generated in randomized sequence and is presented to the participant by the case manager. Participants and family members are encouraged to interview potential service providers and make their own choice. If the participant or parent/guardian wishes to select a provider that is not an approved waiver service provider, the Office of Medicaid Policy and Planning (OMPP) and the Division of Aging (DA) will assist in reviewing and processing applications from potential providers.

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):

The Indiana Office of Medicaid Policy and Planning (OMPP) will retain responsibility for service plan approvals made by the Division of Aging (DA) as defined in the Memorandum of Understanding (MOU). As part of its routine operations, DA will review each service plan submitted to ensure the plan addresses all pertinent issues identified through the assessment, including physical health issues.

The OMPP will review and approve the policies, processes and standards for developing and approving waiver service plans. Based on the terms and conditions of this waiver, the Medicaid agency may review and overrule the approval or disapproval of any specific service plan acted upon by the DA serving in its capacity as the operating agency for this waiver.

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:

Every ninety days or more frequently when necessary

- 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:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The waiver case manager is the entity responsible for monitoring implementation of the service plan as well as the general health and welfare of the participant. The state requires the case manager to meet face-to-face with the participant at a minimum of every ninety (90) days. At this 90 Day Review, the case manager completes the 90 Day Checklist to assure that approved services continue to meet the medical needs and goals of the participant. The 90-Day Checklist is a comprehensive assessment tool which addresses the following domains via responses from both the case manager and the participant: service plan implementation and applicability, behavior, rights, medical issues, medication issues, seizures, nutrition and dining, health and safety, critical incident reporting and resolution, staffing, and financial issues. This review tool also provides a means of assessing the potential for suspected abuse, neglect or exploitation and forms the basis for any needed revision to the service plan.

All providers rendering services to the participant are required to coordinate efforts and to share documentation regarding the participant's well-being with the case manager. Providers of waiver services are required to have back-up plans to provide staffing for waiver participant's needs. At the ninety (90) Day Review, the case manager verifies with the participant the appropriateness and effectiveness of back up plans and adjusts the plan accordingly.

As part of the monitoring of the participant's health and welfare, the provider is required to send all incident reports to both the Division of Aging (DA) and the case manager. If follow-up is required for an incident, the State requires the case manager to provide follow-up every 7 days until the incident is deemed resolved. Similarly, the State may require the case manager to address any provider complaints filed by the participant, or on their behalf.

If changes to the service plan are warranted in order to meet the medical needs and goals of the participant, the case manager submits additional information and an updated service plan to the DA's Waiver Operations Unit. The DA's waiver specialist determines if the additional services are appropriate based on the assessment and documentation provided.

The case manager serves as the primary contact for the participant and family and is expected to coordinate needs with the participant's providers.

The quality assurance contractor reviews service plan delivery and the supporting documentation through the use of the Person-Centered Compliance and Satisfaction Tool (PCCST).

Additional methods for systemic collection of information about monitoring results are detailed in Appendix H.

b. Monitoring Safeguards. *Select one:*

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

D.1 Number and percent of participant's service plans that address participant's assessed needs and personal goals. Numerator: Number of participant's service plans that address participant's assessed needs and personal goals. Denominator: Number of service plans submitted.

Data Source (Select one):

Other

If 'Other' is selected, specify:

D.1a Electronic Case Management Database System- 90 Day Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

D.1b Person Centered Compliance Tool (PCCT)

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95
<input checked="" type="checkbox"/> Other Specify: QA Contractor	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Statistically valid sample was proportioned across AAAs to assure mixture of rural and urban populations. Distribution was based upon each geographic area's percentage of the total waiver population.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QA Contractor	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 percent of participant's service plans that were developed in accordance with State policies and procedures. Numerator: Number of participant's service plans that were developed in accordance with State policies and procedures. Denominator: Number of service plans submitted.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic Case Management Database

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- c. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 Number and percent of participant's service plans which were updated/revised within 12 months of the previous annual service plan.

Numerator: Number of participant's service plans which were updated/revised within 12 months of the previous annual service plan. **Denominator:** Number of annual service plans due within the previous 12 month period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic Case Management Database

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

D.4 Number and percent of participant service plans which were updated/revised when warranted by changes in the waiver participant needs.
Numerator: Number of participant service plans which were updated/revised when warranted by changes in the waiver participant needs. **Denominator:** Number of service plans that identify a change in need.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic Case Management Database System

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input type="checkbox"/> Other Specify: <input type="text"/>

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

D.5 Number and percent of participants receiving services in accordance with the service plan. Numerator: Number of participants receiving services in accordance with the service plan. Denominator: Number of service plans reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

D.5a 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

D.5b Person Centered Compliance Tool (PCCT)

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95
<input checked="" type="checkbox"/> Other Specify: QA Contractor	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Statistically valid sample was proportioned across AAAs to assure mixture of rural and urban populations. Distribution was based upon each geographic area's percentage of

		the total waiver population.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QA Contractor	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- e. **Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.**

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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.6 Number and percent of participants that are afforded choice between/among waiver services and institutional care. Numerator: Number of participant service plans with a signed Freedom of Choice form indicating the choice between waiver services and institutional care. Denominator: Number of participant service plans reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

D.6a Electronic Case Management Database System

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

D.6b Person Centered Compliance Tool (PCCT)

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95
<input checked="" type="checkbox"/> Other	<input type="checkbox"/> Annually	

Specify: QA Contractor		<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Statistically valid sample was proportioned across AAAs to assure mixture of rural and urban populations. Distribution was based upon each geographic area's percentage of the total waiver population.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QA Contractor	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

D.7 Number and percent of participants that are afforded choice between/among waiver services and providers. Numerator: Number of participant's service

plans with a signed Freedom of Choice form indicating the choice between/among waiver services and providers. Denominator: Number of service plans reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

D.7a Electronic Case Management Database System

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

D.7b Person Centered Compliance Tool (PCCT)

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95
<input checked="" type="checkbox"/> Other Specify: QA Contractor	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Statistically valid sample was proportioned across AAAs to assure mixture of rural and urban populations. Distribution was based upon each geographic area's percentage of the total waiver population.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QA Contractor	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify: <input type="text"/>

- 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 State's 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.

Discovery activities specific to each performance measure are carried out on an on-going basis by the Division of Aging (DA) QA/QI unit using electronic reports which gather data from each participant's individual electronic case management record, including the Service Plan and 90 Day Review. As individual service plan problems are identified through discovery processes, the DA will require corrective measures of the case manager or service provider, as appropriate, to assure the problem is resolved. Corrective actions vary according to the scope and severity of the identified problem. In some cases, informal actions, such as obtaining an explanation of the circumstances surrounding the event, or verification that remediation actions have been taken, may be sufficient to deem the problem resolved. In other situations, more formal actions may be taken. This may consist of a written corrective action plan (CAP), or a referral as a formal complaint to the DA which can result in sanctions up to and including termination as a provider. The DA will monitor implementation of corrective measures to verify resolution. As a safeguard against interruption of services, an extension service plan will be generated when necessary to continue services. If a participant's services are directly impacted by the suspension or termination of a provider, the case manager will be directed to assist the participant in choosing a new provider and the operating agency will assist in expediting this change.

D.1: Identification of an individual service plan which does not meet a participant's assessed needs and personal goals will result in a review of casenotes to identify the circumstances surrounding non-compliance. If resolution activities have not already been initiated, the DA's QIS Program Director will contact the waiver case manager (CM) and require an updated assessment or development of compliant service plan, as appropriate, recognizing the individual participant's choice of services and providers, and who to include in service planning. Failure by the CM to address the unmet need(s) may result in referral to the DA for handling as a formal complaint.

D.2, D.3, D.4, D.6 and D.7: Identification of a service plan for which evidence indicates that the plan was not developed in accordance with State policies and procedures will result in a review of casenotes, timelines and signatures to identify the circumstances surrounding non-compliance. If resolution activities have not already been initiated, the DA's QIS Program Director will contact the CM to determine steps needed to restore compliance. Potential areas of non-compliance for these measures include: timeliness; signatures indicating Freedom of Choice of providers and institution/waiver not in place; overdue 90 Day Review at time of plan submission; signatures of participant or legal guardian, or Case Manager missing; and not updating or revising the service plan to reflect a change in need. The required resolution will be completion of a revised or new service plan by the participant's CM. Findings of late service plan submission will be tracked to identify area or CM-specific trends, or other systemic issues. A case manager who does not adequately address a non-compliant issue, or who is found to have recurrent negative findings, will be referred to the DA for handling as a formal complaint.

D.5: Identification of a participant for whom services are not being delivered in accordance with the service plan will result in a review of casenotes, incident reports and other available documentation to determine the cause and circumstance of the finding. If resolution activities have not already been initiated, the DA's QIS Program Director will contact the waiver case manager to determine steps needed to obtain

compliance. Findings and remediations for this measure vary greatly as participant choice, medical conditions or interventions, and innumerable life circumstances, such as a vacation or a change in residence, can prompt a negative response on the tool used for this measure. Remediation may involve interruption or termination of the service plan if the participant is unable to benefit from, or chooses not to receive, services. A negative finding may also reflect a provider service delivery or quality issue. If attempts to remediate a provider issue have not been successful, the case manager will be directed to discuss alternative providers with the participant, respecting the participant's right of choice in selecting or maintaining a provider. If evidence indicates that billing has occurred when services have not been delivered, the provider will be referred to FSSA Program Integrity for review. The provider may also be referred for handling as a formal complaint.

Performance measures D.1, D.5, D.6 and D.7 have a secondary data source derived from the Person Centered Compliance Tool (PCCT) administered by the QA contractor to a statistically significant sample population. When specific PCCT probes reveal negative findings, the QA reviewer implements a formal remediation process utilizing a CAP, submitted by the appropriate provider, with approval or denial by the Reviewer, under supervision of the DA. If a CAP is denied, the provider is required to re-submit the CAP. Once approved, the Reviewer verifies successful implementation of the CAP. Any provider not completing the required corrective action(s) is referred to the DA for handling as a formal complaint. The complaint process can result in sanctions up to and including termination as a waiver provider. Prior to termination any current participants will be assisted in securing services from other providers. Any provider who is decertified as a result of failing to complete corrective actions will be notified of the decision, and of their right to appeal.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QA Contractor	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid gray; height: 20px; width: 100%;"></div>

c. Timelines

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

- No**
- Yes**

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

Appendix E: Participant Direction of Services

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

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

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

- Yes. The State requests that this waiver be considered for Independence Plus designation.**
- No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

The case manager's responsibilities include provision of both written and oral explanations of the participant's, or the guardian's-if appropriate, right to the Medicaid Fair Hearing process. This notification will occur at the time of initial assessment, annual reassessments and for any updates to the service plan related to participant's choice between institutional care and community based services, selection of services and service providers if community based care is chosen. This notification will include rights of appeal if services are suspended, denied, reduced or terminated.

The Notice of Action § State Form 46015 § HCBS5 § is used to notify each Medicaid applicant or participant of any action that affects the individual's Medicaid waiver benefits. An action may be a suspension, termination, reduction, or increase of all or any amount of covered services. This also includes actions taken to approve or deny new applicants. An explanation regarding a HCBS waiver service participant's appeal rights and the opportunity for a fair hearing is located on each Notice of Action. Part 2, §Your Right to Appeal and Have a Fair Hearing§ advises individuals of their right to appeal and the timely actions which are required. Part 3, §How to Request an Appeal§ provides instructions for individuals regarding the procedures that are necessary in the appeal process.

The waiver Notice of Action informs the participant (and the participant's guardian or advocate, as appropriate) of his/her right to an appeal. The Notice of Action also advises the participant that services will be continued if he/she files the appeal in a timely manner, which is within 33 days of the decision date noted on the Notice of Action.

Written materials will be maintained in the participant's information folder kept in the home. Additionally, written materials detailing the service plan and service providers are mailed to the participant to allow for a right to appeal the service delivery plan and right to a Medicaid Fair Hearing. This formal notice occurs after the initial service plan is developed and at time of renewal or at any time there is a change in the service plan.

The case manager maintains copies of all written notices and electronically filed documents related to an individual's service plan and the individual's right to a Medicaid Fair Hearing. The case manager must ensure that the Notice of Action is sent to the applicant or participant within 10 working days of the issue date and must document the date the Notice of Action was sent to the applicant or participant.

If an applicant is denied waiver services, a written Notice of Action is sent detailing the reasons for denial and explains the individual's right to appeal this decision and right to a Medicaid Fair Hearing. Written notice will be provided at least 10 days prior to a participant's waiver services being decreased, suspended or terminated. The written notice will detail the reasons for the decision and explain the individual's right to appeal this decision and right to a Medicaid Fair Hearing.

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.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

- No. This Appendix does not apply**
 Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

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

The Division of Aging is responsible for managing complaints related to participants receiving services coordinated and administered by the DA.

- 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).

DIVISION OF AGING GRIEVANCE/ COMPLAINT SYSTEM

A. TYPES OF GRIEVANCES/COMPLAINTS THAT PARTICIPANTS MAY REGISTER

DA accepts complaints from any person or entity, when such complaints are related to, participants receiving services that are coordinated and administered by the Division of Aging.

Complaints not specific to the DA are referred to the appropriate entity (agency/division/authority).

B. PROCESS AND TIMELINES FOR ADDRESSING GRIEVANCES/ COMPLAINTS

Complaints are acted upon by the QA/QI Unit in accordance with the nature of the complaint. Issues that immediately affect a participant's health and welfare are entered as incidents and classified as "Sentinel". This classification requires an immediate response and follow-up until the incident is resolved. A detailed description of resolution activities is provided in Appendix G-1d. An issue would be identified as a complaint only when there is not an immediate impact on the participant.

CRITICAL/Not Immediate - affecting participant's health and welfare; require a 4 day response time.

URGENT- serious problem, but not affecting participant's health and welfare; require a 7 day response time.

STANDARD- general complaint with no critical or urgent impact; require a 21 day response time.

Complaints will be resolved through

- direct contact/ interviews with the complainant, service provider and other entities, as necessary
- documentation review, as necessary
- on-site visit, if indicated
- referral to the case manager for follow up -including the participant freedom of choice to select other providers

C. MECHANISMS THAT ARE USED TO RESOLVE GRIEVANCES/ COMPLAINTS

Complaints may require specific action by the DA as required by State and Federal law, regulation or policy depending on the type of complaint.

Complaints concerning licensed providers quality of care issues will be referred to the State Department of Health as appropriate within four (4) business days.

Complaints alleging fraudulent billings or falsified time records will be researched through claims management and referred to Program Integrity/Service Utilization Review, as appropriate, for follow-up or action within four (4) business days.

Systemic complaints may be referred to internal FSSA investigators or the Attorney General s office for consumer protection.

When there is not timely resolution; additional actions may be taken including:

- a request for a provider corrective action plan within two weeks
- a formal provider review within 30 days
- a hold (up to 60 days) on new referrals while corrective action/ formal review takes place
- termination of the provider agreement for non-compliance after 60 day notice

CLOSING THE GRIEVANCE/ COMPLAINT

The complaint will be closed by the QA/QI Unit when the participant s needs have been addressed. The participant (or individual filing the complaint on participant s behalf) will be notified in writing (or e-mail when available) of the resolution and closure.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

- Yes. The State operates a Critical Event or Incident Reporting and Management Process** (complete Items b through e)
- No. This Appendix does not apply** (do not complete Items b through e)
If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

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

Indiana s 455 IAC 2 requires all providers of HCBS waiver services, including case managers, to submit incident reports to the DA when specific events occur. The nature of these events is defined as an unusual occurrence

affecting the health and safety of an HCBS participant.

Events which must be reported include, but are not limited to:

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

All service providers, including case managers, with knowledge of an incident event are required to submit an incident report through the DA web-based Incident Reporting system. If web access is unavailable, incidents can be reported to the DA by telephone, e-mail or fax. Recent changes to the incident reporting system allow for incident submission with less required information. This enhancement makes the system more accessible to participants, family members and direct caregivers.

Additionally, 455 IAC 2 requires reporting of known or suspected abuse, neglect, or exploitation (A-N-E) of an adult to Adult Protective Services. A twenty-four (24) hour hot-line connected to the statewide Adult Protective Services (APS) system is available for this reporting, or reports can be made to the local APS or County Prosecutor's office. A toll-free twenty-four (24) hour number is available through Indiana Department of Child Services (DCS) for reporting child abuse, neglect or exploitation.

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

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

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

As a part of the service plan process, participants, family members and/or legal guardians are advised by the case manager via written materials of the DA's abuse, neglect and exploitation reporting procedures. The case manager will discuss the information concerning who to contact, when to contact and how to report incidents with all persons involved in service plan development. The age appropriate toll-free hotline number is written inside of the 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.

- 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 received by the DA via a secure web-based reporting system which links to the electronic incident database. Incident reporting contract staff process the incidents within one (1) work day of receipt of the reports. Processing each report includes coding the incident by Type, Apparent Cause, Resources Utilized and when applicable, Perpetrator, sub-type(s), and Outcome. Reviewers also determine what level of follow-up is required, if any, and send notifications to the case manager, DA, and provider of specific required actions.

Required actions may include:

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

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

All incidents which are not resolved require case manager follow-up and reporting every seven (7) days until the incident is determined by the incident reviewer to be resolved. Follow-up reports are also submitted via the web-based incident reporting system.

Aggregated incident data is reviewed by the QA/QI Unit and the QA Committee to determine patterns which may result in required plan of corrections from providers, enhanced service provision for participants, or other modifications or enhancements to the waiver program.

The DA forwards geographic specific reports to each case management entity to aid them in tracking unresolved incident reports. Unresolved reports are monitored weekly by the DA.

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

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

The 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 a case manager, a referral to another entity, or a systemic recommendation; or
- close a case with no recommendation(s).

- 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 incidents is the direct responsibility of the Division of Aging. The web-based incident reporting system is augmented with e-mail tracking and cc-ing to DA's QA staff. QA staff are notified daily of all reports of A-N-E and death.

Additional reports track:

- Non-resolved Reports generated weekly to DA QA staff with area-specific reports to the AAAs and independent case managers
- Incidents by Type report reviewed by the QA/QI Committee
- Sentinel Status report Identifies not-resolved and days-to-resolve A-N-E and other critical incidents reviewed by the QA/QI Committee.
- Statewide and Area-specific Dashboard Reports identify number of total incidents, deaths, and A-N-E reports, with year-by-year comparisons. Reviewed on-demand and at each QA/QI Committee meeting

The QA/QI Committee reviews incident reporting data at each meeting. In addition to the DA QA Unit staff, the QA/QI Committee includes OMPP representatives, APS Program Director, and the Waiver Unit designee. Contractor staff who initially review the web-based incident reports are also represented on the committee.

Appendix G: Participant Safeguards

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

a. Use of Restraints or Seclusion. *(Select one):*

The State does not permit or prohibits the use of restraints or seclusion

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

The DA prohibits the use of restraints or seclusion in the provision of services regardless of the waiver setting. Reporting of prohibited restraint and/or seclusion usage by a provider is reported through the web-based incident reporting system.

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

The Division of Aging has responsibility for oversight that these prohibitions are enforced. Case managers are responsible for initial oversight of participant's care, the thirty (30) day follow up and the ninety (90) day face-to-face review of the care plan. These reviews will be utilized as opportunities to monitor for any prohibited restraint usage or seclusion of the participant.

The use of restraints or seclusion 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 or Seclusion.** 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 or 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 restraints or 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-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

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:

The DA prohibits the use of restrictive interventions by its service providers regardless of the waiver setting. Reporting of prohibited usage of restrictive interventions by a provider is reported through the web based incident reporting procedure.

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

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

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

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

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

Appendix G: Participant Safeguards

Appendix G-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 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 and Adult Family Care (AFC) service and may include Adult Day Services (ADS) when participants have medications that must be consumed during the times they are attending the ADS. These providers are responsible for the medication management and all necessary follow ups to ensure the health and welfare of the individuals within their care. Additionally, medication administration / management is allowed only within the scope of the practice for the delivery of the medications. In Indiana, medication management and oversight may include reminders, cues, opening of medication containers or providing assistance to the participant who is competent, but otherwise unable to accomplish the task.

AL, ADS and AFC waiver providers must include in their waiver provider application the procedures and forms they will use to monitor and document medication consumption. These providers must also adhere to the DA 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 DA's Incident Reporting (IR) policies and procedures related to unusual occurrences which includes medication errors. All approved waiver providers that are responsible for medication management are

required to report specific medication errors as defined in DA's incident reporting policy to the Division of Aging (DA). Additionally, AL providers licensed by the Indiana State Department of Health (ISDH) must also report medication errors to the ISDH. Please refer to Appendix G1-b for specific details regarding the IR process.

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 administration 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.

The case manager conducts a face-to-face visit with the participant at least every ninety (90) days to assure all services, including medication management, are within the expectations of the waiver program. Additionally, non-licensed providers will be surveyed by the DA, 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 case managers, DA 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. Case managers review services, including medication management, during their 90 day participant service plan review. Additionally, other scheduled visits to participants using AL, AFC and ADS services are conducted by the QA Liaison staff.

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

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

- ii. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws,

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

In Indiana, 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). Waiver providers that are not licensed by ISDH are restricted to medication management services. Waiver providers licensed by ISDH 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 management are required to report specific medication errors as defined in DA's incident reporting policy to the Division of Aging (DA). AL waiver service providers must also report medication errors to the Indiana State Department of Health (ISDH).

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

AL waiver service providers, by ISDH regulation, 410 IAC 16.2-5-4(e)(7), any error in medication shall be noted in the resident's record. All approved waiver providers that are responsible for medication management are required to record medication errors in the participants' record as per DA's IR policy.

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

For AL waiver providers, the facilities are required to report to ISDH any unusual occurrences which may include medication errors if it directly threatens the welfare, safety or health of a resident as per 410 IAC 16.2-5-1.3(g)(1). The current ISDH policy on unusual occurrences includes the reporting of medication errors to ISDH that caused resident harm or require extensive monitoring for 24-48 hours. Waiver providers that are responsible for medication management must report medication errors in accordance with the DA's IR policy which includes errors of wrong medication, wrong dosage, missed dosage or wrong route.

- 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.

ISDH has responsibility for monitoring the licensed providers through survey and compliance review processes. Additionally, DA gathers data through incident reporting, complaints, provider surveys, and mortality review which is reviewed by the QA/QI committee. Identified problems with medication administration involving licensed waiver providers are referred to ISDH. The QA/QI committee reviews and reports medication administration error trends to the DA executive staff for further remedial action as deemed necessary.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

G.1 Number and percent of sentinel incidents, including abuse, neglect, and exploitation (A-N-E), that are monitored to appropriate resolution. Numerator: Number of sentinel incidents of sentinel incidents, including abuse, neglect, and exploitation (A-N-E), that are monitored to appropriate resolution. Denominator: Number of Sentinel Incidents reported.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Sentinel Resolution 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>

	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

G.2 Number and percent of participants that report they are free from abuse, neglect, and exploitation (A-N-E). Numerator: Number of participants that report they are free from abuse, neglect, and exploitation (A-N-E). Denominator: Number of participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

G.2a 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>

<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

G.2b Person Centered Compliance Tool (PCCT)

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95
<input checked="" type="checkbox"/> Other Specify: QA Contractor	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Statistically valid sample was proportioned across AAAs to assure mixture of rural and urban populations. Distribution was based upon each geographic area's percentage of the

		total waiver population.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QA Contractor	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

G.3 Number and percent of active participants with 90 Day Reviews indicating primary care is being provided. Numerator: Number of participants indicating primary care was received in the previous 12 months as reflected in the 90 day review Denominator: Number of active participants reviewed.

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

		Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

G.4 Number and percent of participants indicating their health care needs are being addressed. Numerator: Number of participants indicating their current health care needs are being addressed as reflected in the 90 Day Review. **Denominator:** Number of participants reviewed.

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	

		<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

G.5 Number and percent of participants whose acute health needs are addressed in a timely manner. Numerator: Number of participants whose acute health needs are addressed in a timely manner. Denominator: Number of participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Person Centered Compliance Tool (PCCT)

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95
<input checked="" type="checkbox"/> Other Specify: QA Contractor	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Statistically valid sample was proportioned across AAAs to assure mixture of rural and urban populations. Distribution was based upon each geographic area's percentage of the total waiver population.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QA Contractor	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

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

The state utilizes various electronic reports, generated on a monthly basis, which directly relate to the performance measures identified in the approved waiver. Each negative finding is individually researched by the DA QA/QI unit to determine if the problem or issue has been resolved. If existing documentation does not indicate resolution, QA/QI unit personnel initiate remediative actions, usually by contacting the waiver case manager. The QA/QI unit is responsible for verifying that corrective actions are completed.

b. Methods for Remediation/Fixing Individual Problems

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

The DA monitors participant safeguards using a variety of internal reports and service site reviews conducted by a quality assurance contractor. When a Service Reviewer identifies a negative finding, they implement a formal remediation process which requires a Corrective Action Plan (CAP) be submitted by the appropriate provider within a two-week time period, with approval or denial by the Reviewer under supervision of the DA. If a CAP is denied, the provider is required to re-submit it. Once approved, the Reviewer verifies successful implementation of the CAP. Any provider not successfully completing the CAP process is referred to the DA for handling as a formal complaint. The complaint process can result in sanctions up to and including termination as a provider. Any provider who is decertified as a result of failing to complete corrective actions will be notified of the decision, and of their right to appeal. If any participant's services are directly impacted by the suspension or termination of a provider, the case manager will be directed to assist the participant in choosing a new provider and the operating agency will assist in expediting this change.

The State seeks to assure safeguards for all participants, but respects individual participant's choices regarding lifestyle and tolerance for risk. In some cases, the case manager may be encouraged to work with the participant to develop a formal "acceptable risk agreement". When a participant chooses an unacceptable level of risk and there is reason to believe the participant's ability to make decisions is compromised, the CM will be directed to contact APS.

G.1: The Division of Aging (DA) has a highly structured system for reporting, reviewing and tracking resolution of critical incidents. All reports of abuse, neglect and exploitation (ANE) are designated as "Sentinel Events" and each member of the DA QA Unit, including the APS Program Director, is notified. Sentinel incidents are tracked electronically and monitored by the DA QA Supervisor to ensure that immediate protective measures have been put in place. A separate report monitors this process to assure all critical incidents are appropriately resolved. When negative findings are identified, the QIS Program Director alerts the QA Supervisor who reviews the incident documentation, contacting the case manager (CM) or other entities to ascertain the incident status. If emergency protective measures have not been put in place, the QA Supervisor assists the CM in developing a plan to implement measures within 48 hours. This may involve working with APS to obtain protective orders, changing providers, modifying the service plan, or other measure as appropriate. Failure to report or respond to an incident of ANE will result in referral for handling as a formal complaint with the potential of sanctions up to and including termination as a provider.

G.2: In addition to requiring incident reports for allegations and suspicion of ANE, the DA includes

monitoring of ANE through the 90 Day Review and the Person Centered Compliance Tool (PCCT). Identification of a participant for who the 90 Day Review reflects that they are not free from ANE will result in a review of casenotes, incident reports and other available documentation to determine the circumstance of the finding and whether or not corrective actions have been taken. If corrective actions have not already been taken, the DA QIS Program Director will contact the CM to initiate steps toward assuring the participant's health, safety and welfare. Any remediation action will respect the participant's rights to make individual life choices when they are able to do so. Specific remediations for this measure vary greatly as participant choice, prior interventions and innumerable life circumstances may prompt a negative response on the tool used for this measure. The State will require a formal incident report to DA and APS for any incident, suspicion or allegation of ANE which was not previously reported.

When specific PCCT probes reveal negative findings indicating an unresolved environment or occurrence of ANE, or failure of provider to respond appropriately to an ANE allegation or occurrence, the PCCT Reviewer implements the formalized CAP process detailed above and requires submission of an incident report, if not already submitted. The Reviewer also notifies the DA and APS if this has not already occurred.

G.3 and G.4: Identification of a participant who reports that they have not had primary medical care services or lack care for general health needs results in a review of casenotes to determine if corrective actions have been implemented by the CM, family or provider(s). If corrective measures have not been initiated, the DA QIS Program Director will contact the CM to initiate steps toward assuring access to appropriate medical care. When a participant chooses not to obtain adequate levels of healthcare, the CM is instructed to fully inform the participant of the risks and consequences of this choice.

G.5: When specific PCCT probes reveal findings that a participant's acute health needs are not appropriately addressed, the PCCT Reviewer implements the formal remediation/CAP process to address the unmet need. When a participant chooses not to obtain adequate care for acute health needs, the CM is instructed to fully inform the participant of the risks and consequences of this choice.

ii. Remediation Data Aggregation

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

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

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 2)

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 QMS 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;
- 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 QMS* 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 QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

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

Initial analysis of discovery data is conducted by various DA program staff and contract staff as part of their day-to-day activities. This discovery data is obtained from the following activities and sources:

Electronic Case Management Database queries

The DA utilizes several electronic case management 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.

Incident review

The DA requires all waiver service providers to report critical incidents via a web-based submission tool. All reports are processed by contracted incident review staff within one working day of receipt. Processing entails coding reports by type, designation of sentinel events, determining whether or not follow-up is required, assuring that all events or allegations of abuse, neglect or exploitation are reported to APS or CPS appropriately, and directing notifications to involved entities. Follow-up reports, when required, are due from the case manager within 7 days of the processing date, at which time the review staff may close the incident or require additional follow-up. All reports of actual or alleged ANE are designated as sentinel events and forwarded to the DA for additional review in addition to the required submission to APS/CPS.

Mortality Review

All incident reports of waiver participants deaths are forwarded to the DA Quality Assurance team 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.

Complaints System

The DA operates a complaint hot-line and all complaints are tracked and addressed by designated DA staff.

Person-Centered Compliance Tool (PCCT)

A statistically valid random sample of waiver program participants is visited each year for the purpose of completing the PCCT. This service review tool is used to validate the receipt of appropriate services and determine the overall satisfaction the consumer has with delivered services, formal and informal supports, access to services and opportunities outside the home, and freedom from abuse, neglect and exploitation. The collection of this information involves a review of service documentation and staff training related to the subject participant, and if found deficient, will result in a corrective action plan (CAP) process for the provider. Meetings are held monthly with the QA contractor to discuss their on-site reviews and participant findings.

Provider Compliance Tool (PCT)

The PCT review involves a service review visit to each non-licensed/non-certified provider at least one time every three years to establish that the provider continues to meet all provider requirements contained in 455 IAC 2. Additional provider reviews may be authorized by DA administration as warranted by complaints, critical incidents, or other extenuating circumstances. 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. Meetings are held monthly with the QA contractor to discuss their on-site reviews and provider findings.

QA Contractor Quarterly Report

Provides aggregation, analysis and summarization of PCCT and PCT review findings conducted in the preceding quarter, along with remediation activities and results.

Indiana State Department of Health (ISDH) licensure monitoring

The DA and ISDH work cooperatively to assure that licensed providers continue to meet all waiver requirements. Licensed providers are reviewed each year for a compliance review. 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

The DA and OMPP have 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 DA Quality Assurance Unit staff and is provided to the OMPP and QA/QI Committee for trend analysis and remediation of systemic issues. Remediation of individual findings is initiated immediately at the program and service level.

The QA/QI Committee is composed of DA QA/QI Unit staff, including the APS program director and liaison, and representatives from the OMPP, the incident processing contractor, Case Management representative and the DA Waiver Unit. The QA/QI Committee 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. The Committee also reviews reports and descriptions of best-practice quality improvement approaches from other states. QA/QI Committee recommendations for system improvements will be researched and developed into proposals by the Waiver QIS Work Group for consideration by the DA Management Group.

SYSTEM IMPROVEMENT and DESIGN

The DA Management Group includes upper management personnel from DA and OMPP, and may include legal representation. The group's role 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.

Proposals for system improvements are considered by the DA Management Group. The Management Group may assign research, design or implementation activities back to QA staff, the Waiver QIS Work Group, other DA or 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;
- ability to measure results and outcomes of system improvements;
- organizational will: Are the necessary system actors motivated to implement desired changes?

The Division of Aging and OMPP are sensitive to the complexities of the service delivery system and the profound impact that change can have on both that system and on the individuals 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;
- abide by existing State protocols for approval, development and implementation of new policies, technologies and general practices.

Decisions regarding changes to the waiver program will be documented in meeting notes and minutes which will be distributed internally to OMPP, the DA Waiver Unit and the DA QA/QI Unit, as well as other members of the Management Group. The DA Waiver Unit will have primary responsibility for implementing changes as directed by the DA Management Group, and for communicating changes to stakeholders. Documentation of communication to external stakeholders will be maintained within the electronic case management database.

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.

ii. System Improvement Activities

Responsible Party(<i>check each that applies</i>):	Frequency of Monitoring and Analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Other Specify: <input type="text"/>

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.

The DA utilizes several electronic case management database applications which provide routine reports on various performance indicators in addition to allowing for on-demand report generation. These reports provide key data and allow the DA QA/QI Unit to monitor and assess the outcome and effects of system design changes.

The DA and OMPP have 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 DA QA/QI Unit's QIS Program Director. This information is disseminated throughout the DA QA/QI Unit and is provided to OMPP and the QA/QI Committee for review and analysis. These entities assess the outcome of system design changes through comparison of current and past performance measure results. Findings are then used to assess the need for additional changes or refinement, in continuation of the quality improvement cycle.

Lessons learned from these activities will be communicated internally by the DA QA/QI Unit to the DA Waiver Unit and the DA Management Group, and externally to Case Management and provider entities at regional training and update meetings conducted by the DA for these groups.

- 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 the focal point for incoming data is the DA QA/QI Committee, this committee will have primary, but not exclusive, responsibility for analyzing QIS system performance. The committee will assess the reliability of the information presented to it by comparing the consistency of performance measurements across various perspectives. For example, results from incident reporting can be compared to health and safety data collected in the electronic case management database and results from the PCCT. Trend analysis may suggest more effective or more targeted performance measures, or reveal emerging risks which may not have been monitored previously.

As many of the data collection and analysis tools are electronic in nature, the committee will review opportunities to integrate new technology into the QIS. The committee 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 the Committee. The QA/QI Committee will formally review the QIS at least annually, and make recommendations for changes or improvements to the DA Management Group.

The DA Management Group will assess the recommended changes and improvements and coordinate with internal advisory and regulatory groups such as Rules Committee or Technology Committee to evaluate and authorize potential changes. Once a change is approved, the DA Management Group will in most cases authorize the appropriate office to implement the approved changes, in coordination with the Waiver Work Group.

Modifications to the Quality Improvement Strategy will be submitted annually with the 372 report.

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).

a) Annual Independent Financial Audits are contractually required of all Area Agencies on Aging that provide waiver services. These independent financial audits include the single state audit requirement for compliance with OMB Circular A133. The entities that conduct independent financial audits are accounting firms operating in Indiana and are hired by the Area Agencies on Aging to perform the audit.

(b) The Indiana State Board of Accounts is responsible for the state's financial audit program. As an agency of the executive branch, the State Board of Accounts audits the financial statements of all governmental units within the state, including cities, towns, utilities, schools, counties, license branches, state agencies, hospitals, libraries, townships, and state colleges and universities. The Indiana State Board of Accounts, as part of the audit process, renders opinions on the fairness of presentation of the various units financial statements in accordance with the same professional auditing standards required of all independent audit organization. Investigatory audits are performed to reveal fraud or noncompliance with local, state and federal statutes. (IC 5-11).

Approximately forty state units receive federal assistance. In addition to compliance with state statutes and regulations, these units are required to comply with specific federal regulations. The State Board of Accounts is required to annually audit the federal programs in compliance with the OMB Circular A-133, Audits of State, Local Governments, and Non-Profit Organizations. The staff at the State Board of Accounts must continually be aware of changing regulations to ensure proper audit coverage.

Medicaid is a unit that receives financial assistance. The State Board of Accounts annually reviews components of the Medicaid program.

Providers in accordance with their service agreement must maintain for the purposes of the service agreement an accounting system of procedures and practices that conforms to Generally Accepted Accounting Principles (GAAP).

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

The State of Indiana employs a hybrid Program Integrity (PI) approach to oversight of the waiver programs, incorporating oversight and coordination by a dedicated waiver specialist position within the Surveillance and Utilization Review (SUR) Unit, as well as engaging the full array of technology and analytic tools available through the Fraud and Abuse Detection System (FADS) Contractor arrangements. The Office of Medicaid Policy and Planning (OMPP) has expanded its PI activities using a multi-faceted approach to SUR activity that includes provider self-audits, desk audits and on-site audits. The FADS team analyzes claims data allowing them to identify providers and/or claims that indicate aberrant billing patterns and/or other risk factors.

The PI audit process utilizes data mining, research, identification of outliers, problematic billing patterns, aberrant providers and issues that are referred by other divisions and State agencies. In 2011, the State of Indiana formed a

Benefit Integrity Team comprised of key stakeholders that meets bi-weekly to review and approve audit plans, provider communications and make policy/system recommendations to affected program areas. The SUR Unit also meets with all waiver divisions on a quarterly basis, at a minimum, and receives referrals on an ongoing basis to maintain open lines of communication and aid in understanding specific areas of concern such as policy clarification.

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

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

The SUR Unit offers education regarding key program initiatives and audit issues at waiver provider meetings to promote ongoing compliance with Federal and State guidelines, including all Indiana Health Coverage Programs (IHCP) and waiver requirements. Detailed information on SUR policy and procedures is available in the Medicaid Provider Manual Chapter 13: Utilization Review posted at:

www.indianamedicaid.com.

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

The State's Medicaid Management Information System (MMIS) is used for claims payment submitted by approved waiver providers. The MMIS only reimburses waiver services that have been approved on an appropriate plan of care. Providers submit claims via the MMIS. The electronic case management database system sends authorization for specific units of services to the claims payment system. The claims payment system pays only those claims that meet all authorization requirements. The Indiana Medicaid fiscal intermediary uses system edits and audits to make the appropriate reimbursement for services. When an audit shows a misuse of funds, the State recoups the money from the provider.

(c) The Family and Social Services Administration Audit Unit is responsible for the annual review of services and billing performed by the Area Agencies on Aging with full reporting to the Office of Medicaid Policy and Planning and the Division of Aging.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability

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. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

I.1 Number and percent of claims paid during the review period according to the published service rate. Numerator: Number of claims paid during the review period according to the published service rate. Denominator: Number of claims submitted during the review period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Medicaid Management Information System claims data

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="text"/>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

I.2 Number and percent of claims paid during the review period for participants enrolled in the waiver on the date that the service was delivered. Numerator: Number of claims paid during the review period for participants enrolled in the waiver on the date that the service was delivered. Denominator: Number of claims submitted during the review period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Medicaid Management Information System claims data

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

I.3 Number and percent of claims paid during the review period for services that are specified in the participant's approved service plan. Numerator: Number of claims paid during the review period due to services having been identified on the approved service plan. Denominator: Number of claims submitted during the review period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Medicaid Management Information System claims data

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

	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

The State assures financial accountability through a systematic approach to the review and approval of services that are specifically coded as waiver services within the waiver case management system and the MMIS. The MMIS links to the waiver case management system in order to ensure that only properly coded services, that are approved in an individual's plan of care, are processed for reimbursement to providers who are enrolled Medicaid Traumatic Brain Injury providers.

The DA receives monthly printouts from the Medicaid MMIS contractor listing the claims that have been reimbursed for individual participants. DA reviews this information to identify any issues in relationship with expectations for approved plans of care. This may include identifying issues of possible under or over utilization of monthly services for followup. DA investigates these issues and may refer them for followup under the Medicaid Surveillance Utilization Review program. Identified problems requiring further resolution are shared with OMPP as applicable.

When a need for systems change is identified by the OMPP Operations and Systems Unit or imbedded quality staff, a process is in place to address the issue. The issue is referred to the Change Control Board for action.

b. Methods for Remediation/Fixing Individual Problems

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

I.1, I.2, and I.3 The performance measures in this Appendix will result in a percentage of errors as claims appropriately deny or adjust for valid reasons as addressed in the automated remediation process built into the MMIS.

As part of processing a claim, the MMIS performs electronic edit checks disallowing payments that do not meet criteria for billing HCB waiver services.

When the MMIS receives a claim for waiver services, it first verifies that the required fields of the standard claim form are complete and that the information included in these fields is valid. The claim is validated against member and provider files to ensure their Medicaid enrollment is active on the date the services were rendered.

Next the claims are subjected to pricing review. The claim pricing process calculates the Medicaid-allowed amount for claims based on claim type, published service rate and the member service authorization on file.

Additional system checks are in place to ensure that providers do not perform excessive or unnecessary services without prior approval. If the claim fails any of the system edits, the claim may be systematically denied, cutback or suspended.

If a provider bills more than the published service rate, the MMIS will systematically cut back payment of a claim to pay no greater than the published service rate. Claims requiring medical policy review are placed in a suspended status by the MMIS. The Resolutions Unit (staff of the fiscal contractor) examines suspended claims and makes a decision based on approved adjudication guidelines for the date of service. The approved guidelines indicate the course of action that must be taken for each edit. These guidelines are based on the medical policies established by the OMPP. Suspended claims are reviewed within 30 days. Documentation and records are not requested from the provider during this process.

Resolutions Unit team members have the following options when processing suspended claims, depending on the edit or audit failed:

- Add or change data (only used when the claim is suspended due to data entry errors by HP)
- Force the claim to process by overriding the edit
- Deny the claim
- Put the claim on hold (used when there is a system problem or a pending policy decision)
- Resubmit the claim to MMIS for reprocessing

Providers receive a weekly Remittance Advice (RA) statement about the status of processed claims. The provider should review the reasons the claim was returned, make the appropriate corrections, and then resubmit the claim for processing consideration.

Providers must submit all claims for services rendered within one year of the date of service. When submitting claims beyond the one-year filing limit, the provider can submit the claim electronically or on paper with documentation for justification.

Claims reimbursement issues may be identified by a case manager, the public, a provider, contractor, or state staff. Such inquiries are directed to communicate the issue using one of the following avenues.

Customer Assistance
1-800-577-1278 or
(317) 655-3240 in the Indianapolis local area

Written Correspondence
P.O. Box 7263
Indianapolis, IN 46207-7263

or via email to the OMPP Policy Consideration Unit at Policyconsideration@fssa.in.gov

Provider Relations field consultant
View a current territory map and contact information online at indianamedicaid.com

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

If the issue is identified as a systems issue, the OMPP Data Unit will extract pertinent claims data to verify the problem and determine if correction is needed. If the problem indicates a larger systemic issue, it is referred to the Change Control Board for a systems fix.

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

ii. Remediation Data Aggregation

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

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

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 Division of Aging in collaboration with the Office of Medicaid Policy and Planning reviewed the rate structure for all waivers including the Traumatic Brain Injury waiver in FY 2007. The Division of Aging and the Office of Medicaid Policy and Planning collaborated with the Indiana Association for Home and Hospice Care and the Indiana Association of Area Agencies on Aging regarding the waiver rate reviews. 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.

Rates are set by establishing state-wide fee-for-service rates. There are rate differentials based upon whether the provider is an agency or non-agency (individual) provider. Non-agency provider's rates are less than agency rates based upon less administrative and general incurred expenses than agency provider rates.

The Division of Aging reviews waiver rates bi-annually. The Division of Aging and the Office of Medicaid Policy and Planning will continue to collaborate on any revisions made to the Traumatic Brain Injury waiver rates. The Division of Aging and the Office of Medicaid Policy and Planning will continue to collaborate with the Indiana Association for Home and Hospice Care and the Indiana Association of Area Agencies on Aging regarding future rate changes.

Notifications of any rate changes are posted to the Division of Aging's OPTIONS website and are available via the Office of Medicaid Policy and Planning's website: www.indianamedicaid.com. All other providers are notified of rate changes through banner pages; bulletins; and newsletters as prepared by the Division of Aging in collaboration with the Office of Medicaid Policy and Planning and distributed by the Office of Medicaid Policy and Planning's fiscal agent contractor.

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

Claims for TBI waiver services flow directly from the providers to the Indiana Medicaid Management Information System and payments are made via Medicaid's contracted fiscal agent.

Appendix I: Financial Accountability

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

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

- No. State or local government agencies do not certify expenditures for waiver services.**
- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

- Certified Public Expenditures (CPE) of State Public Agencies.**

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

- Certified Public Expenditures (CPE) of Local Government Agencies.**

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

Appendix I: Financial Accountability

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

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

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

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

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

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

Documentation and verification of service delivery consistent with paid claims is reviewed during the post payment review of the operating agency as well as by the Office of Medicaid Policy and Planning when executing Surveillance Utilization (SUR) activities. Additional information about these reviews can be found in chapter 13 of the Indiana Health Coverage Programs Provider Manual at the following link:

<http://provider.indianamedicaid.com/ihcp/manuals/chapter13.pdf>

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 case 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 currently in the design phase of a new integrated case management system which will mirror the functions previously described with added features and increased process automation. The implementation of the new system is slated for the summer of 2013.

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

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

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

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

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

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

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

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

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

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

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

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

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

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

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

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

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

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

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

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

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

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

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

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

ii. Organized Health Care Delivery System. *Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

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

(e) how it is assured that OHCDs contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDs arrangement is used:

iii. **Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

- 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) (MCO) 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.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

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

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

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

- Other State Level Source(s) of Funds.**

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

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

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

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

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

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

Other Local Government Level Source(s) of Funds.

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

Appendix I: Financial Accountability

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

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

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

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

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

Appendix I: Financial Accountability

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

a. Services Furnished in Residential Settings. *Select one:*

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

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

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

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

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

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

Appendix I: Financial Accountability

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

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

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C -3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

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

Appendix I: Financial Accountability

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

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

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

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

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

- Nominal deductible
- Coinsurance
- Co-Payment
- Other charge

Specify:

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

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

Appendix I: Financial Accountability

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

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

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

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

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-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

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

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	30021.34	26621.06	56642.40	57999.86	5969.11	63968.97	7326.57
2	30526.07	27743.32	58269.39	59739.86	6244.16	65984.02	7714.63
3	31091.36	28913.81	60005.17	61532.06	6532.26	68064.32	8059.15
4	31689.90	30134.50	61824.40	63378.02	6834.04	70212.06	8387.66
5	32176.02	31407.46	63583.48	65279.36	7150.17	72429.53	8846.05

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 Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		Nursing Facility	ICF/MR
Year 1	200	146	54
Year 2	200	146	54
Year 3	200	146	54
Year 4	200	146	54
Year 5	200	146	54

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.

Based on historical lapse rates, approximately 7% of waiver enrollees are projected to lapse each year. An equal number of new entrants are projected to enter the waiver each year, maintaining the slot count at 200 for each of the five waiver years in the third renewal period.

Appendix J: Cost Neutrality Demonstration

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

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

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

The last complete waiver year, Waiver Year 4 of the current approved filing (January 2011 □ December 2011) was used as the base year. Values of Factor D for Waiver Year 1 through Waiver Year 5 of the Third Renewal (CY 2013 □ CY 2017) were projected from actual base year (2011) data as follows:

- The Number of Users of each service was adjusted based on projected slots.
- Average Units per User was adjusted based on average length of stay.
- Average Cost per Unit is inflated at an annual rate of 2% per year (reduced from the 3% rate increase assumption used for the prior filing).

Assisted Living Adjustments

Eight (8) TBI waiver recipients were assumed to utilize the new Assisted Living service during WY 1. The number of individuals using the service was assumed to increase by two individuals per year, growing to sixteen (16) by WY 5 of the renewal. The WY 1 cost for Assisted Living services was developed based on data from Division of Aging waiver recipients currently using this service. During WY 1, it was projected to be approximately \$18,500 per year per recipient.

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:

Values were developed based on actual claims experience from the base year, WY 4 of the current filing. Factor D' includes all State Plan services received by TBI waiver recipients while enrolled on the waiver. It was inflated at a rate of approximately 5% per year, consistent with the current Medicaid Forecast.

Enrollees using the new Assisted Living service are also projected to experience significantly reduced utilization of other state plan services, especially home health services. Utilization reductions were developed based on recent experience data from enrollees on the Aged & Disabled Waiver and the Money Follows the Person Grant.

Home health services cost per recipient were projected to have an annual trend of 6%, while other State Plan services were projected at an annual trend of 3%. The cost per recipient trends include both fee schedule and utilization increases.

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:

The current approved TBI waiver includes two levels of cares: Nursing Facility level of care with a primary TBI diagnosis and ICF/MR level of care with a primary TBI diagnosis. As with WY 5 of the current renewal, we have assumed that 54 of the 200 slots will be eligible for ICF/MR LOC, and the remaining slots meet eligibility for Nursing Facility LOC.

Factor G was developed based on actual institutional WY 4 claims experience, weighted by level of care. The base Nursing Facility cost factor was inflated at an annual rate of 3.0%. An additional one-time adjustment of approximately 7.2% was made to projected Nursing Facility average cost per recipient in order to take into account reimbursement changes implemented this year. Factor G was developed based on actual institutional WY 4 claims experience, weighted by level of care. The base Nursing Facility cost factor was inflated at an annual rate of 3.0%. An additional one-time adjustment of approximately 7.2% was made to projected Nursing Facility average cost per recipient in order to take into account reimbursement changes implemented this year.

The ICF/MR cost factor was inflated at an annual rate of 3.0%.

- 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:

Factor G' was developed based on actual Waiver Year 4 claims experience, weighted by level of care. Factor G' includes all State Plan services received by the respective comparison populations while institutionalized. This factor was trended at a rate of approximately 3% per year.

Appendix J: Cost Neutrality Demonstration

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

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

Waiver Services	
Adult Day Services	
Attendant Care	
Case Management	
Homemaker	
Residential Based Habilitation	
Respite	
Structured Day Program	
Supported Employment	
Adult Family Care	
Assisted Living	
Behavior Management/ Behavior Program and Counseling	
Community Transition	
Environmental Modifications	
Health Care Coordination	
Home Delivered Meals	
Nutritional Supplements	
Personal Emergency Response System	
Pest Control	
Specialized Medical Equipment and Supplies	
Transportation	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration

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

d. **Estimate of Factor D.**

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

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						26483.48
Adult Day Services	1/4 Hour	4	2969.00	2.23	26483.48	
Attendant Care Total:						3081710.88
Attendant Care	1/4 Hour	123	6096.00	4.11	3081710.88	
Case Management Total:						222000.00
Case Management	Month	185	12.00	100.00	222000.00	
Homemaker Total:						26784.12
Homemaker	1/4 Hour	11	788.00	3.09	26784.12	
Residential Based Habilitation Total:						1455838.86
Residential Based Habilitation	1/4 Hour	79	2581.00	7.14	1455838.86	
Respite Total:						433561.50
Respite	1/4 Hour	46	1775.00	5.31	433561.50	
Structured Day Program Total:						275424.08
Structured Day Program	1/4 Hour	23	3308.00	3.62	275424.08	
Supported Employment Total:						66169.44
Supported Employment	1/4 Hour	8	867.00	9.54	66169.44	
Adult Family Care Total:						14487.35
Adult Family Care	Day	1	205.00	70.67	14487.35	
Assisted Living Total:						147912.40
Assisted Living	Day	8	265.00	69.77	147912.40	
Behavior Management/ Behavior Program and Counseling Total:						168251.07
Behavior Management/ Behavior Program and Counseling	1/4 Hour	47	201.00	17.81	168251.07	
Community Transition Total:						1102.78
Community Transition	Unit	1	1.00	1102.78	1102.78	
GRAND TOTAL:						6004268.04
Total Estimated Unduplicated Participants:						200
Factor D (Divide total by number of participants):						30021.34
Average Length of Stay on the Waiver:						343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Modifications Total:						32999.75
Environmental Modifications	Unit	7	1.00	4714.25	32999.75	
Health Care Coordination Total:						58.78
Health Care Coordination	Month	1	1.00	58.78	58.78	
Home Delivered Meals Total:						20560.54
Home Delivered Meals	Meal	13	286.00	5.53	20560.54	
Nutritional Supplements Total:						499.45
Nutritional Supplements	Unit	1	7.00	71.35	499.45	
Personal Emergency Response System Total:						9679.36
Personal Emergency Response System	Unit	32	8.00	37.81	9679.36	
Pest Control Total:						453.90
Pest Control	Unit	1	1.00	453.90	453.90	
Specialized Medical Equipment and Supplies Total:						1986.15
Specialized Medical Equipment and Supplies	Unit	3	1.00	662.05	1986.15	
Transportation Total:						17561.30
Transportation	Trip	10	1163.00	1.51	17561.30	
Vehicle Modifications Total:						742.85
Vehicle Modifications	Unit	1	1.00	742.85	742.85	
GRAND TOTAL:						6004268.04
Total Estimated Unduplicated Participants:						200
Factor D (Divide total by number of participants):						30021.34
Average Length of Stay on the Waiver:						343

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						26704.28
Adult Day Services	1/4 Hour	4	2941.00	2.27	26704.28	
Attendant Care Total:						3111804.06
Attendant Care	1/4 Hour	123	6038.00	4.19	3111804.06	
Case Management Total:						226440.00
Case Management	Month	185	12.00	102.00	226440.00	
Homemaker Total:						27027.00
Homemaker	1/4 Hour	11	780.00	3.15	27027.00	
Residential Based Habilitation Total:						1470581.84
Residential Based Habilitation	1/4 Hour	79	2557.00	7.28	1470581.84	
Respite Total:						437495.88
Respite	1/4 Hour	46	1758.00	5.41	437495.88	
Structured Day Program Total:						278118.99
Structured Day Program	1/4 Hour	23	3277.00	3.69	278118.99	
Supported Employment Total:						66864.56
Supported Employment	1/4 Hour	8	859.00	9.73	66864.56	
Adult Family Care Total:						14634.27
Adult Family Care	Day	1	203.00	72.09	14634.27	
Assisted Living Total:						188600.50
Assisted Living	Day	10	265.00	71.17	188600.50	
Behavior Management/ Behavior Program and Counseling Total:						169944.01
Behavior Management/ Behavior Program and Counseling	1/4 Hour	47	199.00	18.17	169944.01	
Community Transition Total:						1124.84
Community Transition	Unit	1	1.00	1124.84	1124.84	
GRAND TOTAL:						6105214.48
Total Estimated Unduplicated Participants:						200
Factor D (Divide total by number of participants):						30526.07
Average Length of Stay on the Waiver:						343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Modifications Total:						33659.78
Environmental Modifications	Unit	7	1.00	4808.54	33659.78	
Health Care Coordination Total:						59.96
Health Care Coordination	Month	1	1.00	59.96	59.96	
Home Delivered Meals Total:						20786.35
Home Delivered Meals	Meal	13	283.00	5.65	20786.35	
Nutritional Supplements Total:						509.46
Nutritional Supplements	Unit	1	7.00	72.78	509.46	
Personal Emergency Response System Total:						9871.36
Personal Emergency Response System	Unit	32	8.00	38.56	9871.36	
Pest Control Total:						462.97
Pest Control	Unit	1	1.00	462.97	462.97	
Specialized Medical Equipment and Supplies Total:						2025.87
Specialized Medical Equipment and Supplies	Unit	3	1.00	675.29	2025.87	
Transportation Total:						17740.80
Transportation	Trip	10	1152.00	1.54	17740.80	
Vehicle Modifications Total:						757.70
Vehicle Modifications	Unit	1	1.00	757.70	757.70	
GRAND TOTAL:						6105214.48
Total Estimated Unduplicated Participants:						200
Factor D (Divide total by number of participants):						30526.07
Average Length of Stay on the Waiver:						343

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						27041.92
Adult Day Services	1/4 Hour	4	2914.00	2.32	27041.92	
Attendant Care Total:						3148637.64
Attendant Care	1/4 Hour	123	5981.00	4.28	3148637.64	
Case Management Total:						230968.80
Case Management	Month	185	12.00	104.04	230968.80	
Homemaker Total:						27294.63
Homemaker	1/4 Hour	11	773.00	3.21	27294.63	
Residential Based Habilitation Total:						1486795.01
Residential Based Habilitation	1/4 Hour	79	2533.00	7.43	1486795.01	
Respite Total:						442074.72
Respite	1/4 Hour	46	1741.00	5.52	442074.72	
Structured Day Program Total:						281460.66
Structured Day Program	1/4 Hour	23	3246.00	3.77	281460.66	
Supported Employment Total:						67603.44
Supported Employment	1/4 Hour	8	851.00	9.93	67603.44	
Adult Family Care Total:						14779.53
Adult Family Care	Day	1	201.00	73.53	14779.53	
Assisted Living Total:						230836.20
Assisted Living	Day	12	265.00	72.59	230836.20	
Behavior Management/ Behavior Program and Counseling Total:						172440.18
Behavior Management/ Behavior Program and Counseling	1/4 Hour	47	198.00	18.53	172440.18	
Community Transition Total:						1147.34
Community Transition	Unit	1	1.00	1147.34	1147.34	
GRAND TOTAL:						6218272.11
Total Estimated Unduplicated Participants:						200
Factor D (Divide total by number of participants):						31091.36
Average Length of Stay on the Waiver:						343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Modifications Total:						34332.97
Environmental Modifications	Unit	7	1.00	4904.71	34332.97	
Health Care Coordination Total:						61.16
Health Care Coordination	Month	1	1.00	61.16	61.16	
Home Delivered Meals Total:						20966.40
Home Delivered Meals	Meal	13	280.00	5.76	20966.40	
Nutritional Supplements Total:						519.61
Nutritional Supplements	Unit	1	7.00	74.23	519.61	
Personal Emergency Response System Total:						10071.04
Personal Emergency Response System	Unit	32	8.00	39.34	10071.04	
Pest Control Total:						472.23
Pest Control	Unit	1	1.00	472.23	472.23	
Specialized Medical Equipment and Supplies Total:						2066.37
Specialized Medical Equipment and Supplies	Unit	3	1.00	688.79	2066.37	
Transportation Total:						17929.40
Transportation	Trip	10	1142.00	1.57	17929.40	
Vehicle Modifications Total:						772.86
Vehicle Modifications	Unit	1	1.00	772.86	772.86	
GRAND TOTAL:						6218272.11
Total Estimated Unduplicated Participants:						200
Factor D (Divide total by number of participants):						31091.36
Average Length of Stay on the Waiver:						343

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						27328.80
Adult Day Services	1/4 Hour	4	2895.00	2.36	27328.80	
Attendant Care Total:						3186575.76
Attendant Care	1/4 Hour	123	5942.00	4.36	3186575.76	
Case Management Total:						235586.40
Case Management	Month	185	12.00	106.12	235586.40	
Homemaker Total:						27709.44
Homemaker	1/4 Hour	11	768.00	3.28	27709.44	
Residential Based Habilitation Total:						1505241.51
Residential Based Habilitation	1/4 Hour	79	2517.00	7.57	1505241.51	
Respite Total:						447517.44
Respite	1/4 Hour	46	1728.00	5.63	447517.44	
Structured Day Program Total:						284832.00
Structured Day Program	1/4 Hour	23	3225.00	3.84	284832.00	
Supported Employment Total:						68492.16
Supported Employment	1/4 Hour	8	846.00	10.12	68492.16	
Adult Family Care Total:						15000.00
Adult Family Care	Day	1	200.00	75.00	15000.00	
Assisted Living Total:						275724.96
Assisted Living	Day	14	266.00	74.04	275724.96	
Behavior Management/ Behavior Program and Counseling Total:						174106.80
Behavior Management/ Behavior Program and Counseling	1/4 Hour	47	196.00	18.90	174106.80	
Community Transition Total:						1170.28
Community Transition	Unit	1	1.00	1170.28	1170.28	
GRAND TOTAL:						6337980.48
Total Estimated Unduplicated Participants:						200
Factor D (Divide total by number of participants):						31689.90
Average Length of Stay on the Waiver:						344

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Modifications Total:						35019.60
Environmental Modifications	Unit	7	1.00	5002.80	35019.60	
Health Care Coordination Total:						62.38
Health Care Coordination	Month	1	1.00	62.38	62.38	
Home Delivered Meals Total:						21290.49
Home Delivered Meals	Meal	13	279.00	5.87	21290.49	
Nutritional Supplements Total:						530.04
Nutritional Supplements	Unit	1	7.00	75.72	530.04	
Personal Emergency Response System Total:						10270.72
Personal Emergency Response System	Unit	32	8.00	40.12	10270.72	
Pest Control Total:						481.68
Pest Control	Unit	1	1.00	481.68	481.68	
Specialized Medical Equipment and Supplies Total:						2107.71
Specialized Medical Equipment and Supplies	Unit	3	1.00	702.57	2107.71	
Transportation Total:						18144.00
Transportation	Trip	10	1134.00	1.60	18144.00	
Vehicle Modifications Total:						788.31
Vehicle Modifications	Unit	1	1.00	788.31	788.31	
GRAND TOTAL:						6337980.48
Total Estimated Unduplicated Participants:						200
Factor D (Divide total by number of participants):						31689.90
Average Length of Stay on the Waiver:						344

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						27570.40
Adult Day Services	1/4 Hour	4	2860.00	2.41	27570.40	
Attendant Care Total:						3212397.15
Attendant Care	1/4 Hour	123	5869.00	4.45	3212397.15	
Case Management Total:						240292.80
Case Management	Month	185	12.00	108.24	240292.80	
Homemaker Total:						27848.92
Homemaker	1/4 Hour	11	758.00	3.34	27848.92	
Residential Based Habilitation Total:						1518125.62
Residential Based Habilitation	1/4 Hour	79	2486.00	7.73	1518125.62	
Respite Total:						450452.24
Respite	1/4 Hour	46	1706.00	5.74	450452.24	
Structured Day Program Total:						287249.76
Structured Day Program	1/4 Hour	23	3186.00	3.92	287249.76	
Supported Employment Total:						69087.04
Supported Employment	1/4 Hour	8	836.00	10.33	69087.04	
Adult Family Care Total:						15070.50
Adult Family Care	Day	1	197.00	76.50	15070.50	
Assisted Living Total:						320204.80
Assisted Living	Day	16	265.00	75.52	320204.80	
Behavior Management/ Behavior Program and Counseling Total:						175795.04
Behavior Management/ Behavior Program and Counseling	1/4 Hour	47	194.00	19.28	175795.04	
Community Transition Total:						1193.69
Community Transition	Unit	1	1.00	1193.69	1193.69	
GRAND TOTAL:						6435203.24
Total Estimated Unduplicated Participants:						200
Factor D (Divide total by number of participants):						32176.02
Average Length of Stay on the Waiver:						343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Modifications Total:						35720.02
Environmental Modifications	Unit	7	1.00	5102.86	35720.02	
Health Care Coordination Total:						63.63
Health Care Coordination	Month	1	1.00	63.63	63.63	
Home Delivered Meals Total:						21414.25
Home Delivered Meals	Meal	13	275.00	5.99	21414.25	
Nutritional Supplements Total:						540.61
Nutritional Supplements	Unit	1	7.00	77.23	540.61	
Personal Emergency Response System Total:						10475.52
Personal Emergency Response System	Unit	32	8.00	40.92	10475.52	
Pest Control Total:						491.31
Pest Control	Unit	1	1.00	491.31	491.31	
Specialized Medical Equipment and Supplies Total:						2149.86
Specialized Medical Equipment and Supplies	Unit	3	1.00	716.62	2149.86	
Transportation Total:						18256.00
Transportation	Trip	10	1120.00	1.63	18256.00	
Vehicle Modifications Total:						804.08
Vehicle Modifications	Unit	1	1.00	804.08	804.08	
GRAND TOTAL:						6435203.24
Total Estimated Unduplicated Participants:						200
Factor D (Divide total by number of participants):						32176.02
Average Length of Stay on the Waiver:						343