

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

1. Request Information

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

B. **Program Title:**

Indiana PathWays for Aging (PathWays)

C. **Waiver Number:**IN.2407

D. **Amendment Number:**IN.2407.R00.03

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

12/31/25

Approved Effective Date of Waiver being Amended: 07/01/24

2. Purpose(s) of Amendment

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

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

- Adjust Money Follows the Person (MFP) Reserve Capacity estimates to align with 2025 MFP Budget Request
- Update waitlist management procedures
- Clarify Integrated Health Care Coordination (IHCC) is considered duplicative of MCE care coordination
- Clarify MCEs provide Community Transition Services for their enrollees
- Modify the policies regarding payment for waiver services furnished by LRIs, Relatives and Legal Guardians, including authorization of LRIs to receive payment for furnishing Attendant Care services and related limits for LRIs (aggregate 40 hours per week), Relatives and Legal Guardians (each 40 hours per week).
- Combine Home Modification and Home Modification Assessment Services
- Discontinue the Participant Directed Home Care Services (PDHCS) pilot and implement an updated model for select services
- Revise Structured Family Caregiving service definition to align service across waivers
- Update dollar value limitations for Community Transition service to reflect current limit of \$2,500.
- Update dollar value limitations for select services to reflect current limits
- Respond to new 1915(c) waiver application prompts to reflect current practice
- Restructure service definition format and make alignment changes across the service array
- Make miscellaneous updates and clarifications to various service definitions and related provider qualifications
- Update cost neutrality demonstration information
- Make technical changes to support alignment across multiple HCBS waivers operated and administered by the Indiana Family and Social Services Administration (FSSA)
- Align the use of National Core Indicators for performance measures with other waivers operated by FSSA
- Remove language regarding expedited waiver eligibility
- Update dollar value limitations for Community Transition service to reflect current limit of \$2,500

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
Waiver Application	1-G, 2, 4-C, 6-I, Attachment 1
Appendix A - Waiver Administration and Operation	
Appendix B - Participant Access and Eligibility	B-3-c, B-3-f
Appendix C - Participant Services	C-1/C-3, C-1-d, C-2-a, C-2-b, C-2-d, C-2-e, C-2-g, C-5
Appendix D - Participant Centered Service Planning and Delivery	D-1-a, D-1-c, D-1-d, Quality Improvement, D-2-a
Appendix E - Participant Direction of Services	E-1-a, E-1-c, E-1-d, E-1-e, E-1-f, E-1-g, E-1-i, E-1-j, E-1-l, E-1-m, E-1-n, E-2-a,
Appendix F - Participant Rights	F-1

Component of the Approved Waiver	Subsection(s)
Appendix G - Participant Safeguards	Quality Improvement
Appendix H	
Appendix I - Financial Accountability	
Appendix J - Cost-Neutrality Demonstration	J-1, J-2

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

Modify target group(s)

Modify Medicaid eligibility

Add/delete services

Revise service specifications

Revise provider qualifications

Increase/decrease number of participants

Revise cost neutrality demonstration

Add participant-direction of services

Other

Specify:

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 section 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*):

C. Type of Request: amendment

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

3 years 5 years

Waiver Number: IN.2407.R00.03

Draft ID: IN.018.00.03

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

E. Proposed Effective Date of Waiver being Amended: 07/01/24

Approved Effective Date of Waiver being Amended: 07/01/24

PRA Disclosure Statement

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

Hospital as defined in 42 CFR § 440.10

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

Inpatient psychiatric facility for individuals age 21 and under as provided 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:

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR § 440.140**Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)**

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

1. Request Information (3 of 3)

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

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

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

Waiver(s) authorized under section 1915(b) of the Act.

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

The PathWays 1915(b) waiver was approved effective July 1, 2024.

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

section 1915(b)(1) (mandated enrollment to managed care)

section 1915(b)(2) (central broker)

section 1915(b)(3) (employ cost savings to furnish additional services)

section 1915(b)(4) (selective contracting/limit number of providers)

A program operated under section 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 section 1915(i) of the Act.

A program authorized under section 1915(j) of the Act.

A program authorized under section 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.

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

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

Through PathWays, Indiana seeks to achieve the following:

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

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

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

3. Components of the Waiver Request

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

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

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

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

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

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

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

Yes. This waiver provides participant direction opportunities. Appendix E is required.

No. This waiver does not provide participant direction opportunities. Appendix E is not required.

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

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

H. Quality Improvement Strategy. Appendix H contains the quality improvement strategy for this waiver.

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

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

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in section 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 section 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 section 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 section 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 inpatients of a hospital, nursing facility or ICF/IID.

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

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

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

F. FFP Limitation. In accordance with 42 CFR Part 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. 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 Part 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:

The public comment period for this amendment was held for 37 days from July 9, 2025 through August 15, 2025. The comment period, which was initially scheduled to end on August 8, 2025, was extended by seven days. All official notices contained the correct email address for submitting comments; however, there was a discrepancy in the address listed in the amendment draft, as printed from the CMS Waiver Management System. To maintain consistency across all documentation and to ensure that any comments sent to an incorrect email address were considered, the extension was communicated to the public. Electronic copies of the public notice and draft amendment were posted on the FSSA webpage at <https://www.in.gov/fssa/public-notices/> and the Indiana Register website at <http://iac.iga.in.gov/iac/irtoc.htm>. Additionally, paper copies of the public notice and the entire amended waiver application were made available at local Division of Family Resources offices. The tribal consultation period was held for 60 days from July 2, 2025, through August 30, 2025. Additionally, three webinars were hosted at which FSSA presented a summary of the amended waiver applications and how to submit comments. The webinars were recorded and made available for replay on the FSSA website.

The state received 229 comments regarding the proposed PathWays waiver amendment. Comments are summarized below and are grouped by theme, followed by state response.

Attendant Care Services

A total of 39 comments were received regarding proposed changes to Attendant Care Services. As described further below, comments centered around: (1) the revised service definition and associated documentation requirements; (2) LRIs and associated “extraordinary care” requirements; and (3) the 40-hour per week limitations for “relative” providers.

Service Definition & Associated Documentation Comments

While several commenters recognized the importance of revising the service definition to ensure clarity and accountability in service delivery, many also expressed concern that narrowing the definition to primarily physical assistance would overlook essential non-medical supports such as cognitive, mobility, and communication assistance. They urged the state to restore key ADL/IADL supports—including redirection, cueing, and passive range of motion. Two commenters requested clarity on the definition of “hands-on assistance with nutrition,” questioning whether meal planning and preparation is limited to physical contact with food or includes supervision, cueing, and coaching for independence. One commenter believes transportation has not been appropriately included in the Attendant Care reimbursement rate and the state should either increase the rate to cover transportation or permit separate billing and mileage reimbursement. Another commended the state for including language indicating assistance with homemaking activities is allowable when incidental to the provision of hands-on care with ADLs. Multiple commenters expressed concern about the proposed changes requiring Attendant Care providers to document nine detailed data points and obtain both provider and service recipient signatures for each hour of service rendered. Commenters stated that such a change would be overly burdensome, was unrealistic given the nature of these services, exceed EVV system capabilities, shift direct support professional’s focus away from care delivery, and may increase provider operational costs. Finally, some commenters noted the requirement for state plan home health to be exhausted before Attendant Care services is inequitable and causes inappropriate delays, denials, and confusion; they further noted the state should reconsider the policy preventing a single caregiver from providing both home health aide and Attendant Care services.

State Response: While Attendant Care services do not address all supports referenced above, the service does provide assistance with mobility, including assistance with transfers, ambulation, proper body mechanics and use of assistive devices. Additionally, other Medicaid HCBS waiver services (such as Skilled Respite and Home and Community Assistance Services) and/or Medicaid state plan services (such as Home Health Services) can provide supports for redirection/cueing/prompting, managing mail, mobility, community participation, assistance with feeding tubes/catheters/ostomies. Individuals should work with their service coordinator/case manager to discuss their specific needs and identify appropriate Medicaid services to support those needs. The state is not modifying the Attendant Care service definition based on these comments.

Regarding the modified documentation requirements, the state’s intent for making these changes was to gain better insight into the activities and tasks addressed during each hour of authorized Attendant Care services and not to establish overly burdensome documentation requirements. OMPP agrees that the wording of the proposed changes could be interpreted to go beyond the state’s intent. The state has revised the Attendant Care documentation requirements to clarify that staff members are not required to record separate entries during each hour of service, but rather -- for each period of uninterrupted services -- staff must document allowable/reimbursable activities/tasks completed each hour. Additionally, this documentation requirement is separate and apart from providers’ EVV obligations. Providers may maintain the required documentation in their EVV system or in a separate service record for the individual.

State plan Home Health services must be used before reimbursing waiver Attendant Care services, as required by federal rules to avoid service duplication. Therefore, no changes will be made based on these comments.

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

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

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

7. Contact Person(s)

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

Last Name:

Wills

First Name:

Amanda

Title:

PathWays for Aging Manager

Agency:

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

Address:

402 West Washington Street, Room W374 (MS07)

Address 2:

City:

Indianapolis

State:

Indiana

Zip:

46204

Phone:

(317) 234-7428

Ext:

TTY

Fax:

(317) 234-5076

E-mail:

Amanda.wills@fssa.in.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Indiana

Zip:

Phone:

Ext:

TTY

Fax:

E-mail:

8. Authorizing Signature

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

Signature:

BRIAN GILBERT

State Medicaid Director or Designee

Submission Date:

Dec 2, 2025

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

Last Name:

Roob

First Name:

Mitchell

Title:

	Indiana Interim Medicaid Director		
Agency:	Indiana Family & Social Service Administration, Office of Medicaid Policy & Planning		
Address:	402 West Washington Street, Room W374 (MS07)		
Address 2:			
City:	Indianapolis		
State:	Indiana		
Zip:	46204		
Phone:	(317) 233-4690	Ext:	TTY
Fax:	(317) 232-7382		
E-mail:	Mitch.roob@fssa.in.gov		
Attachments			

Attachment #1: Transition Plan

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

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

Adding or decreasing limits to a service or a set of services, as specified in Appendix C.

Reducing the unduplicated count of participants (Factor C).

Adding new, or decreasing, a limitation on the number of participants served at any point in time.

Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.

Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

Transition Plan for the Elimination of Participant-Directed Home Care Services (PDHCS)

Transferring PDHCS pilot participants to the new self-directed services array will require assessing how their support needs can be met utilizing some combination of the expanded self-directed service array, traditional services, and state plan services (where applicable). There is currently one individual utilizing the PDHCS pilot program. To support a smooth transition to the new expanded self-direction program, one-on-one preparation and planning will be offered to accommodate the differences between the current pilot program and the new self-directed services option. The following steps will support the transition for those individuals currently receiving PDHCS.

- As of October 2025, participants currently using PDHCS will be notified of planned changes to FSSA's self-direction program, including the discontinuation of the PDHCS pilot.
- Meetings will be held with planning teams of PDHCS pilot participants to discuss options for accommodating support needs without use of the PDHCS service and instead using the new self-directed service options and/or other available services.
- Pilot program participant selects MCE (if applicable)
- MCE Service Coordinator works with participant to develop service plan. They will have access to the self-directed spending plan tool to plan with the self-directed budget. As part of the routine planning process, individuals/members are notified of their Fair Hearing Rights.
- Pilot program participants are served with the new self-directed services starting January 1, 2026.

Transition Plan for Integrated Health Care Coordination (IHCC)

Through this waiver amendment, the state is clarifying that Integrated Health Care Coordination (IHCC) is considered duplicative of MCE care coordination as MCEs are contractually required to provide comparable supports through their care coordination programs. For example, comparable supports the MCEs must provide include the following: care management; coordination of care across service providers and social supports; transitional support between care settings; and advance care planning. To prevent duplication of services, FSSA in collaboration with the MCEs, will identify all PathWays enrollees receiving IHCC and crossmatch with their MCE/D-SNP enrollment. FSSA will confirm the enrollee has an assigned care coordinator through their MCE/D-SNP. These enrollees will be notified via their quarterly service plan review and advance written notice. The service plan will be updated through the person-centered service planning process. Further, the MCE/D-SNP care coordinator will conduct enrollee outreach ten days in advance of the IHCC end date. Additionally, all impacted individuals and their legal representatives (if any) will be provided written notice of the changes and informed of the opportunity to request a Fair Hearing in accordance with the provisions set forth Appendix F-1 of this waiver. This change will be implemented on a rolling basis, as a participant's service plan is due for review.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Continued from the C-1/C-3: Service Specification for Case Management due to character limitations.

- Performing incident follow-up activities, including but not limited to:
 - Preparing and submitting a follow-up report to OMPP concerning the incident within seven days of the date of the initial report; and every seven days thereafter until the incident is resolved.
 - Notifying families/guardians of incidents reported and sharing results of the provider's investigation.
 - Evaluating the effectiveness of all services. Evaluation is demonstrated through but not limited to:
 - (1) Monitoring the progress from identifying need to meeting goals/preferences identified by the individual.
 - (2) Directly collaborating and coordinating with providers to ensure services are within the individual's preferences.
 - (3) Receiving quarterly progress reports from service providers, reviewing status and uploading reports to the document library of the individual in the state's case management system
 - (4) Adjusting service plans appropriately to identify changing needs that meet the individual's needs.
 - Coordinating and collaborating with the individual's integrated health care coordination provider to review any and all updates about the individual from the health care coordination provider. The case manager shall perform follow up meetings with the individual about changes in medical and social services as well as interventions implemented by the health care coordinator provider to ensure the individual's needs are being met. The case manager shall communicate information learned in these follow-up meetings with the integrated health care coordination provider and shall work together to resolve any un-met needs identified.
 - Supporting individual through the Medicaid Nursing Facility level of Care Home and Community- Based Services Waivers termination procedures when an individual is no longer eligible to receive services under the waiver program. This includes providing a thirty (30) day notice to any individual the case manager is terminating.
 - Assisting individuals to transition to a new case management agency in the event an individual chooses a new agency. The goal is to assure a seamless transition for the individual.

SERVICE STANDARDS

- Case Management services must be included on the individual's service plan
- Case Management services must address needs identified in the person-centered planning process,
- Enhance the individual's functional and social well-being.
- Broker community resources that align with the individual's unique needs.
- Case managers will engage the individual and their circle of support in all aspects of the case management process and tailor the person centered support plan to the individual's needs, preferences, goals, and strengths.
- Case managers will coordinate and collaborate with other case managers, other organizations, community partners, and OMPP staff to ensure quality case management is being delivered and options are being discovered and presented to the individual to optimize their overall functioning capability.
- Case manager's maximum Medicaid Waiver caseload is not to exceed 65 individuals at any time.
- Case managers are responsible for identifying when an individual is residing in a provider owned or controlled setting, monitoring HCBS characteristics, monitoring person centered modifications to HCBS characteristics, and documenting in the service plan as such.
- Case managers may not be financially influenced in the course of their service delivery. There may be no financial relationship between the referring case management agency, its staff, and the provider of other waiver services.

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 455 IAC 2 Home and Community Based Services.

Additionally, the provider must comply with the following standards:

- The provider must document the following data elements for services rendered:
 - Name of individual served
 - IHCP Member ID (RID) of the individual served
 - Service rendered
 - Date of service (include month, day and year)
 - Number of units of service rendered that day
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
- Upon request, all documentation must be made available to auditors, quality monitors, MCEs, service coordinators/case managers and any other government entity.

Summary continued from "Public Input" section:

Attendant Care LRI and Extraordinary Care

Six commenters expressed support regarding the policy permitting LRIs to provide Attendant Care Services. However, 14 requested revisions to the associated definition of “extraordinary care.” Several commenters believed the definition limits the receipt of Attendant Care services to those requiring complex medical support and believed the definition should be function-based. They indicated the definition is too focused on medical situations, excluding those who need support with ADLs and high functional or behavioral support needs. Other commenters indicated “vague language” like “comparable to nursing services” will lead to inconsistent implementation. A few commenters stated they liked the aggregate 40-hour per week payment limitation for Attendant Care services furnished by LRIs, while a few other commenters suggested the state remove the payment limitations for LRIs.

State Response: The state appreciates the commenters’ support regarding the policy to permit LRIs to provide ATTC. The state is not modifying the aggregate 40-hour per week payment limitation for Attendant Care services furnished by LRIs based on the comments received. However, the state will continue to monitor and evaluate the provision of Attendant Care services by LRIs over time and will make future adjustments to these payment limitations as needed.

Regarding comments on the “extraordinary care” definition, the state’s policies for making payment to LRI’s (as described in Appendix C-2-d) do not limit who can receive Attendant Care services nor do such policies limit what types of supports are available under this service. The policy only limits when the state will make payment to LRI’s who provide Attendant Care services. If an individual requires “extraordinary care” and all other circumstances described in Appendix C-2-d are met, then an LRI may be reimbursed for furnishing Attendant Care services.

Prior to the public comment period for this waiver amendment, the state reviewed the proposed “extraordinary care” definition with the DDRS Advisory Council and held a separate 30-day comment period requesting public input on the proposed definition. This expanded definition of extraordinary care has been added to the waiver in direct response to comments received as part of previous waiver amendments and renewals. The state is not modifying its “extraordinary care” definition for Attendant Care services based on the comments received at this time.

Relative Providers

A total of 46 comments were received regarding the 40-hour per week limitation for each relative providing Attendant Care services to their family members. Several commenters raised concerns that this limit imposes rigid and arbitrary restrictions on family caregivers, potentially forcing families into uncompensated labor. Some commenters indicated the limits may violate the settings rule and Olmstead, reduce freedom of choice, and disproportionately impact underserved or multigenerational families, risking institutionalization and diminishing continuity and quality of care. Some support the cap, noting it discourages families from commercializing care, but others point out that it discriminates against single parents and qualified family members, who face more restrictions than unrelated aides. If maintained, many urge that the cap should come with a transition plan and hours adjusted to assessed needs. Other commenters noted that the expanded “relative” definition shrinks the pool of paid caregivers.

State Response: In its 1915(c) Waiver Application “Instructions, Technical Guide and Review Criteria” version 3.7 released in late 2024, CMS confirms that the state may decide whether waiver services may be provided by a relative and/or legal guardian of the participant and set the policies (conditions or limitations) that the state places on such payments. Policies that may be set by the state include but are not limited to: (1) the types of relatives or legal guardians that may be paid to furnish waiver services, and (2) the types of waiver services, and any limitations on the amount of waiver services, for which payment may be made to a relative or legal guardian.

The proposed amendment limits payment to relatives and legal guardians (who are not “legally responsible individuals”) for furnishing Attendant Care services to not more than 40 hours per week per paid relative or legal guardian (provided all conditions specified in Appendix C-2-e are met). This weekly limitation was in effect for legal guardians prior to this amendment, while this limitation is new for relatives. To be clear, this “40-hour per week” limitation is not a limit on the hours of service an individual can receive, nor is it a combined limit for all relatives and legal guardians of a single participant. This limit is a “40-hour per week” limit per each paid relative or legal guardian. The state is not modifying these limitations based on the comments received.

Structured Family Caregiving (SFC)

A total of 31 comments were submitted regarding SFC. Several commenters supported aligning the definition across the state’s 1915(c) waivers, noting this allows for consistent service delivery. However, one commenter believed the waiver amendment “quietly reduces” the maximum number of individuals permitted to receive SFC services within a single household from four to three. This commenter also indicated the allowance of up to 15 days of respite per year under SFC lacks operational, financial, and safety details. While one commenter supported the proposed modifications to the SFC in-home visit requirement, which clarified that a provider agency is required to “conduct a minimum of one home visit per month with no less than two of those visits being conducted by an RN or an LPN within the plan year,” several opposed this change. These commenters are concerned

that the increase in required visits, coupled with daily logs, and mandatory RN oversight for non-medical services will unnecessarily raise costs, administrative burdens, and caregiver fatigue, without enhancing care quality. They argue that nursing oversight should be reserved for skilled medical services, particularly given current nursing shortages, and that such mandates—absent additional funding—could force smaller agencies out, limit family options, and pose legal and regulatory risks as SFC agencies cannot oversee or bill for clinical tasks. Commenters requested more flexibility, such as fewer in-person visits and the ability to use virtual oversight and training, to reduce strain on both caregivers and provider agencies; in the absence of such updates, the commenters recommended increased reimbursement to support these requirements.

Several commenters expressed concern about the proposed changes to the daily record-keeping requirements and quarterly progress reports. Commenters stated that such changes would be overly burdensome, and quarterly reports would duplicate service coordinator/case manager requirements. Other commenters expressed concern that principal caregivers would be required to maintain electronic records and requested the state allow hand-written records. SFC provider agencies noted that the requirement to maintain a copy of the SFC LOS assessment form may be difficult because the SFC agency providers have had prior difficulty obtaining these forms from the service coordinators/case managers.

Multiple commenters also noted SFC “must remain a stipend model” and requested FSSA issue formal guidance on the tax classification of SFC payments. They are concerned recent interpretations by the Department of Labor risk misclassifying these payments as taxable W-2 wages, which they believe contradicts the design and purpose of the program.

Comments were also received regarding the SFC service limitations. This included requests that the state permit separate billing for Home and Community Assistance, Home Health Aide, and Caregiver Coaching.

State Response: Upon further review of the proposed requirements and comments received, the state has modified the SFC service definition in several ways. First, the state will require: (1) One in-home visit per quarter conducted by an RN, LPN, Caregiver Trainer, or SFC Home Manager who is employed by the agency and who does not live in the home; and (2) An RN, LPN, Caregiver Trainer, or SFC Home Manager must also attend separate case management quarterly meetings.

The state’s intent for revising documentation standards was to clarify requirements, improve consistency in provider record keeping, and align documentation standards (to the extent possible) across all services and waivers administered by FSSA. Upon further review and consideration of commenters’ concerns, the state has determined that additional time is needed to further evaluate, obtain additional input from interested parties, and revise these documentation standards. At this time, the state has reverted back to the documentation standards in the currently approved PathWays waiver for all services except Attendant Care and Case Management.

The state still believes it is important to clarify documentation requirements, improve consistency in provider record keeping and align documentation standards (to the extent possible) across all services and all waivers administered by FSSA. To that end, the state intends to revise documentation standards in a future amendment.

The state has included a caregiver training component in the SFC service to ensure that the principal caregiver receives appropriate training based on their assessed needs and receives ongoing support to provide high quality care. The caregiver training component is integral to the provision of SFC services, and the state will not reduce the required number of hours or separate this component based on the comments received. However, the state does agree with commenters who recommended allowing caregiver training to be delivered virtually. The state revised the SFC service definition to allow caregiver training to be delivered either in-person or virtually.

Additionally, the state had not intended to reduce the maximum allowable number of participants residing in a single SFC household. Therefore, we have updated references limiting participants residing within a single household to “four” versus “three.”

The state has not made updates to services which may be billed in conjunction with SFC as the requested changes represent activities that are integral to and inherent in the provision of SFC. Therefore, separate payments would be duplicative.

Regarding the request for the state to issue guidance on the tax classification of SFC payments, FSSA cannot provide tax advice. Individuals should consult IRS rules & state tax rules (e.g., Indiana Code, Indiana Department of Revenue) to understand application to their unique situation.

Adult Day Service

Eight comments were submitted regarding Adult Day Services (ADS). Commenters opposed consolidating ADS payment categories, viewing this as a reimbursement reduction. One commenter also expressed concern that the ADS LOS Assessment

could unintentionally reduce service levels without enough family input, requested information about its scoring system, and recommended the state implement an appeal and reassessment process. One commenter praised the improved structure and clarity of the service definition, calling it an important step toward accountability and transparency; they also noted that progress reports and clear provider expectations are commendable additions. One commenter supported the addition of language requiring “a positive event that occurred during the reporting period that contributed to the individual’s good life” in the quarterly progress report and suggested this be added to Adult Family Care and Assisted Living.

State Response: The state has not made any modifications to the application as a result of these comments, except for updates to the documentation requirements, as described above. The state confirms it has not reduced ADS payment levels. As described in the ADS service definition, there are three ADS service levels; this has not been modified, and the state continues to tier ADS payments by service level. Previously, there were also two ADS provider categories. The state is consolidating these provider categories and will reimburse at the prior category 1 (i.e., higher rate) for all ADS providers. Additionally, the state assures enrollees have appeal rights if they disagree with the amount and/or duration of authorized services.

Home Modifications and Assessments

Four comments were submitted regarding Home Modifications and Assessment. One commenter supported the combination of these services into one definition. Another raised concerns about potential conflicts of interest if the same entity conducts both the assessment and modification and emphasized the need for a model that ensures impartiality. One commenter also asked whether the state would consider a two-part payment process for home modifications, allowing partial upfront payments to support the ordering of supplies and final payment upon completion. Another commenter suggested removing the lifetime cap for this service.

State Response: The state appreciates the support received for consolidating these services and confirms, as noted in the service definition, that the assessment must not be conducted by the same provider that completes the subsequent modification. The state is not modifying the lifetime cap on Home Modification and Assessment Services based on these comments or permitting upfront payment.

Case Management Service

Five comments were received regarding the Case Management service definition. While commenters acknowledge the positive shift toward advocacy and collaboration in the expanded case management definition, they also highlighted concerns. They noted that the increase in documentation requirements and the maintenance of a 65-person caseload limit creates impractical workloads for case managers, especially since additional responsibilities—such as clinical oversight and legal or financial duties—are being assigned by FSSA without corresponding resources, reimbursement, or appropriate training. The commenters emphasized that these expanded duties, including documentation for multiple services and oversight of medical, financial, and contractual matters, often exceed the expertise and licensure of case managers, posing potential legal and professional risks. One commenter also recommended the service definition be updated to permit case management meetings be held remotely.

State Response: The service-specific documentation requirements added to the case management service definition are not new responsibilities for case managers. These documentation requirements were previously included in the respective service definitions. The state moved the requirements from the separate service definitions to the case management definition to clarify the case manager’s responsibilities. Additionally, the state offers several training opportunities for case managers, such as monthly webinars hosted by the Bureau of Disabilities Services (BDS). The state is not modifying case management service definition based on the comments received.

Integrated Health Care Coordination

A total of 118 comments were received regarding the proposed updates to the IHCC service definition intended to clarify this service is considered duplicative of MCE care coordination. Commenters are concerned that discontinuing IHCC services would increase costs, hospitalizations, and institutionalization, with personal accounts highlighting enhanced patient satisfaction, improved health outcomes, and cost-effectiveness associated with receiving this service. Commenters view IHCC as essential, particularly for seniors without support systems, and complementary to MCE care coordination versus redundant. Several commenters noted MCEs have inconsistently communicated the proposed change and emphasized IHCC is distinct from MCE care coordination in staffing, qualifications, and service intensity. Commenters noted the discontinuation poses challenges for small healthcare businesses, assisted living facilities, and adult day programs, potentially threatening financial stability and leading to closures. Legal and regulatory concerns were cited by some commenters, including inconsistencies with Indiana Code and state licensure requirements, and the risk of violating HCBS person-centered care principles. Recommendations included refining IHCC eligibility to target those with complex needs, ensuring service coordinators/case managers authorize services only when clinically justified, and evaluating MCE capacity and performance before implementing changes. One commenter commended FSSA for allowing this service to be delivered via telehealth.

State Response: FSSA is committed to preventing duplication of services while ensuring the provision of high-quality, medically necessary care. State reviews of PathWays enrollee service plans and utilization have revealed patterns of duplication between IHCC, services included in the assisted living facility per diem and service definition, and MCE care management requirements. The person-centered planning process should continue to be utilized to identify, on a case-by-case basis, if IHCC services are necessary to supplement other state plan, PathWays 1915(c), and/or MCE care coordination services. This is reflected in IHCC service definition language, such as “when this is unavailable through any other Medicaid authority.” There is not a blanket exclusion of IHCC coverage for managed care enrollees. Additionally, MCE care coordinators for complex case management (for which all PathWays 1915(c) beneficiaries are enrolled) are required to be licensed in the state as either an RN or social worker; these qualifications are aligned with IHCC. As such, the state is not making any revisions to the waiver amendment in response to these comments.

Adult Family Care (AFC)

One comment was received regarding AFC. This commenter noted a typo in the service definition referencing institutional care; specifically, the statement “This service also preserves the dignity, self-respect, and privacy of the individual by ensuring high-quality care in an institutional setting.” They also recommended the monthly plan of care submission be eliminated unless changes in condition or service are reported, simplification of documentation requirements, publication of the AFC/SFC LOS assessment scoring rubric, and creation of an appeal/review process.

State Response: The state has addressed the typo and updated “institutional” with “non-institutional.” No other changes have been made in response to this comment, except for updates to the documentation requirements, as described above.

Provider Qualifications

One commenter supported removing Personal Service Agency (PSA) licensure from several services and requested this change also be made for Attendant Care and Home and Community Assistance to address: (1) misalignment between PSA and waiver regulations; (2) inconsistent operational requirements; and (3) programmatic differences. Another commenter sought confirmation that the direct reference to home health agency licensure removal from several service definitions does not mean home health agencies are excluded from providing these services. One commenter was appreciative of these changes as they believe this will permit community-based agencies to serve more people without unnecessary red tape. Another commenter requested the state clearly outline within the Attendant Care Provider Qualifications the procedures it uses to inform family members of a provider applicant’s criminal background and the circumstances under which FSSA determines a limit on employment or service provision is appropriate.

State Response: The state appreciates the supportive comments received and affirms that these changes do not mean home health agencies are excluded from participation. As the methods to inform family members of an applicant’s criminal background are not a provider participation standard, this section of the application has not been updated to address the comment requesting additional process details.

HCBS Settings Rule

One commenter expressed concern regarding FSSA's enforcement of the HCBS Settings Rule, especially for Assisted Living Facilities that are subject to heightened scrutiny. The commenter indicated uncertainty about how FSSA reviews, responds to, or addresses public comments related to heightened scrutiny reviews and indicated the state’s response in Appendix C-5 does not alleviate their concerns. They are concerned FSSA relies too heavily on the complaint investigation process.

State Response: The state assures it enforces the HCBS Settings Rule in accordance with regulatory requirements and has made no modifications to the application as a result of this comment.

Alignment of National Core Indicators

One commenter noted appreciation for the state adding the use of NCI-AD performance measures in alignment with the state’s other 1915(c) waivers.

State Response: The state appreciates this support and agrees alignment will permit comparison across waivers.

Participant Direction

Seven comments were submitted regarding participant direction. One individual expressed concern about individuals who self-direct their care having the authority to set employee pay rates and manage the recruitment, hiring, training, and supervision of their support workers. The commenter acknowledged the goal to enhance autonomy and choice but suggested there may be potential impacts on the quality and consistency of care. Conversely, another commenter was concerned that the state’s interpretation of participant-direction does not fully align with the philosophy of self-direction, citing requirements such as involvement of service coordinators/case managers and allowing guardians and representatives to engage in decision-making on

behalf of participants. Several commenters asked for accessible training, including clear guidance on legal and financial risks associated with participant-direction and comprehensive supports to help participants avoid involuntary termination. One commenter suggested the state create a provider enrollment pathway for additional fiscal intermediaries.

State Response: The state is committed to participant-direction and anticipates this model will promote positive outcomes for participants and their families, improve satisfaction, and deliver services in a cost-effective manner. FSSA has sought to develop a program that meets CMS requirements and carefully balances participant autonomy and appropriate safeguards. The state does not share commenters concerns regarding self-direction outcomes and oversight. Peer-reviewed research from across the United States demonstrates that self-direction improves outcomes for participants and their families, and Section 2402(a) of the Affordable Care Act encourages states to maximize self-directed options for Home and Community-Based Services delivery. Self-direction oversight, monitoring, and quality management procedures are described in Appendix E of this proposed waiver amendment. Further, beneficiaries who self-direct any waiver services may choose to voluntarily terminate self-direction and transition to agency-based services at any time. Additionally, the program has been designed to ensure participants are provided with information and supports necessary to direct their care. Regarding contracting with multiple FMS vendors, the state conducted a competitive procurement process and awarded one contract. As such, no updates have been made to the application in response to these comments.

However, upon review and further consideration of the rate of growth projected for the self-directed program, the state has revised its projections in Appendix E-1-n to estimate that 2% of the waiver population will elect to participate in the self-direction program during the waiver year including December 31, 2025. Thereafter, the estimated percentage of participation will increase by 2% each year to a total of 10% of the waiver population electing to participate in the self-direction program within five years.

Additionally, upon further review and consideration, the state added a new “Provider Type” for each service that can be self-directed. To ensure clarity, the new provider type will include qualifications and verification information tailored specifically for providers furnishing supports to individuals who self-direct their services.

Participant Directed Home Care Service (PDHCS)

Five comments were submitted opposing the end to PDHCS. Commenters described the personal impact of this service and were concerned its elimination will force enrollees into institutions. One commenter also indicated the average cost of one PDHCS unit is higher than self-directed attendant care, which will require participants using PDHCS to hire new caregivers willing to accept a lower reimbursement rate; they also questioned why the waiver indicates the termination will be effective as of 12/30/25 rather than 12/31/25.

State Response: In consultation with CMS, the state has decided to discontinue the PDHCS pilot and implement an updated model for self-direction. Through the updated self-direction program, individuals who are currently utilizing PDHCS will be offered and made available comparable support through the opportunity to utilize self-directed attendant care and self-directed home and community assistance. These two services provide assistance and support with activities of daily living and instrumental activities of daily living. In addition, individuals can access and choose to utilize self-directed skilled respite in the waiver and/or skilled home healthcare support through Indiana’s Medicaid state plan. The 12/30/25 date is referenced as the last day for which PDHCS will be considered a covered service, in alignment with the 12/31/25 effective date of this amendment. As such, no updates to the application were made as a result of comments received.

Transition Plan and Waiver Public Comment Period

Three comments were received regarding the public input process and Attachment 1 – Transition Plan. Commenters indicated the following boxes should be selected: (1) “Adding or Decreasing Limits to a Service;” (2) “Reducing the unduplicated count of participants;” (3) “Other” with description of the LRI and participant-direction changes; and (4) “Making any changes that could result in reduced services to participants.” They further requested the addition of narrative that describes how the state will mitigate service disruptions, support families affected by these changes, ensure continuity of care, and safeguard against institutionalization. Other commenters urged the state to improve the public comment process to ensure meaningful input, raising issues such as a 30-day period being insufficient, suggesting changes be staggered versus released all at once, and ensuring clear notices to permit more meaningful stakeholder access.

State Response: The state appreciates the feedback received regarding potential opportunities to improve the public input process and will consider these opportunities for future waiver amendments. The “40-hour per week” limitation for relatives and guardians is not a limit on the hours of service an individual can receive. Therefore, the state does not believe it would be appropriate to update the transition plan to reflect this policy.

Managed Care Service Coordinator Qualifications

One commenter supported the addition of language noting service coordinators must complete “Person-Centered Thinking Training” within 90 days of their hire date and on an annual basis. They also stressed that if it is identified that a service coordinator has not treated an enrollee with respect or been proficient in performing person-centered planning, the MCE use this as a teachable moment and/or apply “progressive discipline.”

State Response: The state appreciates the commenter’s support. MCEs are responsible for monitoring their staff and implementing corrective actions as appropriate and OMPP conducts comprehensive oversight of the MCEs for compliance with contractual obligations. Therefore, no updates to the application draft were necessary in response to this comment.

Waitlist Management

Twenty-two comments were received regarding the PathWays waiting list. While some commenters appreciated the updated language in Appendix B-3-f “Selection of Entrants to the Waiver” as it aligns with practice, others were concerned about the addition of language regarding deadlines for enrollment and waitlist invitation acceptance. Specifically, they believe these inflexible timelines lead to the removal of individuals from the waiting list due to circumstances beyond their control. Multiple comments were submitted on behalf of individuals on the waiting list, noting the hardships caused by not being able to enter the waiver, and expressing concern that there are no new waiver slots being added.

State Response: The state developed timelines for the waiting list invitation and enrollment process to provide sufficient time for individuals to complete the necessary steps to enroll in the waiver. Without establishing a deadline within which an individual must complete the necessary steps for waiver enrollment, the state would be unable to appropriately invite others off the waiting list in a timely manner. Therefore, no updates were made to the waiver application in response to these comments.

Money Follows the Person (MFP) Reserved Capacity

Two comments were received regarding the adjustment of MFP Reserved Capacity estimates to align with the 2025 MFP Budget Request. Commenters were concerned about these changes, noting this would lead to more individuals in nursing homes or other institutions. They urged the state to maintain or increase the current number of reserved slots and invest in other transition supports to ensure compliance with ADA and Olmstead obligations.

State Response: The MFP Reserve Capacity estimates were adjusted to align with 2025 MFP Budget Request submitted to and approved by CMS. The state is not modifying the MFP Reserve Capacity estimates based on the comments received.

Expedited Waiver Eligibility

Two comments were received regarding the removal of expedited waiver eligibility (EWE) language. One commenter understood the need for FSSA to align the waiver with the state’s decision to pause this policy, but noted, along with the other commenter, the important role EWE played in institutional rebalancing efforts.

State Response: No updates were made to waiver language in response to these comments. The state continues to evaluate cost-effective ways to support institutional rebalancing efforts while maintaining program integrity.

Comments Related to the PathWays Waiver but Beyond the Scope of the Proposed Changes:

PathWays Managed Care Delivery System

The state received eight comments addressing concerns and recommendations related to the 2024 transition to managed care. Stakeholders highlighted reduced access, delays in service and claims payments, provider instability, and increased administrative burdens. They noted challenges with operational procedures, inadequate support from call centers and care coordinators, and confusion arising from program naming conventions (i.e., referring to both the 1915(c) waiver and state plan services as “PathWays”). Several commenters expressed that consumers and providers faced difficulties coordinating care, long authorization wait times, and diminished support, with some warning that unresolved issues may lead providers to exit the program. Recommendations included strengthening oversight and accountability of MCEs, establishing centralized provider and member support, improving system clarity, requiring direct access to care coordinators versus call center queues, capping caseloads, and publishing transparent performance data to enhance support and transparency. One commenter also noted additional populations should be permitted to opt-out of managed care enrollment and another recommended the program be run by the AAAs.

State Response: The state oversees its MCEs through comprehensive monitoring and applies non-compliance remedies when necessary. Recent enhancements include standardized service planning forms, person-centered monitoring tools, and improved notices of action, reflecting feedback from partners and oversight findings. The state holds IHCP listening sessions with PathWays 1915(c) waiver providers to help address concerns and guide systemwide improvements. PathWays will not move to fee-for-service but will be continually monitored and updated as needed. Additionally, as extensive resources and stakeholder

input went into branding, the program name will remain PathWays.

HCBS in Acute Care Hospitals

Three commenters expressed concern that the state does not allow the provision of HCBS in acute care hospitals under the PathWays waiver and recommended allowing such services.

State Response: While Appendix C-2-g is a new section of the 1915(c) waiver application, the state's policy not to allow the provision of HCBS in acute care hospitals under the PathWays waiver was in place prior to this amendment. The state is not modifying the policy regarding HCBS in acute care hospitals based on these comments.

Waiver Level of Care and Eligibility Groups

One commenter recommended the state incorporate and define the TEFRA 134 eligibility group and the use of hospital level of care determinations, believing this update would align policy with existing practice, provide clarity, and streamline eligibility.

State Response: No updates were made to the waiver as a result of this comment as the PathWays waiver does not include children and eligibility is based on nursing facility versus hospital level of care.

Equipment & Modifications

Two commenters noted limits on home modifications, vehicle modifications, and annual repairs are insufficient to cover the cost and suggested a process to permit participants to request an exemption and receive additional modifications when there is a change in need. One commenter indicated the requirement to receive two bids for these services creates barriers, particularly in rural areas where these services are limited. Another commenter recommended adding language allowing modifications in newly purchased homes, explicitly covering pre-installed vehicle modifications, covering accident-related repairs, and revising "activities not allowed" in Specialized Medical Equipment and Supplies to permit coverage of therapeutic and safety equipment such as adaptive tricycles, therapeutic pool lifts, and hospital beds.

State Response: The state is unable to increase service limits at this time but will retain these comments for future consideration.

Caregiver Coaching

One commenter recommended the state "comprehensively revise" the service definition for Caregiver Coaching to better align with the principles and approach of the Family and Caregiver Training services under the Family Supports Waiver, noting the current PathWays service is a complex and misaligned program.

State Response: No updates were made to the service definition as a result of this comment, but the state will retain this comment for future consideration.

Transportation

One comment was received regarding the Transportation service definition. The commenter noted public transportation and shared ride services are not addressed. They were unsure if Attendant Care providers can render the service and are concerned transportation is not available to participants receiving Adult Family Care, Structured Family Caregiving, or Assisted Living Waiver services.

State Response: Ride share services may enroll as an Indiana Medicaid provider and are therefore accounted for in the FSSA/OMPP approved Transportation Agency provider type listed in the waiver application. Transportation may be provided under Attendant Care, as noted in the service definition, when incidental to the provision of hands-on care with ADLs. Separate payment for participants receiving residential services is not made for Transportation because this activity is integral to and inherent in the provision of the residential services. As such, the state has not made updates to the waiver application in response to these comments.

Duplication of Home and Community Assistance and Attendant Care

One commenter reported that a recent FSSA audit led to recoupment of payments for Attendant Care and Home and Community Assistance. They are concerned that state definitions do not account for clients who need both services at different times. The provider believes some service authorizations have been updated to allocate 20 hours for each service, but this adjustment seems driven by cost management rather than the client's actual needs.

State Response: The state cannot respond to this scenario due to insufficient information, as it is based solely on one audit finding. However, service plans and hours allocation are developed based on a person-centered planning process and OMPP oversees MCE compliance with their contractual obligations for service planning. As such, no updates to the application were made in response to this comment.

Recommendations for Service Additions

One commenter requested the addition, either within Nutritional Supplements or a new category, to include essential non-covered disposable medical supplies that are critical for daily care. They cited examples such as vitamins or supplements not covered under the pharmacy benefit, incontinence-related supplies such as wipes, and personal protective items. This commenter also recommended the state consider developing a waiver service titled "Rent and Food Expenses for Live-in Caregiver" and adding Behavior Management/Behavior Program and Counseling.

State Response: The state is unable to add these benefits at this time but will retain this comment for future consideration.

Provider Pick Lists

One commenter recommended changes to improve the provider pick lists such as mandated bi-annual maintenance, improved accessibility, search and sort functionality.

State Response: As these are operational considerations and details, the state has not updated the waiver application but will retain this comment for future operational considerations.

Level of Care

Six comments were received concerning the level of care (LOC) assessment process. Commenters requested increased transparency such as automatic notification of LOC denial, information about appeal rights, copies of relevant assessments, and assistance throughout the appeals process. One commenter suggested individuals be provided with options counseling regarding alternative resources, services, and support available to address their needs. Another commenter noted the importance of sending notices through multiple means, referencing US Postal Service delays. Additionally, one commenter recommended the state include robust quality assurance and inter-rater reliability to audit LOC determinations, assign assessors based on geographic proximity to participants, and protect providers from claims denials that occur due to state LOC processing delays or errors.

State Response: The state ensures that individuals denied LOC receive notice and appeal rights as required by federal law. The Level of Care Assessment Representative (LCAR) contractor contacts these individuals to discuss alternative services and is monitored by the state for compliance. Additionally, in accordance with federal requirements, eligibility for 1915(c) waiver services is contingent upon an enrollee having a LOC evaluation so the state is unable to add language permitting claims reimbursement in the absence of such as assessment. Therefore, the state has not made updates to the waiver application in response to these comments.

Appendix A: Waiver Administration and Operation

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

The waiver is operated by the state Medicaid agency.

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

The Medical Assistance Unit.

Specify the unit name:

Office of Medicaid Policy and Planning (OMPP)

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

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

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

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

Appendix A: Waiver Administration and Operation

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

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

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

MANAGED CARE ENTITIES (MCE)

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

- Service planning
- Prior authorization of waiver services
- Utilization management
- Execution of Medicaid provider agreements
- Quality assurance and quality improvement activities

FISCAL AGENT

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

ACTUARIAL CONTRACTOR

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

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

EXTERNAL QUALITY REVIEW ORGANIZATION (EQRO)

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

NCI SURVEY CONTRACTOR

FSSA contracts with an entity responsible for NCI survey administration.

UTILIZATION MANAGEMENT CONTRACTOR

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

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

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

conducting waiver operational and administrative functions:

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

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

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

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

Appendix A: Waiver Administration and Operation

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

MANAGED CARE ENTITIES (MCE)

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

FISCAL AGENT

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

ACTUARIAL CONTRACTOR

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

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

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

LEVEL OF CARE ASSESSMENT REPRESENTATIVE (LCAR) CONTRACTOR

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

EQRO

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

NCI SURVEY ADMINISTRATOR

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

AREA AGENCIES ON AGING (AAA)

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

UTILIZATION MANAGEMENT CONTRACTOR

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

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR § 431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment			
Waiver enrollment managed against approved limits			
Waiver expenditures managed against approved levels			
Level of care waiver eligibility evaluation			
Review of Participant service plans			
Prior authorization of waiver services			

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Utilization management			
Qualified provider enrollment			
Execution of Medicaid provider agreements			
Establishment of a statewide rate methodology			
Rules, policies, procedures and information development governing the waiver program			
Quality assurance and quality improvement activities			

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

A.1 Number and percentage of quarterly reports submitted to OMPP by Managed Care Entities (MCE) within the required time period. Numerator: Number of quarterly reports received. Denominator: Number of quarterly reports due.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MCE Reports

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

Data Aggregation and Analysis:

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

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

Performance Measure:

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

Data Source (Select one):

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:

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

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

	Other Specify: 	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

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

implemented.

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

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

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

No

Yes

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

Appendix B: Participant Access and Eligibility

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

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more

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

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
		Aged	65		
		Disabled (Physical)	60	64	
		Disabled (Other)	60	64	
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury			
		HIV/AIDS			
		Medically Fragile			
		Technology Dependent			
Intellectual Disability or Developmental Disability, or Both					
		Autism			
		Developmental Disability			
		Intellectual Disability			
Mental Illness					
		Mental Illness			
		Serious Emotional Disturbance			

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

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

Not applicable. There is no maximum age limit

The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

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

Appendix B: Participant Access and Eligibility

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

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and

community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

No Cost Limit. The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

Cost Limit in Excess of Institutional Costs. The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

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

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

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount (*select one*)

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

Specify the formula:

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

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	

Waiver Year	Unduplicated Number of Participants
	39842
Year 2	39842
Year 3	39842
Year 4	39842
Year 5	39842

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

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

The state limits the number of participants that it serves at any point in time during a waiver year.

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

Not applicable. The state does not reserve capacity.

The state reserves capacity for the following purpose(s).

Purpose(s) the state reserves capacity for:

Purposes
Age-out of Health & Wellness 1915(c) Waiver
Maintain access to assisted living services for those who are newly Medicaid eligible
Community transition of institutionalized person due to "Money Follows the Person" initiative

Appendix B: Participant Access and Eligibility

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

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

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

Purpose (describe):

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

Describe how the amount of reserved capacity was determined:

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

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

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

Appendix B: Participant Access and Eligibility

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

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

Maintain access to assisted living services for those who are newly Medicaid eligible

Purpose (describe):

Individuals who (i) are currently residing in a Medicaid enrolled assisted living facility, (ii) are determined by the state to newly meet financial eligibility for full Medicaid coverage as a result of change in their income and assets, (iii) do not require the Special Income Limits in order to be Medicaid eligible, and (iv) are relying on Medicaid financial and functional eligibility to continue to reside in the assisted living facility are given priority for the PathWays waiver so long as they meet nursing facility level of care, are Medicaid eligible, and are able to access long-term services and supports (LTSS services).

Priority access by Reserved Waiver Capacity is made available as long as available waiver capacity exists for the current waiver year.

The State does not limit or restrict participant access to waiver services except as provided in Appendix C.

Describe how the amount of reserved capacity was determined:

Reserved waiver capacity for Waiver Years 2 – 5 is based on the number of individuals who were added to waitlist from April 2024 through June 2024, matched to an assisted living service address and then apportioned to either this waiver or the Health and Wellness waiver. Of approximately 600 identified individuals, 500 were apportioned to reserved capacity for this waiver, while 100 were apportioned to reserved capacity for the Health and Wellness waiver.

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

Waiver Year	Capacity Reserved
Year 1	0
Year 2	500
Year 3	500
Year 4	500
Year 5	500

Appendix B: Participant Access and Eligibility

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

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

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

Purpose (describe):

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

Describe how the amount of reserved capacity was determined:

The State reviewed the number of patients currently receiving institutional care above age 60 and determined, based upon the number of waiver slots, the realistic number of individuals that could be transitioned in year 1 through 5. It was determined that we could move a total of 680 individuals over the course of this waiver term. Indiana plans to continue transitioning persons from the nursing facility to HCBS settings maximizing the MFP program.

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

Waiver Year	Capacity Reserved
Year 1	200
Year 2	120
Year 3	120
Year 4	120
Year 5	120

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:

All individuals seeking the waiver are placed on the waiting list. Eligible individuals who meet reserve capacity criteria will be assigned a reserve capacity slot when available.

Individuals are invited each month from the waiting list in the following order:

1. Those transitioning from 100% state funded budgets to the waiver, nursing facilities to the waiver, or discharging from inpatient hospital settings receive first priority of targeted waiver invitations each month on a first come first serve basis by date of application.
2. Individuals on the waiting list without a priority status receive the remaining targeted waiver invitations on a first come first served basis by date of application.

Upon invitation, individuals are sent an invitation letter which outlines the steps necessary to complete waiver enrollment. If the individual does not accept the waiver invitation to continue the process within 45 days of the date of the invitation letter or does accept the waiver invitation but the individual does not complete the necessary steps for waiver enrollment within 180 days of the date of the invitation letter, FSSA will rescind the invitation. The individual, case manager/service coordinator and legal representative (if any) will be notified in writing of the rescindment with appeal rights. FSSA will re-assign the available slot.

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)*:

Section 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)

Parents and Other Caretaker Relatives (42 CFR § 435.110)

Pregnant Women (42 CFR § 435.116)

Infants and Children under Age 19 (42 CFR § 435.118)

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 section 1902(a)(10)(A)(ii)(XIII)) of the Act

Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 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 section 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 section 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:

Section 1925 of the Act - Transitional Medical Assistance

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

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

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

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

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

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

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR § 435.217 group effective at any point during this time period.

Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under section 1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

Spousal impoverishment rules under section 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 section 1924 of the Act.

(Complete Item B-5-b (SSI State) and Item B-5-d)

Use regular post-eligibility rules under 42 CFR § 435.726 (Section 1634 State/SSI Criteria State) or under § 435.735 (209b State)

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Spousal impoverishment rules under section 1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

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

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

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(*select one*):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

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

Not Applicable

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

Specify:

Specify the amount of the allowance (select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically

needy income standard established under 42 CFR § 435.811 for a family of the same size. If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

Not Applicable (see instructions) *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

- c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).**

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

- d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)**

The state uses the post-eligibility rules of section 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 section 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 or 42 CFR § 435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions) *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits.

The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State – January 1, 2014 through September 30, 2027 (or other date as required by law).

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State – January 1, 2014 through September 30, 2027 (or other date as required by law).

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules – January 1, 2014 through September 30, 2027 (or other date as required by law).

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the

provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

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

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

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

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

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

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By an entity under contract with the Medicaid agency.

Specify the entity:

Other

Specify:

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

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

- a. A registered nurse with one year's experience in human services; or
- b. A bachelor's degree in health, social work, or related field; or
- c. An associate's degree in nursing; or
- d. A master's degree in any field; and
- e. Cleared by background checks to ensure the individual applicant does not have a criminal background.

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

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

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

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

All applicants to the Pathways Waiver are screened for nursing facility level of care (NFLOC) to evaluate and reevaluate whether an individual needs services through the waiver.

Nursing Facility Level of Care (NFLOC)

The criteria necessary to meet NFLOC are specified in Indiana Administrative Code 405 IAC 1-3-1 through 405 IAC 1-3-3.

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

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

The same instrument is used in determining the level of care for the waiver and for institutional care under the state plan.

A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.

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

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

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

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

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

The final functional level of care determination is documented in the web-based assessment platform.

- g. Reevaluation Schedule.** Per 42 CFR § 441.303(c)(4), reevaluations of the level of care required by a participant are

conducted no less frequently than annually according to the following schedule (*select one*):

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

Every twelve months or more often as needed.

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

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

The qualifications are different.

Specify the qualifications:

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

The Level of Care Assessment Representative (LCAR) contractor maintains a web-based assessment platform which is capable of generating a report that identifies waiver participants who are due to receive an annual level of care (LOC) reevaluation in the upcoming ninety (90) days (90-Day Re-Evaluation Report). LCAR contractor assessors, advisors and supervisors are able to generate this report on demand to conduct first tier reviews to identify waiver participants requiring annual re-evaluation and monitor timely re-assessment.

The LCAR contractor will send copies of the 90-Day Re-evaluation Report to designated FSSA staff and FSSA state staff will also have access to the web-based platform to generate the 90-Day Re-Evaluation Report on demand. FSSA state staff are responsible for conducting second tier reviews to monitor timely re-evaluations. If reevaluations are not completed in a timely manner, the FSSA state staff will remediate the issue as outlined within the LCAR contract.

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

The evaluation and reevaluation documentation is maintained for a minimum of three years within the electronic database maintained by the LCAR contractor.

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

B.1 Number and percent of applicants who received a Level of Care (LOC) evaluation prior to waiver enrollment. Numerator: Number of applicants who received an LOC evaluation prior to waiver enrollment. **Denominator:** Total number of applicants who were eligible for waiver enrollment and completed the application process.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Reports from Level of Care Assessment Representative (LCAR) Contractor

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

	Other Specify: 	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

- c. Sub-assurance:** *The processes and instruments described in the approved waiver are applied*

appropriately and according to the approved description to determine participant level of care.

Performance Measures

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

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

Performance Measure:

B.2. Number and percent of individuals whose initial level of care (LOC) assessments were completed in accordance with established LOC criteria. Numerator: The total number of individuals whose initial LOC assessment was completed in accordance with established LOC criteria. Denominator: The total number of individuals with an initial LOC assessment.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Reports from Level of Care Assessment Representative (LCAR) Contractor

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

	Other Specify: 	
--	---	--

Data Aggregation and Analysis:

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

Performance Measure:

B.3 Number and percent of individuals whose annual level of care (LOC) assessment was conducted based on requirements for determining LOC in the waiver.

Numerator: The total number of individuals whose annual LOC assessment was conducted based on requirements for determining LOC in the waiver. **Denominator:** The total number of individuals due for an annual LOC assessment.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Reports from Level of Care Assessment Representative (LCAR) Contractor

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>
State Medicaid Agency	Weekly	100% Review

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

Data Aggregation and Analysis:

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

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

- 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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

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

If the FSSA, or any other entity, identifies any instance of a new applicant not having received a LOC evaluation prior to enrollment, FSSA will ascertain any related MCE capitation payments that have been made and reconcile and recoup accordingly. The MCE, FSSA, and LCAR Contractor will collaborate to ensure a proper LOC evaluation is conducted immediately. If it is identified that the applicant does not meet the LOC criteria, the service coordinator is required to explore other community or public funded services that may be available to the individual. All LOC decisions are subject to the applicant's rights to appeal and have a Medicaid Fair Hearing.

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

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

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

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

No

Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

The service coordinator (or case manager for FFS enrollees) is responsible for explaining all available PathWays service options, including choice of institutional or HCBS, through the person-centered service planning process. This includes informing individuals about available LTSS, service alternatives, and service delivery options. The service plan must reflect that this was discussed with the enrollee and signature must be obtained from the member, their designated representative (if applicable), and any others involved in the service planning process.

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Adult Day Service		
Statutory Service	Attendant Care		
Statutory Service	Case Management		
Statutory Service	Home and Community Assistance Service		
Statutory Service	Skilled Respite		
Other Service	Adult Family Care		
Other Service	Assisted Living		
Other Service	Caregiver Coaching		
Other Service	Community Transition		

Service Type	Service		
Other Service	Home Delivered Meals		
Other Service	Home Modification Assessment (Terminated as of 12/30/2025)		
Other Service	Home Modifications (Terminated as of 12/30/2025)		
Other Service	Home Modifications and Assessments (Effective 12/31/2025)		
Other Service	Integrated Health Care Coordination		
Other Service	Nutritional Supplements		
Other Service	Participant Directed Home Care Service (Terminated as of 12/30/2025)		
Other Service	Personal Emergency Response System		
Other Service	Pest Control		
Other Service	Specialized Medical Equipment and Supplies		
Other Service	Structured Family Caregiving		
Other Service	Transportation		
Other Service	Vehicle Modifications		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Service

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04050 adult day health

Category 2:

04 Day Services

Sub-Category 2:

04060 adult day services (social model)

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

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

Individuals attend Adult Day Services on a planned basis.

SERVICE LEVELS

There are three service levels of adult day service: Basic, Enhanced and Intensive. The appropriate service level is determined through the person-centered planning process by completing the Adult Day Service Level of Service Assessment (ADS LOS Assessment). Service coordinators/case managers complete this assessment at least annually to accurately reflect the relative support need of the individual. The ADS LOS Score determines the level of service to be utilized in the individual's next service plan.

The breakdown is as follows:

- Basic (Level 1) – ADS LOS Assessment Score of 0 - 11.
- Enhanced (Level 2) – ADS LOS Assessment Score of 12 - 22.
- Intensive (Level 3) – ADS LOS Assessment Score of 23 - 36.

REIMBURSABLE ACTIVITIES

BASIC ADULT DAY SERVICES (Level 1) include the following activities:

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

ENHANCED ADULT DAY SERVICES (Level 2) includes Level 1 activities and the following additional activities:

- Hands-on assistance with two or more ADLs or hands-on assistance with bathing or other personal care
- Initial health assessment conducted by RN consultant prior to beginning services as well as regular monitoring or intervention with health status
- Medication assistance
- Psychosocial needs assessed and addressed, including counseling as needed for individuals and caregivers
- Therapeutic structure and intervention for individuals with mild to moderate cognitive impairments in a safe environment
- Minimum staff ratio: One staff for each six individuals
- RN Consultant available
- Minimum of one full-time licensed practical nurse (LPN) staff person with monthly RN supervision

INTENSIVE ADULT DAY SERVICES (Level 3) includes Level 1 activities, Level 2 activities, and the following additional activities:

- Hands-on assistance or monitoring with all ADLs and personal care
- One or more direct health intervention(s) required
- Rehabilitation and restorative services, including physical therapy, speech therapy, and occupational therapy (coordinated or available)
- Therapeutic intervention to address dynamic psychosocial needs such as depression or family issues affecting care
- Therapeutic interventions for those with moderate to severe cognitive impairments
- Minimum staff ratio: One staff for each four individuals
- RN Consultant available
- Minimum of one full-time LPN staff person with monthly RN supervision
- Minimum of one qualified full-time staff person to address individual's psychosocial needs.

SERVICE STANDARDS

- ADS must be included in the individual's service plan
- ADS must address needs identified in the person-centered planning process and the ADS Level of Service Assessment Form

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

Adult Day Services are limited to a maximum of 10 hours per day.

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

Adult Day Services will not be reimbursed when provided by the spouse of a participant (also known as a Legally Responsible Individual) or a Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

Adult Day Services will be reimbursed when provided by a Relative, ONLY when all conditions specified in Appendix C-2-e of this waiver are met.

ACTIVITIES NOT ALLOWED:

- Services to individuals receiving Assisted Living waiver service

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Adult Day Service

Provider Category:

Agency

Provider Type:

FSSA/OMPP approved Adult Day Service Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 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 Protecting Individuals: Procedures for Protecting Individuals
 - 455 IAC 2 Protecting Individuals: Unusual occurrence; reporting
 - 455 IAC 2 Protecting Individuals: Transfer of individual's record upon change of provider
 - 455 IAC 2 Protecting Individuals: Notice of termination of services
 - 455 IAC 2 General Administrative Requirements for Providers: Provider organizational chart
 - 455 IAC 2 General Administrative Requirements for Providers: Collaboration and quality control

- 455 IAC 2 General Administrative Requirements for Providers: Resolution of disputes
- 455 IAC 2 General Administrative Requirements for Providers: Data collection and reporting standards
- 455 IAC 2 General Administrative Requirements for Providers: Quality assurance and quality improvement system
- 455 IAC 2 Financial Information: Disclosure of Financial information
- 455 IAC 2 Property and Personal Liability Insurance: Liability insurance
- 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
- 455 IAC 2 Personnel Records: Maintenance of personnel records
- 455 IAC 2 Personnel Policies and Manuals: Adoption of personnel policies
- 455 IAC 2 Personnel Policies and Manuals: Operations manual
- 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
- 455 IAC 2 Maintenance of Records of Services Provided: Individuals personal file; site of service delivery
- 455 IAC 2 Services: Coordination of services and plan of care
- 455 IAC 2 Residential Day Services: Safety and security policies and procedures
- 455 IAC 2 Residential Day Services: Emergency telephone numbers

Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Attendant Care

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:**Sub-Category 4:****Service Definition (Scope):**

Attendant Care services (ATTC) provides direct, hands-on care to individuals for their functional needs with activities of daily living (ADLs). The service also provides assistance with general homemaking and transportation activities that are incidental to the provision of hands-on care with ADLs but may not comprise the entirety of the service.

REIMBURSEABLE ACTIVITIES

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

1. Assistance with personal care, which may include:
 - Bathing, partial bathing
 - Oral hygiene
 - Hair care including clipping of hair
 - Shaving
 - Hand and foot care
 - Intact skin care
 - Application of cosmetics
 - Dressing
2. Assistance with mobility, which may include:
 - Transfers (including lifting with mechanical assistance with appropriate training)
 - Ambulation
 - Proper body mechanics
 - Use of assistive devices
3. Assistance with elimination, which may include:
 - Assists with bedpan, bedside commode, toilet
 - Incontinent or involuntary care
 - Emptying urine collection and colostomy bags
4. Hands-on assistance with nutrition, which may include:
 - Meal planning and preparation
5. Assistance with safety, which may include:
 - Use of the principles of health and safety in relation to self and individual
 - Identifying and eliminating safety hazards
 - Practicing health protection and cleanliness by appropriate techniques of hand washing
 - Reminding individual to self-administer medications

All assistance with homemaking and transportation activities must be incidental to the provision of hands-on care with ADLs, and may include the following:

- General homemaking activities such as laundry, bed-making, meal preparation clean-up, cleaning floors/walls, and waste disposal.
- Transportation of individuals (who require ADL supports) to community activities. Out of State transportation is limited to within 50 miles of State geographic limits. Escorting of individuals does not include costs that are not associated with the provision of personal care, for example mileage.

SERVICE STANDARDS

- ATTC must be included on the individual's service plan
- ATTC must address needs identified in the person-centered planning process

ATTC may be provided from the following:

- Agency Provider - an agency enrolled in the program is responsible to hire and render services
- Individual Provider - an individual enrolled in the program is responsible to render services
- Participant Directed - the individual (or representative appointed by the individual) is the employer and acts as the agency directing their care

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 455 IAC 2 Home and Community Based Services and Electronic Visit Verification. Additionally, the provider must comply with the following standards:

- The provider must document the following data elements for each uninterrupted period of services rendered:
 - Name of individual served
 - IHCP Member ID (RID) of the individual served
 - Service rendered
 - Date of service (include month, day and year)
 - Time frame of service (include start time, end time and a.m./p.m.)
 - Name of person providing service (if the person providing the service is required to be a professional, their title must also be included)
 - Primary location of service delivery
 - Each staff member providing direct care or supervision of care to the individual must document allowable/reimbursable activities/tasks completed during each hour of service.
 - Signature of individual (or their designated representative) verifying the service was provided
 - Signature of person providing the service that must at least include the person's last name and first initial. (Electronic signatures are permissible when in compliance with the Uniform Electronic Transactions Act [IC 26-2-8])
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
- Upon request, all documentation must be made available to auditors, quality monitors, MCEs, service coordinators/case managers and any other government entity.

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

The maximum number of hours of ATTC services that may be reimbursed when provided by LRIs must not exceed an aggregate of forty (40) hours per week per waiver participant.

The maximum number of hours of ATTC services that may be reimbursed when provided by Relatives and Legal Guardians (who are NOT LRIs) must not exceed forty (40) hours per week per paid Relative caregiver and/or paid Legal Guardian caregiver.

ATTC services will be reimbursed when provided by the spouse of a participant (also known as a Legally Responsible Individual), Relative or Legal Guardian ONLY when all applicable conditions specified in in C-2-d and C-2-e of this waiver are met.

ATTC will not be reimbursed when provided by a LRI or Legal Guardian if the participant is self-directing this service per Indiana Code 12-10-17.1-10.

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

ACTIVITIES NOT ALLOWED:

- Services available through the Medicaid State Plan (demonstration that individual is using and has exhausted all available home health services under the state plan, or Medicaid State Plan prior authorization denial for home health services is required before waiver reimbursement is available through the Medicaid waiver for this service).
- Services provided for an individual regarding specialized feeding, (such as difficulty swallowing, refuses to eat, or does not eat enough); unless permitted under law and not duplication of State Plan services.
- Services used as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician, or other health professional.
- Services used to set up and administer medications.
- Services used to assist with catheter and ostomy care.
- Services provided to household members other than to the individual.
- Services to individuals receiving Adult Family Care waiver service, Structured Family Caregiving waiver service, or Assisted Living waiver service.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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
Individual	FSSA/OMPP approved Attendant Care Individual
Individual	Self-Directed Attendant Care - Individual

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Attendant Care

Provider Category:

Agency

Provider Type:

Licensed Personal Services Agency

Provider Qualifications

License (specify):

IC 16-27-4

Certificate (specify):

Other Standard (specify):

OMPP (or its designee) approved

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Attendant Care

Provider Category:

Individual

Provider Type:

FSSA/OMPP approved Attendant Care Individual

12/05/2025

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

Enrolled as an active Medicaid provider

- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 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 Protecting Individuals: Procedures for protecting individuals
 - 455 IAC 2 Protecting Individuals: Unusual occurrence; reporting
 - 455 IAC 2 Protecting Individuals: Transfer of individual's record upon change of provider
 - 455 IAC 2 Protecting Individuals: Notice of termination of services
 - 455 IAC 2 General Administrative Requirements for Providers: Collaboration and quality control
 - 455 IAC 2 General Administrative Requirements for Providers: Resolution of disputes
 - 455 IAC 2 General Administrative Requirements for Providers: Data collection and reporting standards
 - 455 IAC 2 General Administrative Requirements for Providers: Quality assurance and quality improvement system
 - 455 IAC 2 Financial Information: Disclosure of financial information
 - 455 IAC 2 Property and Personal Liability Insurance: Liability insurance
 - 455 IAC 2 Transportation of an Individual: Transportation of an individual
 - 455 IAC 2 Professional qualifications and requirements: Documentation of qualifications
 - 455 IAC 2 Personnel Records: Maintenance of personnel records
 - 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
 - 455 IAC 2 Maintenance of Records of Services Provided: Individual's personal file; site of service delivery
 - 455 IAC 2 Services: Coordination of services and plan of care IC 12-10-17.1-10 Registration; prohibition
 - IC 12-10-17.1-11 Registration requirement
 - IC 12-10-17.1-12 Registration by the division; duties of the division
 - 455 IAC 1 Attendant care service provider registration requirement; preclusion
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.
- Individuals performing lifting services with mechanical assistance must be trained on the general standards for operating a lift and specific instructions on how to safely operate the individual's lift (at the location where the individual will need those services) in accordance with the manufacturer's instructions and manual. Provider must maintain documentation that individuals performing lifting services have satisfied this training requirement.

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

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

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Attendant Care

Provider Category:

Individual

Provider Type:

Self-Directed Attendant Care - Individual

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Individual providers furnishing supports for individuals who self-direct their services:

- Must enroll with FMS vendor and submit forms/documentation as required by the FMS vendor.
- Must be verified by FMS vendor as meeting all required qualifications.
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 455 IAC 2 Provider Qualifications: General requirements for direct care staff
 - 455 IAC 2 Transportation of an Individual: Transportation of an individual
 - 455 IAC 2 Personnel Records: Maintenance of personnel records
 - 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
- If performing lifting services with mechanical assistance, must be trained on the general standards for operating a lift and specific instructions on how to safely operate the individual's lift (at the location where the individual will need those services) in accordance with the manufacturer's instructions and manual. Provider must maintain documentation that individuals performing lifting services have satisfied this training requirement.
- Individuals who self-direct their services, as the employer, may require additional reasonable staffing requirements based on their preferences and level of needs.
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/DDRS HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.
- FSSA may reject any applicant with a conviction of a crime against persons or property, a conviction for fraud or abuse in any federal, state, or local government program, (42 USC §1320a-7) or a conviction for illegal drug possession. FSSA may reject an applicant convicted of the use, manufacture, or distribution of illegal drugs (42 USC §1320a-7). FSSA may reject an applicant who lacks the character and fitness to render services to the dependent population or whose criminal background check shows that the applicant may pose a danger to the dependent population. FSSA may limit an applicant with a criminal background to caring for a family member only if the family member has been informed of the criminal background.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Services Vendor

Frequency of Verification:

At least every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

01 Case Management

Sub-Category 1:

01010 case management

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Case Management is a process of assessment, discovery, planning, facilitation, advocacy, collaboration, and monitoring of the holistic needs of each individual, regardless of funding sources. Case management services include and case manager is responsible for (i) evaluation referral, (ii) person-centered service planning, development and implementation, (iii) on-going monitoring, evaluation and support.

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

REIMBURSABLE ACTIVITIES

• Evaluation Referral

- Referring individuals to the Level of Care Assessment Representative (LCAR) contractor for level of care evaluation activities.

• Person-Centered Service Planning, Development and Implementation

- Discovering the individuals' strengths, needs, goals, and preferences.

- Facilitating use of person-centered discovery tools and practice to engage the individual and their circle of support.

- Assisting the individual to fully understand their ability to make choices concerning all services they receive and the provider from whom they receive services. This includes case management services.

- Brokering community resources to meet the individual's functional and social needs.

- Developing the person-centered service plan that identifies the services and supports funded by the waiver to appropriately meet the individual's needs. To meet the HCBS Settings Rule, case managers must support the person to lead and direct their planning process as much as possible, and to the extent the person wants. The circle of support must include people the

individual wishes to include. Additionally, the case manager must ensure the following service-specific information is properly documented in the individual's service plan, level of service assessment (if applicable), and/or service record:

- (1) Adult Day Services. Documentation for ADS must include but is not limited to:
 - (i) justification of need
 - (ii) types of ADL support the individual may require
 - (iii) level of service as determined by the ADS LOS Assessment
 - (iv) description of structure needed for the individual (medical, social, recreational)
 - (v) who will be providing ADS and their relationship to the individual
- (2) Attendant Care. Documentation for ATTC must include but is not limited to:
 - (i) justification of need
 - (ii) types of ADL support the individual may require
 - (iii) type of ATTC (provider managed or participant-directed) determined to meet the needs of the individual
 - (iv) the activities to be performed and frequency of care that will meet the individual's needs (must also be accurately documented in LOC assessment tool)
 - (v) demonstration that individual is using and has exhausted all available home health service under the state plan, OR state plan prior authorization request for home health services, denial decision, and reason for denial
 - (v) who will be providing ATTC and their relationship to the individual
 - (vi) If the individual has skilled LOC (i.e. requires skilled care), CM must document and describe how the skilled need is being met, the frequency of care and activities to be performed.
 - (vii) If ATTC services are participant-directed, CM must document and who is the employer, who is the employee/direct worker and their relationship to the individual (if any).
- (3) Home and Community Assistance. Documentation for HCA must include but is not limited to:
 - (i) justification of need
 - (ii) types of IADL support the individual may require
 - (iii) the activities to be performed and frequency of care that will meet the individual's needs
 - (iv) who will be providing HCA and their relationship to the individual
- (4) Skilled Respite. Documentation for Skilled Respite must include but is not limited to:
 - (i) justification of need
 - (ii) the activities to be performed and frequency of care that require skilled respite
 - (iii) name of primary caregiver being relieved
 - (iv) confirmation that primary caregiver is not being paid by the agency to provide skilled respite to themselves.
 - (v) who will be providing skilled Respite and their relationship to the individual
- (5) Adult Family Care. Documentation for AFC must include but is not limited to:
 - (i) justification of need
 - (ii) types of ADL and IADL support the individual may require
 - (iii) level of service as determined by the AFC/SFC LOS Assessment.
 - (iv) the activities to be performed and frequency of care that will meet the individual's needs (must also be accurately documented in LOC assessment tool)
 - (v) If the individual has skilled LOC (i.e. requires skilled care), CM must document and describe how the skilled need is being met, the frequency of care and activities to be performed.
- (6) Assisted Living. Documentation for AL must include but is not limited to:
 - (i) justification of need
 - (ii) types of ADL and IADL support the individual may require
 - (iii) level of service as determined by the AL LOS Assessment.
 - (iv) the activities to be performed and frequency of care that will meet the individual's needs (must also be accurately documented in LOC assessment tool)
 - (v) who will be providing AL and their relationship to the individual
 - (vi) If the individual has skilled LOC (i.e. requires skilled care), CM must document and describe how the skilled need is being met, the frequency of care and activities to be performed.
- (7) Community Transition Services. Documentation for CTS must include but is not limited to:
 - (i) justification of need
 - (ii) items/furnishings or set up expenses that will meet the individual's needs
 - (iii) copies of receipts for all expenditures, showing the amount and what item or deposit was covered
 - (iv) If case manager requests full \$1,500 and not all funds are used, CM must complete a service plan update to reduce the amount to ensure Medicaid is not over-reimbursing for these services.
- (8) Home Delivered Meals. Documentation for HDM must include but is not limited to:
 - (i) justification of need
 - (ii) the number and frequency of meals to be delivered that will meet the individual's needs
- (9) Home Modification and Assessment. Documentation for Home Modification and Assessment must include but is not limited to:

- (i) justification of need
- (ii) description of home modification that will meet the individual's needs
- (iii) copies of bids in compliance with the bid requirements set forth in the service definition
- (iv) When home is rented or family owned, case manager must document (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, and (4) written agreement of landlord or homeowner for modification including agreement about items purchased during the modification, such as a bathtub, upon individual moving from the property or eviction.
- (v) copy of completed Home Modification assessment and final inspection report
- (v) any discrepancies or complaints about the work while it is being completed. CM must notify FSSA within forty-eight hours upon learning of any issue
- (10) Nutritional Supplements. Documentation for Nutritional Supplements must include but is not limited to:
 - (i) justification of need
 - (ii) the number and description of supplements that will meet the individual's needs
 - (iii) state plan prior authorization request, denial decision, and reason for denial
- (11) Personal Emergency Response Systems. Documentation for PERS must include but is not limited to:
 - (i) justification of need for PERS and PERS maintenance
 - (ii) whether the person is residing alone or alone for significant parts of the day without a caregiver present
 - (iii) interventions implemented as a result of fall data from the PERS provider.
 - (iv) back-up plan in the event of equipment failure.
- (12) Pest Control. Documentation for Pest Control must include but is not limited to:
 - (i) justification of need
 - (ii) the types of pests to eradicate that will meet the individual's needs
- (13) Specialized Medical Equipment and Supplies. Documentation for SMES must include but is not limited to:
 - (i) justification of need
 - (ii) description of how the equipment is expected to improve the individuals quality of life
 - (iii) equipment or supplies that will meet the individual's needs
 - (iv) copies of bids in compliance with the bid requirements set forth in the service definition
 - (v) state plan prior authorization request, denial decision, and reason for denial
- (14) Structured Family Caregiving. Documentation for SFC must include but is not limited to:
 - (i) justification of need
 - (ii) types of ADL and IADL support the individual may require
 - (iii) level of service as determined by the AFC/SFC LOS Assessment.
 - (iv) the activities to be performed and frequency of care that will meet the individual's needs (must also be accurately documented in LOC assessment tool)
 - (v) who will be providing SFC and their relationship to the individual
 - (vi) If the individual has skilled LOC (i.e. requires skilled care), CM must document and describe how the skilled need is being met, the frequency of care and activities to be performed.
- (15) Vehicle Modification. Documentation for Vehicle Modification must include but is not limited to:
 - (i) justification of need
 - (ii) description of vehicle modification that will meet the individual's needs
 - (iii) copies of bids in compliance with the bid requirements set forth in the service definition
- Completing annual service planning and development. The case manager is responsible to coordinate changes in the service plan that include but are not limited to notifying all providers about the change and when they are to begin or end services, and notifying all providers when a service plan is in a terminated or re-start status.
- Ongoing Monitoring, Evaluation, and Support
- Monitoring progress for all services displayed on the service plans.
- Providing and coordinating high quality services to the individual, while promoting seamless, integrated, coordinated care.
- Conducting face-to-face contact every 90 days from the initial service plan activation. When the initial service plan is activated, the case manager will either call or visit the individual within 30 days and no more than 40 days from initial service plan activation to ensure implementation of services.

The C-1/C-3: Service Specification for Case Management is continued in the Main Module: Additional Needed Information (Optional) due to character limitations.

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

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

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 by the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

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 AAA that has been granted permission by the FSSA to provide direct services to waiver participants.

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

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

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Case Management

Provider Category:

Agency

Provider Type:

FSSA/OMPP approved Case Management Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 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 Protecting Individuals: Procedures for protecting individuals
 - 455 IAC 2 Protecting Individuals: Unusual occurrence; reporting
 - 455 IAC 2 Protecting Individuals: Transfer of individual's record upon change of provider
 - 455 IAC 2 Protecting Individuals: Notice of termination of services
 - 455 IAC 2 General Administrative Requirements for Providers: Provider organizational chart
 - 455 IAC 2 General Administrative Requirements for Providers: Collaboration and quality control
 - 455 IAC 2 General Administrative Requirements for Providers: Resolution of disputes
 - 455 IAC 2 General Administrative Requirements for Providers: Data collection and reporting standards
 - 455 IAC 2 General Administrative Requirements for Providers: Quality assurance and quality improvement system
 - 455 IAC 2 Financial Information: Disclosure of financial information
 - 455 IAC 2 Property and Personal Liability Insurance: Liability insurance
 - 455 IAC 2 Professional Qualifications and Requirements Documentation of qualifications
 - 455 IAC 2 Personnel Records: Maintenance of personnel records
 - 455 IAC 2 Personnel Policies and Manuals: Adoption of personnel policies
 - 455 IAC 2 Personnel Policies and Manuals: Operations manual
 - 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
 - 455 IAC 2 Maintenance of Records of Services Provided: Individual's personal file; site of service delivery
 - 455 IAC 2 Case Management: Case Management
 - 455 IAC 2 Services: Coordination of services and plan of care
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.

Individuals providing case management services must be employed by the specified agency and must possess the following education and work experience:

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

Individuals providing case management services must be employed by the specified agency and must demonstrate competency regarding the HCBS settings criteria and person-centered service plan development.

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

OMPP

Frequency of Verification:

Up to three years

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Individual

Provider Type:

FSSA/OMPP approved Case Management Individual

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 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 Protecting Individuals: Procedures for protecting individuals
 - 455 IAC 2 Protecting Individuals: Unusual occurrence; reporting
 - 455 IAC 2 Protecting Individuals: Transfer of individual's record upon change of provider
 - 455 IAC 2 Protecting Individuals: Notice of termination of services
 - 455 IAC 2 General Administrative Requirements for Providers: Collaboration and quality control
 - 455 IAC 2 General Administrative Requirements for Providers: Resolution of disputes
 - 455 IAC 2 General Administrative Requirements for Providers: Data collection and reporting standards
 - 455 IAC 2 General Administrative Requirements for Providers: Quality assurance and quality improvement system
 - 455 IAC 2 Financial Information: Disclosure of financial information
 - 455 IAC 2 Property and Personal Liability Insurance: Liability insurance
 - 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
 - 455 IAC 2 Personnel Records: Maintenance of personnel records
 - 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
 - 455 IAC 2 Maintenance of Records of Services Provided: Individual's personal file; site of service delivery
 - 455 IAC 2 Case Management: Case Management
 - 455 IAC 2 Services: Coordination of services and plan of care
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.

Individuals providing case management services must possess the following education and work experience:

- An individual continuously employed as a Care/Case Manager by an Area Agency on Aging (AAA) since June 30, 2018; or
- A registered nurse, a licensed practical nurse, or an associate's degree in nursing with at least one year of experience serving the program population; or
- A Bachelor's Degree in Social Work, Psychology, Counseling, Gerontology, Nursing or Health & Human Services; or
- A Bachelor's Degree in any field with a minimum of two years full-time, direct service experience with older adults or person with disabilities (this experience includes assessment, care plan development, and monitoring); or
- A Master's degree in Social Work, Psychology, Counseling, Gerontology, Nursing or Health & Human Services; or
- An Associate's degree in any field with a minimum four years full-time, direct service experience with older adults or persons with disabilities (this experience includes assessment, care plan development, and monitoring).
- Individuals providing case management services must demonstrate competency regarding the HCBS settings criteria and person-centered service plan development.

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

OMPP

Frequency of Verification:

Up to three years

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

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

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

Home and Community Assistance Service

HCBS Taxonomy:**Category 1:**

08 Home-Based Services

Sub-Category 1:

08050 homemaker

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

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

ALLOWABLE ACTIVITIES

Provides IADL care as identified in the person-centered service plan that includes but is not limited to the following:

- Dusting and straightening furniture
- Cleaning floors and rugs by wet or dry mop and vacuum sweeping
- Cleaning the kitchen, including washing dishes, pots, and pans; cleaning the outside of appliances and counters and cupboards; cleaning ovens; and defrosting and cleaning refrigerators
- Maintaining a clean bathroom, including cleaning the tub, shower, sink, toilet bowl, and medicine cabinet; emptying and cleaning commode chair or urinal
- Laundering clothes in the home or laundromat, including washing, drying, folding, putting away, ironing, and basic mending and repair
- Changing linen and making beds

- Washing insides of windows
- Minor pet care may be allowed at the discretion of the agency
- Assistance with outdoor tasks including raking leaves, snow removal, lawn mowing, and weeding
- Meal planning and preparation, including special diets under the supervision of a registered dietitian or health professional
- Removing trash from the home
- Assistance with correspondence and bill paying
- Completing essential errands and/or unassisted transportation for non-medical and community activities

SERVICE STANDARDS

- HCA services must be included on the individual's service plan
- HCA services must address needs identified in the person-centered planning process

HCA services may be provided from the following:

- Agency Provider - an agency enrolled in the program is responsible to hire and render services.
- Individual Provider - an individual enrolled in the program is responsible to render services.
- Participant Directed—the individual (or representative appointed by the individual) is the employer and acts as the agency directing their care.

DOCUMENTATION STANDARDS

Data record of services provided, including:

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

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

HCA services will not be reimbursed for travel expenses beyond the time spent on the errand when services take place outside the individual's home.

HCA services will not be reimbursed when provided the spouse of a participant (also known as a Legally Responsible Individual) or a Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

HCA services will be reimbursed when provided by a Relative, ONLY when all conditions specified in Appendix C-2-e of this waiver are met.

ACTIVITIES NOT ALLOWED:

- Assistance with ADL hands on care. Specifically, Home and Community Assistance may not provide any ADL assistance such as eating, bathing, dressing, personal hygiene, medication set up and administration.
- HCA services provided to household members other than to the individual.
- HCA services to individuals receiving Adult Family Care waiver service, Structured Family Caregiving waiver service, or Assisted Living waiver service

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Home and Community Assistance Service

Provider Category:

Individual

Provider Type:

FSSA/OMPP approved Home and Community Assistance Individual

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 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 Protecting Individuals: Procedures for protecting individuals
 - 455 IAC 2 Protecting Individuals: Unusual occurrence; reporting
 - 455 IAC 2 Protecting Individuals: Transfer of individual's record upon change of provider
 - 455 IAC 2 Protecting Individuals: Notice of termination of services
 - 455 IAC 2 General Administrative Requirements for Providers: Collaboration and quality control
 - 455 IAC 2 General Administrative Requirements for Providers: Resolution of disputes
 - 455 IAC 2 General Administrative Requirements for Providers: Data collection and reporting standards
 - 455 IAC 2 General Administrative Requirements for Providers: Quality assurance and quality improvement system
 - 455 IAC 2 Financial Information: Disclosure of financial information
 - 455 IAC 2 Property and Personal Liability Insurance: Liability insurance
 - 455 IAC 2 Professional qualifications and requirements: Documentation of qualifications
 - 455 IAC 2 Personnel Records: Maintenance of personnel records
 - 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
 - 455 IAC 2 Maintenance of Records of Services Provided: Individual's personal file; site of service delivery
 - 455 IAC 2 Services: Coordination of services and plan of care
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Home and Community Assistance Service****Provider Category:**

Agency

Provider Type:

Licensed Personal Services Agency

Provider Qualifications**License (specify):**

IC 16-27-4

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

OMPP (or its designee) approved

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

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Home and Community Assistance Service****Provider Category:**

Individual

Provider Type:

Self-Directed Home and Community Assistance - Individual

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

Individual/Agency providing services for individuals who self-direct their services:

- Must enroll with FMS vendor and submit forms and documentation as required by the FMS vendor

- Must be verified by FMS vendor as meeting all required qualifications.
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 455 IAC 2 Provider Qualifications: General requirements for direct care staff
 - 455 IAC 2 Transportation of an Individual: Transportation of an individual
 - 455 IAC 2 Personnel Records: Maintenance of personnel records
 - 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
- Individuals who self-direct their services, as the employer, may require additional reasonable staffing requirements based on their preferences and level of needs. Providers of self-directed services must submit forms and documentation as required by the FMS vendor. FMS vendor must ensure the individual or agency performing the service meets the required qualifications.
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/DDRS HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.
- FSSA may reject any applicant with a conviction of a crime against persons or property, a conviction for fraud or abuse in any federal, state, or local government program, (42 USC §1320a-7) or a conviction for illegal drug possession. FSSA may reject an applicant convicted of the use, manufacture, or distribution of illegal drugs (42 USC §1320a-7). FSSA may reject an applicant who lacks the character and fitness to render services to the dependent population or whose criminal background check shows that the applicant may pose a danger to the dependent population. FSSA may limit an applicant with a criminal background to caring for a family member only if the family member has been informed of the criminal background.

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

Financial Management Services Vendor

Frequency of Verification:

At least every three years

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

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Skilled Respite

HCBS Taxonomy:**Category 1:**

09 Caregiver Support

Sub-Category 1:

09012 respite, in-home

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

05 Nursing

05020 skilled nursing

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Skilled respite services are those services that are provided temporarily or periodically in the place of the usual caregiver. Skilled respite can occur in home and community based settings.

REIMBURSABLE ACTIVITIES

Under this waiver service, two forms of skilled respite are allowable:

- Home health aide services (RHHA)
- Skilled nursing services (RSKNU)

SERVICE STANDARDS

- Skilled Respite services must be included on the individual's service plan
- Skilled Respite services must address needs identified in the person-centered planning process
- Skilled Respite services may be provided from the following:
 - Agency Provider - an agency enrolled in the program is responsible to hire and render services.
 - Individual Provider - an individual enrolled in the program is responsible to render services.
 - Participant Directed—the individual (or representative appointed by the individual) is the employer and acts as the agency directing their care.

RHHA authorized hours will roll over month-to-month through the duration of the Annual Service Plan. If there are unused hours they must first be used before requesting additional hours.

RSKNU authorized hours will roll over month to month through the duration of the Annual Service Plan. If there are unused hours they must first be used before requesting additional.

Agency providing skilled respite service is responsible for tracking individual's skilled respite hours and notifying individual and Service Coordinator/Case Manager of hours used as well as hours remaining.

DOCUMENTATION STANDARDS

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

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

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

Skilled Respite services will not be reimbursed when provided by the spouse of a participant (also known as a Legally Responsible Individual) or a Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

Skilled Respite services will be reimbursed when provided by a Relative, ONLY when all conditions specified in Appendix C-2-e of this waiver are met.

ACTIVITIES NOT ALLOWED:

- Skilled respite service to individuals 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

Remote/via Telehealth

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	Self-Directed Skilled Respite - Individual
Agency	Licensed Home Health Agency

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

Service Type: Statutory Service

Service Name: Skilled Respite

Provider Category:

Individual

Provider Type:

Self-Directed Skilled Respite - Individual

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Individual/Agency providing services for individuals who self-direct their services:

- Must enroll with FMS vendor and submit forms and documentation as required by the FMS vendor
- Must be verified by FMS vendor as meeting all required qualifications.
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 455 IAC 2 Provider Qualifications: General requirements for direct care staff
 - 455 IAC 2 Transportation of an Individual: Transportation of an individual
 - 455 IAC 2 Personnel Records: Maintenance of personnel records
 - 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
- Individuals providing the RHHA component of Skilled Respite services must be:
 - A Home Health Aide Registered in accordance with IC 16-27-1.5; or
 - A Registered Nurse licensed in accordance with IC 25-23-1; or
 - A Licensed Practical Nurse licensed in accordance with IC 25-23-1.
- Individuals providing the RSKNU component of Skilled Respite services must be:

- A Registered Nurse licensed in accordance with IC 25-23-1; or
- A Licensed Practical Nurse licensed in accordance with IC 25-23-1.

- Individuals who self-direct their services, as the employer, may require additional reasonable staffing requirements based on their preferences and level of needs. Providers of self-directed services must submit forms and documentation as required by the FMS vendor. FMS vendor must ensure the individual or agency performing the service meets the required qualifications.
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/DDRS HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.
- FSSA may reject any applicant with a conviction of a crime against persons or property, a conviction for fraud or abuse in any federal, state, or local government program, (42 USC §1320a-7) or a conviction for illegal drug possession. FSSA may reject an applicant convicted of the use, manufacture, or distribution of illegal drugs (42 USC §1320a-7). FSSA may reject an applicant who lacks the character and fitness to render services to the dependent population or whose criminal background check shows that the applicant may pose a danger to the dependent population. FSSA may limit an applicant with a criminal background to caring for a family member only if the family member has been informed of the criminal background.

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

Financial Management Services Vendor

Frequency of Verification:

At least every three years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Skilled Respite****Provider Category:**

Agency

Provider Type:

Licensed Home Health Agency

Provider Qualifications**License (specify):**

IC 16-27-1

IC 16-27-4

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

OMPP (or its designee) approved

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

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Family Care

HCBS Taxonomy:

Category 1:

02 Round-the-Clock Services

Sub-Category 1:

02023 shared living, other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

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

AFC is designed to provide options for alternatives to long-term care for individuals who meet nursing facility level of care and whose needs can be met in a home-like environment.

The service provides necessary care while emphasizing the individual's independence, which is reached through a cooperative relationship between the individual (or the individual's legal guardian), the individual's HCBS Medicaid waiver service coordinator/case manager, and the AFC provider. The individual's needs must be addressed in a manner that supports and enables the individual to maximize abilities to function at the highest possible level of independence.

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

SERVICE LEVELS

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

The breakdown is as follows:

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

REIMBURSEABLE ACTIVITIES:

The following are included in the daily per diem for AFC:

- Personal care support
- Homemaker or chore support
- Medication oversight (to the extent permitted under State law)

SERVICE STANDARDS:

- AFC must be included on the individual's service plan
- AFC must address needs identified in the person-centered planning process and the AFC/SFC Level of Service Assessment Form
- 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 provider 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, safe place that is free of environmental hazards such as pests, habitable environment, comfortable surroundings, and the opportunity to modify one's living area to suit one's 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 an individual's rights under state and federal law.
- Participant-focused activity plans are developed by the provider with the individual or their representative.
- Providers or provider's employees who provide medication oversight as addressed under allowed activities must receive necessary instruction from a doctor, nurse, or pharmacist on the administration of controlled substances prescribed to the individual.

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

Daily documentation to support services rendered by AFC staff to address needs identified in the person-centered service plan:

- Participant's status, including health, mental health, medication, diet, sleep patterns, social activity/community engagement
- Updates, including health, mental health, medication, diet, sleep patterns, social activity/community engagement
- Participation in consumer focused activities
- Medication management records, if applicable

Monthly updated service plans provided to the participant's service coordinator/case manager from the AFC caregiver.

Maintenance of participant's personal records to include:

- Social security number
- Medical insurance number
- Birth date
- Emergency contact(s)
- All medical information available including all current prescription and non-prescription drug medication
- Most recent prior residence
- Hospital preference
- Primary care physician
- Mortuary (if known)
- Religious affiliation and place of worship, if applicable
- Strengths
- Risks
- Any goals identified by the participant and support provided by AFC staff to help the participant achieve goals.

Participant's personal records must include copies of all applicable documents, which the AFC caregiver will also provide to the participant's service coordinator/case manager on an ongoing basis if there are changes to these documents:

- Advance Directive
- Living Will
- Power of Attorney
- Health Care Representative
- Do Not Resuscitate (DNR) Order
- Letters of Guardianship

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

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

The AFC service per diem does not include room and board.

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

AFC services will not be reimbursed when provided by the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED:

- Services provided in the home of a caregiver who is related by blood or related legally to the waiver participant.
- Payments for room and board or the costs of facility maintenance, upkeep or improvement.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Adult Family Care

Provider Category:

Agency

Provider Type:

FSSA/OMPP approved Adult Family Care Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 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 Protecting Individuals: Procedures for protecting individuals
 - 455 IAC 2 Protecting Individuals: Unusual occurrence; reporting
 - 455 IAC 2 Protecting Individuals: Transfer of individual's record upon change of provider
 - 455 IAC 2 Protecting Individuals: Notice of termination of services
 - 455 IAC 2 General Administrative Requirements for Providers: Provider organizational chart
 - 455 IAC 2 General Administrative Requirements for Providers: Collaboration and quality control
 - 455 IAC 2 General Administrative Requirements for Providers: Resolution of disputes
 - 455 IAC 2 General Administrative Requirements for Providers: Data collection and reporting standards
 - 455 IAC 2 General Administrative Requirements for Providers: Quality assurance and quality improvement system
 - 455 IAC 2 Financial Information: Disclosure of financial information
 - 455 IAC 2 Property and Personal Liability Insurance: Liability insurance
 - 455 IAC 2 Transportation of an Individual: Transportation of an individual
 - 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
 - 455 IAC 2 Personnel Records: Maintenance of personnel records
 - 455 IAC 2 Personnel Policies and Manuals: Adoption of personnel policies
 - 455 IAC 2 Personnel Policies and Manuals: Operations manual
 - 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
 - 455 IAC 2 Maintenance of Records of Services Provided: Individual's personal file; site of service delivery
 - 455 IAC 2 Services: Coordination of services and plan of care
 - 455 IAC 2 Residential Day Services: Safety and security policies and procedures
 - 455 IAC 2 Residential Day Services: Emergency telephone numbers
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage

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

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Adult Family Care****Provider Category:**

Individual

Provider Type:

FSSA/OMPP approved Adult Family Care Individual

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

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 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 Protecting Individuals: Procedures for protecting individuals
 - 455 IAC 2 Protecting Individuals: Unusual occurrence; reporting
 - 455 IAC 2 Protecting Individuals: Transfer of individual's record upon change of provider
 - 455 IAC 2 Protecting Individuals: Notice of termination of services
 - 455 IAC 2 General Administrative Requirements for Providers: Collaboration and quality control
 - 455 IAC 2 General Administrative Requirements for Providers: Resolution of disputes
 - 455 IAC 2 General Administrative Requirements for Providers: Data collection and reporting standards
 - 455 IAC 2 General Administrative Requirements for Providers: Quality assurance and quality improvement system
 - 455 IAC 2 Financial Information: Disclosure of financial information
 - 455 IAC 2 Property and Personal Liability Insurance: Liability insurance
 - 455 IAC 2 Transportation of an Individual: Transportation of an individual
 - 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
 - 455 IAC 2 Personnel Records: Maintenance of personnel records
 - 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
 - 455 IAC 2 Maintenance of Records of Services Provided: Individual's personal file; site of service delivery
 - 455 IAC 2 Services: Coordination of services and plan of care
 - 455 IAC 2 Residential Day Services: Safety and security policies and procedures
 - 455 IAC 2 Residential Day Services: Emergency telephone numbers
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.

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

OMPP

Frequency of Verification:

Up to three years

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

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

Service Type:

Other Service

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

Service Title:

Assisted Living

HCBS Taxonomy:**Category 1:****Sub-Category 1:**

02 Round-the-Clock Services

02013 group living, other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Assisted living (AL) service is defined as personal care support, homemaker support, chore support, companion services, medication oversight (to the extent permitted under state law), non-emergency non-medical transportation and therapeutic social and recreational programming, provided in a congregate residential setting in conjunction with the provision of individual's paid room and board. This service includes 24 hour on-site response staff to meet scheduled and unpredictable needs. The individual receiving services retains the right to assume risk.

SERVICE LEVELS

There are three service levels of Assisted Living each with a unique rate. The applicable rate is determined through completion of the Assisted Living Level of Service Assessment (AL LOS Assessment). Service Coordinators/Case Managers complete this assessment at least annually to accurately reflect the relative support need of the individual. The AL LOS Score determines the reimbursement rate to be utilized in the individual's next service plan.

The breakdown is as follows:

- Level 1 – AL LOS Assessment Score of 0 - 35.
- Level 2 – AL LOS Assessment Score of 36 - 60.
- Level 3 – AL LOS Assessment Score of 61+.

REIMBURSABLE ACTIVITIES

The following are included in the daily per diem for assisted living services:

- Personal care support
- Homemaker or chore support
- Companion services
- Medication oversight (to the extent permitted under state law)
- Non-emergency non-medical transportation
- Therapeutic social and recreational programming

SERVICE STANDARDS:

- Assisted Living services must be included on the individual's service plan. Additionally, the service plan should identify the individual's strengths, goals, support needed to assist the individual in achieving goals, risk and interventions to reduce risk.
- Assisted Living services must address needs identified in the person-centered planning process and the AL LOS Assessment Form.

DOCUMENTATION STANDARDS

Complete and accurate documentation to support daily services rendered by the AL to address needs identified in the Service Plan:

- Participant's strengths, goals, support needed to assist the participant in achieving goals, risk and interventions to reduce risk.
- Community engagement activities performed by the participant
- Participant's status, including health, mental health, medication, diet, sleep patterns, social activity
- Updates, including health, mental health, medication, diet, sleep patterns, social activity
- Participation in consumer focused activities
- Medication management records, if applicable
- Quarterly updated service plans provided to the participant's Service Coordinator/Case Manager from the assisted living

service

Maintenance of participant's personal records to include:

- Social security number
- Medical insurance number
- Birth date
- Emergency contact(s)
- Available medical information including known current prescription and non-prescription drug medication
- Hospital preference
- Primary care physician
- Mortuary (if known)

Participant's personal records must include copies of the following documents, if available, which the assisted living caregiver will also provide to the participant's service coordinator/case manager on an ongoing basis if there are changes to these documents:

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

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

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

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

The Assisted Living service per diem or monthly rate does not include room and board.

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

AL services will not be reimbursed when provided by the spouse of a participant (also known as a Legally Responsible Individual) or a Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

AL services will be reimbursed when provided by a Relative, ONLY when all conditions specified in Appendix C-2-e of this waiver are met.

ACTIVITIES NOT ALLOWED:

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

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Assisted Living Agencies

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Assisted Living

Provider Category:

Agency

Provider Type:

Licensed Assisted Living Agencies

Provider Qualifications

License (specify):

IC 16-28-2

Certificate (specify):

Other Standard (specify):

OMPP (or its designee) approved
410 IAC 16.2-5

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Caregiver Coaching

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09020 caregiver counseling and/or training

Category 2:

10 Other Mental Health and Behavioral Services

Sub-Category 2:

10090 other mental health and behavioral services

Category 3:**Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

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

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

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

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

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

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

REIMBURSABLE ACTIVITIES

- Initial consultation for assessment of the caregiver to determine initial coaching needs, and understand the caregiver's goals, values, needs and strengths.
- Caregiver Coaching provided in the community of the individual, virtually or telephonically, or other identified location

meaningful to the unpaid caregiver, and through HIPAA secure communication platforms that allow for real-time and asynchronous communication between caregivers and caregiver coaches and collaboration with service coordinators/case managers.

SERVICE STANDARDS

- Caregiver Coaching services must be included on the individual's service plan
- Caregiver Coaching services must address needs identified in the person-centered planning process
- Caregiver Coaching services are family-centered, individualized to the needs of the individual and caregiver, and informed by an assessment of each caregiver's goals, values, needs, and strengths.
- A caregiver coach with expertise working with unpaid caregivers will conduct a caregiver assessment developed by FSSA and deliver ongoing education and coaching that is informed by the assessment.
- Caregiver Coaching services may be delivered telephonically and through HIPAA secure electronic communication platforms that enable a caregiver coach and a caregiver to communicate efficiently and, in a manner convenient to the caregiver. Provider agencies must capture any caregiver communications received through an electronic communication platform, such as an app or e-mail, to facilitate the sharing of relevant information with service coordinators/case managers. Providers will communicate with service coordinators/case managers through traditional means to share any relevant information. The service does not require any specific percentage of in-person visits versus virtual visits.
- The service is designed to equip the individual's unpaid caregiver(s) with the necessary skills to manage the individual's medical conditions and associated behavioral health needs related to a cognitive impairment and/or dementia. Part of the caregiver assessment rendered by the caregiver coach will address areas of the caregiver's life that promote socialization and involvement within the community, but ultimately, the decision is based on where the caregiver needs support. If community integration is an area important to the individual, the caregiver coach will support the caregiver in ensuring the individual's goals with regards to community integration are met. Additionally, a caregiver's community integration and supporting an individual's community integration may change over time and will be consistently modified as necessary.
- A caregiver coach engages with a caregiver on a bi-weekly basis to understand the evolving needs of the individual and caregiver and deliver content, strategies and tools related to the management of the individual's needs and behaviors and the caregiver's self-care needs.
- Caregiver training will include infection prevention training; behaviors and triggering events; effective verbal and non-verbal communication strategies; strategies for managing challenging behaviors; and how to address home safety concerns. Coaching will also support a caregiver to apply stress reduction techniques and reduce caregiver isolation.
- Caregiver coach will assist the caregiver and client in creation of a crisis management/emergency plan to address the person and environment.
- Medicaid- participating Structured Family Caregiving agencies and Adult Day agencies may be service providers; agencies must employ caregiver coaches with the experience and qualifications appropriate to the needs of each family. Educational content delivered by provider agencies to caregivers and delivery methods must be appropriate to the needs of unpaid caregivers.

DOCUMENTATION STANDARDS

- Each month, the Caregiver Coaching provider must review and update (as needed) the crisis management/emergency plan and provide a copy to the service coordinator/case manager and waiver/State Plan/Hospice providers as well as emergency contacts and backup caregiver. The crisis management/emergency plan shall include but is not limited to the following:
 - Health conditions
 - Advanced directives, will planning, physician orders for life sustaining treatment.
 - Medications and medication management/assistance to prevent medication errors.
 - Fall prevention interventions
 - Sundowning interventions
 - Healthcare providers including contact information
 - Emergency contacts
 - Identification and contact information for back-up caregiver
 - Contact Information for Caregiver coach and waiver service coordinator/case manager.
 - Caregiver resources available within the caregiver's/individual's community of choice.

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

Caregiver Coaching services are limited to a maximum of thirty-two (32) billable quarter-hour units per month.

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

Separate payment will not be made for Structured Family Caregiving.

Caregiver Coaching services will not be reimbursed when provided by the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/OMPP Approved Structured Family Caregiving Provider or FSSA/OMPP Approved Adult Day Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Caregiver Coaching

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Enrolled as an active Medicaid provider

- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 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 Protecting Individuals: Procedures for protecting individuals
 - 455 IAC 2 Protecting Individuals: Unusual occurrence; reporting
 - 455 IAC 2 Protecting Individuals: Transfer of individual's record upon change of provider
 - 455 IAC 2 Protecting Individuals: Notice of termination of services
 - 455 IAC 2 General Administrative Requirements for Providers: Provider organizational chart
 - 455 IAC 2 General Administrative Requirements for Providers: Collaboration and quality control
 - 455 IAC 2 General Administrative Requirements for Providers: Resolution of disputes
 - 455 IAC 2 General Administrative Requirements for Providers: Data collection and reporting standards
 - 455 IAC 2 General Administrative Requirements for Providers: Quality assurance and quality improvement system
 - 455 IAC 2 Financial Information: Disclosure of financial information
 - 455 IAC 2 Property and Personal Liability Insurance: Liability insurance

- 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
- 455 IAC 2 Personnel Records: Maintenance of personnel records
- 455 IAC 2 Personnel Policies and Manuals: Adoption of personnel policies
- 455 IAC 2 Personnel Policies and Manuals: Operations manual
- 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
- 455 IAC 2 Maintenance of Records of Services Provided: Individual's personal file; site of service delivery
- 455 IAC 2 Services: Coordination of services and plan of care

- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.

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

OMPP

Frequency of Verification:

Every three years

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

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

Service Type:

Other Service

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

Service Title:

Community Transition

HCBS Taxonomy:**Category 1:**

16 Community Transition Services

Sub-Category 1:

16010 community transition services

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Community Transition Services (CTS) are specified in the service plan and 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 their

own living expenses in the community and will not be reimbursable on any subsequent move.

Note: "Own Home" is defined as any dwelling, including a house, an apartment, a condominium, a trailer, or other lodging that is owned, leased, or rented by the 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 CTS are the property of the individual receiving the service, and the individual takes the property with them in the event of a move to another residence, even if the residence from which they are moving is owned by a provider agency.

REIMBURSABLE ITEMS

- Security deposits and application fees that are required to obtain a lease on an apartment or a home
- Essential furnishings and moving expenses required to occupy and use a community domicile including but not limited to a bed, table or chairs, assembly of flat-packed furniture, window coverings, one telephone, eating utensils, housekeeping supplies, food preparation items, hygiene products, microwave, and bed or bath linens
- Set-up fees or deposits for utility or service access including telephone, electricity, heating, internet and water
- Health and safety assurances including pest eradication, allergen control, or one time cleaning prior to occupancy

SERVICE STANDARDS

- CTS must be included on the individual's service plan
- CTS must address needs identified in the person-centered planning process

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

Reimbursement for CTS is limited to a lifetime cap for set up expenses, up to \$2,500.

CTS must be identified, ordered, and delivered within 3 months of the individual's discharge from the qualifying institution.

Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources.

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

Nursing Facilities will not be reimbursed for CTS because those services are part of the provider's per diem. The state will not bill for FFP until after the individual departs the institution and meets waiver eligibility.

CTS will not be reimbursed when provided by the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

This service is not available under the waiver to individuals enrolled with an MCE. Rather, all MCEs provide Community Transition Services as part of their contractual obligations to all individuals who seek to move from an institutional to community-based setting.

ITEMS NOT ALLOWED

- Monthly rental or mortgage expense
- Food
- Regular utility charges
- Large household appliances
- Diversional or recreational items such as hobby supplies
- Cable TV access
- Streaming video services (e.g. Netflix)
- VCRs or DVD players

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Transition

Provider Category:

Agency

Provider Type:

FSSA/OMPP approved Community Transition Service Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 455 IAC 2 Provider Qualifications: Becoming an approved provider; maintaining approval
 - 455 IAC 2 Provider qualifications: General requirements
 - 455 IAC 2 Protecting Individuals: Procedures for protecting individuals
 - 455 IAC 2 Protecting Individuals: Unusual occurrence; reporting
 - 455 IAC 2 Protecting Individuals: Transfer of individual's record upon change of provider
 - 455 IAC 2 Protecting Individuals: Notice of termination of services
 - 455 IAC 2 General Administrative Requirements for Providers: Provider organizational chart
 - 455 IAC 2 General Administrative Requirements for Providers: Collaboration and quality control
 - 455 IAC 2 General Administrative Requirements for Providers: Resolution of disputes
 - 455 IAC 2 General Administrative Requirements for Providers: Data collection and reporting standards
 - 455 IAC 2 General Administrative Requirements for Providers: Quality assurance and quality improvement system
 - 455 IAC 2 Financial Information: Disclosure of financial information
 - 455 IAC 2 Property and Personal Liability Insurance: Liability insurance
 - 455 IAC 2 Transportation of an Individual: Transportation of an individual
 - 455 IAC 2 Professional qualifications and requirements; documentation of qualifications
 - 455 IAC 2 Personnel Records: Maintenance of personnel records
 - 455 IAC 2 Personnel Policies and Manuals: Adoption of personnel policies
 - 455 IAC 2 Personnel Policies and Manuals: Operations manual
 - 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
 - 455 IAC 2 Maintenance of Records of Services Provided: Individual's personal file; site of service delivery
 - 455 IAC 2 Services: Coordination of services and plan of care
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.

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

OMPP

Frequency of Verification:

Up to three years

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

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

Service Type:

Other Service

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

Service Title:

Home Delivered Meals

HCBS Taxonomy:**Category 1:**

06 Home Delivered Meals

Sub-Category 1:

06010 home delivered meals

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

A Home Delivered Meal is a nutritionally balanced meal.

REIMBURSABLE ACTIVITIES

Home delivered meals may include but are not limited to:

- No more than two meals per day will be reimbursed under the waiver
- Diet/ nutrition counseling provided by a registered dietician
- Nutritional education based on needs of each individual
- Diet modification according to a physician's order as required meeting the individual's medical and nutritional needs

SERVICE STANDARDS

- Home Delivered Meal services must be included on the individual's service plan
- Home Delivered Meal services must be based on the individual's needs identified in the person-centered planning process.

- An individual's, social, psychosocial and health should be considered when determining the individual's ability to prepare their own meals.
- Home-Delivered Meals services 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, including but not limited to:
 - A variety of vegetables; dark green, red and orange, legumes (beans and peas), starchy and other vegetables
 - Fruits, especially whole fruit
 - Grains, at least half of which are whole grain
 - Fat-free or low-fat dairy, including milk, yogurt, cheese, and/or fortified soy beverages
 - A variety of protein foods, including seafood, lean meats and poultry, eggs, legumes (beans and peas), soy products, and nuts and seeds
 - Oils, including those from plants: canola, corn, olive, peanut, safflower, soybean, and sunflower. Oils also are naturally present in nuts, seeds, seafood, olives, and avocados.
- Meals shall contain less than 10% daily calories from added sugars unless prior MCE (or OMPP for FFS) or Registered Dietitian approval.
- Meals shall contain less than 10% of daily calories from saturated fats unless prior MCE (or OMPP for FFS) or Registered Dietitian approval.
- Meals shall contain less than 2,300 mg of sodium per day unless prior MCE (or OMPP for FFS) or Registered Dietitian approval.
- Provider labels for expiration dates and instructions for storage and preparation must be communicated in a manner that meets the needs of the individual.

DOCUMENTATION STANDARDS

Date of delivery, how many meals are included, and the name of the care professional or service coordinator/case manager that involved the participant also needs to be documented.

Document any food allergies, food preferences, gluten sensitivity for waiver participants.

Date of expiration included on all meals

Written or oral instruction for appropriate storage of meal

Written or oral instruction for preparing meal

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

Home Delivered Meals are limited to a maximum of two (2) meals per day.

Home Delivered Meals will not be reimbursed when provided by the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED

Services to individuals 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

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

FSSA/OMPP approved Home Delivered Meals Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 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 Protecting Individuals: Procedures for protecting individuals
 - 455 IAC 2 Protecting Individuals: Unusual occurrence; reporting
 - 455 IAC 2 Protecting Individuals: Transfer of individual's record upon change of provider
 - 455 IAC 2 Protecting Individuals: Notice of termination of services
 - 455 IAC 2 General Administrative Requirements for Providers: Provider organizational chart
 - 455 IAC 2 General Administrative Requirements for Providers: Collaboration and quality control
 - 455 IAC 2 General Administrative Requirements for Providers: Resolution of disputes
 - 455 IAC 2 General Administrative Requirements for Providers: Data collection and reporting standards
 - 455 IAC 2 General Administrative Requirements for Providers: Quality assurance and quality improvement system
 - 455 IAC 2 Financial Information: Disclosure of financial information
 - 455 IAC 2 Property and Personal Liability
- Insurance: Liability insurance
 - 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
 - 455 IAC 2 Personnel Records: Maintenance of personnel records
 - 455 IAC 2 Personnel Policies and Manuals: Adoption of personnel policies
 - 455 IAC 2 Personnel Policies and Manuals: Operations manual
 - 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
 - 455 IAC 2 Maintenance of Records of Services Provided: Individual's personal file; site of service delivery
 - 455 IAC 2 Services: Coordination of services and plan of care
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.
- 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:

Frequency of Verification:

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Modification Assessment (Terminated as of 12/30/2025)

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17030 housing consultation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

AS OF THE PATHWAYS IN.2407 THIRD AMENDMENT EFFECTIVE 12.31.2025, HOME MODIFICATION ASSESSMENT AND HOME MODIFICATIONS SERVICES ARE NOW COMBINED AS HOME MODIFICATIONS AND ASSESSMENTS SERVICES. REFER TO ALL SPECIFICATIONS IN THE HOME MODIFICATIONS AND ASSESSMENTS SERVICE.

The service will be used to objectively determine the specifications for a home modification that is safe, appropriate, and feasible in order to ensure accurate bids and workmanship. All participants must receive a home modification assessment with a certified waiver provider selected by the participant prior to any subsequent home modifications as well as a home modification inspection upon completion of the work. A home modification will not be reimbursed until the final inspection has been completed.

The home modification assessment will assess the home for physical adaptations to the home, which as indicated by individual's service plan, are necessary to ensure the health, welfare and safety of the individual and enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

The assessor will be responsible for writing the specifications, review of feasibility and the post-project inspection. Upon completion of the specifications, and review of feasibility, the assessor will prepare and submit the project specifications to the service coordinator/care manager and individual for the bidding process and be paid first installment for completion of home specifications. Once the project is complete, the assessor, consumer and service coordinator/care manager will each be present on an agreed upon date and time to inspect the work and sign- off indicating that it was completed per the agreed upon bid and be paid the final installment of the home modification work. In the event the participant, provider, assessor and/or service coordinator/care manager become aware of discrepancies for complaints about the work being completed, the provider shall stop work immediately, and contact the service coordinator/care manager and MCE for further instruction.

Additional assessment visits may be requested to help resolve a disagreement between the home modification provider and the participant. This payment is not included in the actual home modification cost category and shall not be subtracted from the participant's lifetime cap for home modifications. The MCE will be responsible for maintaining related records that can be accessed by OMPP. For FFS enrollees, the care management provider entity will be responsible for maintaining related records that can be accessed by the state.

ALLOWABLE ACTIVITIES

- Evaluation of the current environment, including the identification of barriers, underneath the home, electrical and plumbing, which may prevent the completion of desired modifications
- Reimbursement for non-feasible assessments
- Drafting of specifications
- Preparation/submission of specifications
- Examination of the modification (inspection/approve)
- Contact county code enforcement

SERVICE STANDARDS

Need for home modification must be indicated in the participant's plan of care

Modification must address the participant's level of service needs

Proposed specifications for modification must conform to the requirements and limitations of the current approved service definition for home modification services

Assessment should be conducted by an approved, qualified individual who is independent of the entity providing the home modifications.

Contact appropriate authority regarding potential code violations.

An annual cap of \$574.38 is available for home modification assessment services, unless the MCE (or OMPP for FFS) requests an additional assessment in order to help mediate disagreements between the home modification provider and the participant.

DOCUMENTATION STANDARDS

Need for home modification must be indicated in the participant's service plan

Modification must address the participant's level of service needs

Any discrepancy noted by the provider, Service Coordinator/Care Manager and/or participant shall be detailed in the final inspection, and addressed by the assessor

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

AS OF THE PATHWAYS IN.2407 THIRD AMENDMENT EFFECTIVE 12.31.2025, HOME MODIFICATION ASSESSMENT AND HOME MODIFICATIONS SERVICES ARE NOW COMBINED AS HOME MODIFICATIONS AND ASSESSMENTS SERVICES. REFER TO ALL SPECIFICATIONS IN THE HOME MODIFICATIONS AND ASSESSMENTS SERVICE.

An annual cap of \$574.38 is available for home modification assessment services, unless the MCE (or OMPP for FFS) requests an additional assessment in order to help mediate disagreements between the home modification provider and the participant.

ACTIVITIES NOT ALLOWED

Home Modification Assessment services shall not be performed by the same provider that performs the subsequent Home Modification.

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

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

This service must not be used for living arrangements that are owned or leased by providers of waiver services.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Architect
Individual	FSSA/OMPP approved Home Modification Assessment Individual

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Modification Assessment (Terminated as of 12/30/2025)

Provider Category:

Individual

Provider Type:

Architect

Provider Qualifications

License (specify):

IC 25-4

Certificate (specify):

OMPP Approved

455 IAC 2 Becoming an approved provider; maintaining approval

455 IAC 2 Provider qualifications: General requirements

455 IAC 2 Financial information

455 IAC 2 Liability insurance

455 IAC 2 Professional qualifications and requirements; documentation of qualifications

455 IAC 2 Warranty required

Compliance with applicable building codes and permits

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

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

Service Type: Other Service**Service Name: Home Modification Assessment (Terminated as of 12/30/2025)**

Provider Category:**Provider Type:****Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:****Frequency of Verification:**

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:

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:**HCBS Taxonomy:****Category 1:****Sub-Category 1:**

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

AS OF THE PATHWAYS IN.2407 THIRD AMENDMENT EFFECTIVE 12.31.2025, HOME MODIFICATION ASSESSMENT AND HOME MODIFICATIONS SERVICES ARE NOW COMBINED AS HOME MODIFICATIONS AND ASSESSMENTS SERVICES. REFER TO ALL SPECIFICATIONS IN THE HOME MODIFICATIONS AND ASSESSMENTS SERVICE.

Home modifications are physical adaptations to the home, as required by the participant's service plan, which are necessary to ensure the health, welfare and safety of the participant, and which enable the participant to function with greater independence in his/her home, and without which the individual would require institutionalization. Incidental structural repairs to facilitate modifications may be included in this service.

Home Ownership

Home modifications will be for when the participant owns a home. Rented homes or apartments or family owned homes are allowed to be modified only when a signed agreement from the property owner is obtained. The signed agreement must be submitted along with all other required documentation. Disputes between different parties may not be within the scope of the MCE (or OMPP for FFS) to be able to intervene in a resolution.

Choice of Provider

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

ALLOWABLE ACTIVITIES

Home modifications may include but are not limited to the following:

Adaptive door openers and locks

Bathroom Modification—including but not limited to:

- Removal of existing bathtub, toilet and/or sink
- Installation of roll in shower, grab bars, toilet and sink
- Installation of replacement incidental items such as flooring, storage space, cabinets that are necessary due to the bath modification

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

Kitchen modification—including but not limited to:

- Removal of existing cabinets, sink; an/or
- Installation of sink, cabinet; and/or
- Installation of replacement incidental items such as flooring, storage space, and cabinets if necessary due to kitchen modification.

Home safety devices such as:

- Door alarms

- Anti-scald devices
- Hand held shower head
- Grab bars for the bathroom

Ramp—including but not limited to: Permanent or portable (only considered for renters)

Vertical lift and/or Stair lift

Single room air or portable conditioner(s)/single room air purifier(s)

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

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

Upon the completion of the modification, the room being modified will be matched to the degree possible with the same paint, wall texture, wall coverings, doors, trim, flooring etc. to the previous color/style/design.

Items requested which are not listed above, must be reviewed and decision rendered by the MCE (or OMPP for FFS).

Requests for modifications at two or more locations may only be approved at the discretion of the MCE (or OMPP for FFS).

Requests for modifications may be denied if the MCE (or OMPP for FFS) determines the documentation does not support residential stability and/or the service requested.

SERVICE STANDARDS

- Participants are allotted \$20,000 lifetime cap to receive home modification services.
- The cap represents a cost for basic modification of a participant's home for accessibility and accommodates the participant's needs for housing modifications. The cost of a home modification includes all materials, equipment, labor, and permits to complete the project. No parts of a home modification may be billed separately as part of any other service category (e.g. Specialized Medical Equipment). In addition to the \$20,000 lifetime cap, \$1000.00 is allowable annually for the repair, replacement, or an adjustment to an existing home modification that was funded by a Home and Community Based Services (HCBS) waiver.
- Home Modification Maintenance is limited to \$1,000.00 annually for the repair and service of home modifications that have been provided through a HCBS waiver. Requests for maintenance must detail cost of part(s) and cost of labor. If the need for maintenance exceeds \$1000.00, the service coordinator/care manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor funded through a non-waiver funding source.

Service Coordinator/Care Manager Standards:

- Responsible to document the need for home modification.
- Share expected modification requests identified by the participant determined through the person centered planning process to the assessor.
- All home modifications must be approved by the waiver program prior to services being rendered.
- Collect two bids if over \$5,000.00. If one bid is obtained the Service Coordinator/Care Manager must document the date of contact, the provider name, and why the bid was not obtained from that provider.
- Notification to the MCE (or participant's care manager and OMPP for FFS) of any discrepancies or complaints about the work while it is being completed. Notice provided within 48 hours upon learning of the issues.
- Before and after drawings are required for bathroom, kitchen and ramps.
- Bid must contain warranty information.
- If a home assessor is available in the county where the participant lives, then all participants must receive a home modification assessment if a provider is available in that county, with a certified waiver provider selected by the participant prior to any subsequent home modifications as well as a home modification inspection upon completion of the work.

Provider Standards:

- Need for home modification must be indicated in the participant's service plan.
- Proposed specifications for modification must conform to the requirements and limitations of the current approved service definition for home modification services.
- Providers are required to provide a written warranty for a new product or service in the form of a binding document stating that, for a period of not less than one year, the service provider shall replace or repair any product or installation.
- If the MCE determines the provider is at fault for poor and/or incorrect work during the home modification, then the provider is responsible for correcting work at the cost of the provider.

- Bid must contain warranty information.
- Before and after drawings are required for bathroom, kitchen, and ramps.
- Bid must be itemized with cost for each major component of the modification.
- Prohibited from placing residential liens.
- All home modifications must be approved by the MCE prior to services being rendered.
- Home modification requests must be provided in accordance with applicable state and/or local building codes. Home modifications must be compliant with applicable building codes.
- Land survey may be required when exterior modification(s) approach property line.
- Provider of services must maintain receipts for all incurred expenses related to the modification; must be in compliance with OMPP and MCE specific guidelines and/or policies.
- Notification to the participant's Service Coordinator/Care Manager and MCE (or OMPP for FFS) of any discrepancies or complaints about the work while it is being completed. Notice provided within 48 hours upon learning of the issues.

DOCUMENTATION STANDARDS

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

- Property owner of the residence where the requested modification is proposed;
- Property owner's relationship to the participant;
- What, if any, relationship the property owner has to the participant;
- Written agreement of landlord or homeowner for modification including agreement about items purchased during the modification, such as a bathtub, upon participant moving from the property or eviction.

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

AS OF THE PATHWAYS IN.2407 THIRD AMENDMENT EFFECTIVE 12.31.2025, HOME MODIFICATION ASSESSMENT AND HOME MODIFICATIONS SERVICES ARE NOW COMBINED AS HOME MODIFICATIONS AND ASSESSMENTS SERVICES. REFER TO ALL SPECIFICATIONS IN THE HOME MODIFICATIONS AND ASSESSMENTS SERVICE.

A lifetime cap of \$20,000 is available for home modifications. The cap represents a cost for basic modification of a participant's home for accessibility and accommodates the participant's needs for housing modifications. The cost of a home modification includes all materials, equipment, labor, and permits to complete the project. No parts of a home modification may be billed separately as part of any other service category (e.g. Specialized Medical Equipment). In addition to the \$20,000 lifetime cap, \$1,000.00 is allowable annually for the repair, replacement, or an adjustment to an existing home modification that was funded by a Home and Community Based Services (HCBS) waiver.

ACTIVITIES NOT ALLOWED

Examples/descriptions of activities not allowed include, but are not limited to the following, such as:

A. Adaptations or improvements which do not address participant accessibility or are not of direct medical or remedial benefit to the participant such as:

1. Central heating and air conditioning
2. Roof repair
3. Structural repair that is not incidental to the original modification
4. Driveways, decks, patios, publicly owned sidewalks, household furnishings
5. Swimming pools, spas or hot tubs
6. Outside storage spaces
7. Home security systems

B. Modifications that create living space or facilities where they did not previously exist (e.g. installation of a bathroom in a garage/basement, etc.).

C. Adaptations which would add to the total square footage of the home.

D. Participants living in foster homes, group homes, assisted living facilities, or homes for special services (any licensed residential facility) are not eligible to receive this service. (Note: The responsibility for home modifications rests with the facility owner or operator).

E. Participants living in a provider owned or controlled residence are not eligible to receive this service. (Note: The responsibility for home modifications rests with the facility owner or operator)

F. Completion of, or modifications to, new construction or significant remodeling/reconstruction are excluded unless there is

documented evidence of a significant change in the participant's medical or remedial needs that now require the requested modification.

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

H. The services under home modification are limited to additional services not otherwise covered under the state plan but consistent with waiver objectives of avoiding institutionalization.

I. This service must not be used for living arrangements that are owned or leased by providers of waiver services.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Architect
Agency	FSSA/OMPP approved Home Modification Agency/ Contractor
Individual	Plumber
Individual	FSSA/OMPP approved Home Modification Individual

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Modifications (Terminated as of 12/30/2025)

Provider Category:

Individual

Provider Type:

Architect

Provider Qualifications

License (*specify*):

IC 25-4

Certificate (*specify*):

Other Standard (*specify*):

OMPP Approved

455 IAC 2 Becoming an approved provider; maintaining approval

455 IAC 2 Provider qualifications: General requirements

455 IAC 2 Financial information

455 IAC 2 Liability insurance

455 IAC 2 Professional qualifications and requirements; documentation of qualifications

455 IAC 2 Warranty required

Compliance with applicable building codes and permits

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

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Modifications (Terminated as of 12/30/2025)

Provider Category:

Agency

Provider Type:

FSSA/OMPP approved Home Modification Agency/ Contractor

Provider Qualifications**License (specify):**

Any applicable licensure

IC 25-20.2 Home inspector

IC 25-28.5 Plumber

Certificate (specify):

IC 25-4 Architect

Other Standard (specify):

OMPP approved

455 IAC 2 Becoming an approved provider; maintaining approval

455 IAC 2 Provider qualifications: General requirements

455 IAC 2 Maintenance of Records of services provided

455 IAC 2 Liability insurance

455 IAC 2 Professional qualifications and requirements; documentation of qualifications

455 IAC 2 Warranty required

Compliance with applicable building codes and permits

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

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Modifications (Terminated as of 12/30/2025)

Provider Category:

Individual

Provider Type:

Plumber

12/05/2025

Provider Qualifications**License (specify):**

IC 25-28.5

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

OMPP approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: General requirements
455 IAC 2 Financial information
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements; documentation of qualifications
455 IAC 2 Warranty required
Compliance with applicable building codes and permits

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

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Home Modifications (Terminated as of 12/30/2025)****Provider Category:**

Individual

Provider Type:

FSSA/OMPP approved Home Modification Individual

Provider Qualifications**License (specify):**

Any applicable licensure must be in place

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

OMPP approved
455 IAC 2 Becoming an approved provider; maintaining approval
455 IAC 2 Provider qualifications: General requirements
455 IAC 2 Maintenance of Records of services provided
455 IAC 2 Liability insurance
455 IAC 2 Professional qualifications and requirements; documentation of qualifications
455 IAC 2 Warranty required
Compliance with applicable building codes/ permits.

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

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Modifications and Assessments (Effective 12/31/2025)

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:

17 Other Services

Sub-Category 2:

17030 housing consultation

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

This service includes “home modifications” and corresponding “home modification assessments.” Home modifications are 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, and enable the individual to function with greater independence in their home. Home modification assessments are services used to (1) review the feasibility of a requested home modifications, (2) develop objective specifications for a safe and appropriate home modifications, and (3) inspect completed home modifications.

Home Ownership

Homes owned by a waiver participant are allowed to be modified. Rented homes or apartments or family-owned homes are allowed to be modified only when a signed agreement from the property owner is obtained.

Assessment Requirement

All individuals must receive home modification assessment services. The feasibility review and specification development must be performed prior to initiation of the work and the inspection must be performed upon completion of the work.

Bid Requirements

At least two (2) bids must be obtained for any home modification expected to exceed \$5,000.00. Bids must be the most cost effective or conservative means to meet the individual’s specific needs. Each bid must be itemized with cost for each major

component of the modification and include:

- Existing and proposed drawings for bathroom modifications, kitchen modifications and ramps
- Written warranty for new products or services in the form of a binding document stating that, for a period of not less than one (1) year, the service provider shall replace or repair any product or installation.

Choice of Provider

The individual chooses the certified provider to perform home modification assessment services. Home modification assessment services must not be performed by the same provider that performs the subsequent home modification.

The individual chooses the certified providers to submit bids for the home modifications. If the individual chooses to continue with the home modification after receiving the bids, then the lowest bid that meets the minimum requirements (such as timeframe to start the work) shall be chosen.

Prior Authorization

All home modifications must be approved by the MCE (OMPP or its designee for FFS) prior to services being rendered. Requests for modifications at two or more locations may only be approved at the discretion of the MCE (or OMPP for FFS). Requests for modifications may be partially approved or denied if the MCE (OMPP or its designee for FFS) determines the documentation does not support residential stability and/or the service requested.

REIMBURSABLE ACTIVITIES

Home modification assessments may include but are not limited to the following:

- Evaluation of the current environment, including the identification of barriers, underneath the home, electrical and plumbing, which may prevent the completion of desired modifications. Reimbursement may be made for evaluations that determine a home modification is not feasible.
- Drafting, preparation and submission of specifications
- Examination of the completed modification (inspection/approve)
- Contact county code enforcement

Home modifications may include but are not limited to the following:

- Installation of ramps - Limited to one per individual primary residence, and only when no other accessible ramp exists
- Widening doorways
 - Includes exterior doorways (maximum one per individual primary residence when no other accessible door exists) and interior doorways as needed to allow for access.
 - Pocket doors may be requested
- Modification of existing bathroom facilities
 - Removal of existing bathtub, toilet and/or sink; and/or
 - Installation of roll in shower, walk-in tub, grab bars, toilet and/or wall-mounted sink; and/or
 - Installation of replacement incidental items such as flooring, storage space, cabinets that are necessary due to the bath modification.
- Installation of specialized electric and plumbing systems necessary for the welfare of the individual
 - Anti-scald devices
 - Door alarms
 - Handheld shower head
- Installation of adaptive door openers, locks, and home control units, including switches and buttons to control:
 - Medical equipment
 - Lights
 - Heat and air conditioning
 - Adaptive door openers are limited to one per primary residence for an individual living alone or who is alone without a caregiver for substantial period of time but has a need to open, close or lock the doors and cannot do so without special adaptation.
- Modification of existing kitchen facilities to promote accessibility for the individual
- Installation of vertical lift and/or stair 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
- Replacement of existing glass windows with plexi-glass or other shatterproof material when there is a documented medical/behavioral reason(s).
- Fence- limited to 200 linear feet and accompanied by documentation of elopement
- Maintenance and repair of the items and modifications provided through a HCBS waiver.

SERVICE STANDARDS

- Home Modification and Assessment services must be included on the individual's service plan, identify the direct medical

or remedial benefit for the individual, and authorized on the request for approval and linked to the individual's service plan.

- Home Modification and Assessment services must address needs identified in the person-centered planning process and must be for the direct medical or remedial benefit of the individual.
- Home modification assessments must be conducted by a provider who is independent of the entity providing the home modifications.
- Proposed specifications for modifications must conform to and be provided in accordance with:
 - the requirements and limitations of the current approved service definition for home modification services
 - applicable state and/or local building codes
- All products shall meet applicable standards of manufacture, design and installation.
- Providers must contact appropriate authority regarding potential code violations.
- Land survey may be required when exterior modification(s) approach property line.
- Residential liens are prohibited.
- In the event the individual, provider, assessor and/or service coordinator/case manager become aware of discrepancies or complaints about the work being completed, the provider shall stop work immediately and contact the MCE (OMPP for FFS) for further instruction within 48 hours.
- Provider must notify service coordinator/case manager, and service coordinator/case manager must notify the MCE (OMPP for FFS) of additional changes identified during work for prior approval before initiating changes.
- Waiver funding covers only basic modifications, and requests for upgraded products or materials will not be approved; however, during completion of the modification, the room will be matched as closely as possible to its previous color, style, and design, including paint, wall texture, wall coverings, doors, trim, and flooring;
- Once the project is complete, the assessor, individual and service coordinator/case manager will each be present on an agreed upon date and time to inspect the work and sign-off indicating that it was completed per the agreed upon bid. Any identified discrepancy must be detailed in the final inspection and addressed by the assessor.
- If the MCE (OMPP or its designee for FFS) determines the provider is at fault for poor and/or incorrect work during the home modification, then the provider is responsible for correcting work at the cost of the provider.

DOCUMENTATION STANDARDS

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

- Property owner of the residence where the requested modification is proposed;
- Property owner's relationship to the participant;
- What, if any, relationship the property owner has to the participant;
- Written agreement of landlord or homeowner for modification including agreement about items purchased during the modification, such as a bathtub, upon participant moving from the property or eviction.
- Each provider must maintain receipts for all incurred expenses related to the modification; must be in compliance with OMPP and MCE specific guidelines and/or policies.

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

The Home Modification Assessment component of this service is limited to a maximum of \$628 per plan year, unless the MCE (OMPP or its designee for FFS) requests an additional assessment in order to help mediate disagreements between the home modification provider and the individual.

Home Modification component of this service is limited to a lifetime cap of \$20,000 per waiver.

The cap represents a cost for basic modification of an individual's home for accessibility and accommodates the individual's needs for housing modifications. The cost of a home modification includes all materials, equipment, labor, and permits to complete the project. No parts of a home modification may be billed separately as part of any other service category (e.g. Specialized Medical Equipment). If the lifetime cap is fully used, and a need is identified, the service coordinator/case manager will work with other available funding streams and community agencies to fulfill the need.

In addition to the applicable lifetime cap for the home modification component, up to \$1,000.00 is allowable per plan year for the maintenance and repair of an existing home modification that was funded by a Home and Community Based Services (HCBS) waiver. Requests for maintenance/repair services must detail cost of part(s) and cost of labor. If the need for maintenance/repair services exceeds \$1000.00, the service coordinator/case manager will work with other available funding streams and community agencies to fulfill the need. If maintenance/repair 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.

Home modification and assessment services will not be reimbursed when provided by the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED

- Modifications to the home that are of general utility or routine home maintenance
- Modifications which do not address accessibility or are not of direct medical or remedial benefit to the individual such as:
 - central heating and air conditioning
 - replacement of carpeting and other floor coverings not related to bath/kitchen modifications
 - roof repair
 - driveways, decks, patios, sidewalks, household furnishings
 - swimming pools, spas, or hot tubs
 - outside storage spaces
 - garage door replacement or repair
 - home security or video monitoring systems
 - installation of standard (non-ADA or ADAAG) home fixtures (for example, sinks, commodes, tub, wall, window and door coverings, and so forth) which replace existing standard (non-ADA or ADAAG) home fixtures
 - whole home generators or whole home air purifiers
- Modifications that create living space or facilities where they did not previously exist (e.g. installation of a bathroom in a garage/basement, etc.)
- Adaptations which add to the total square footage of the home
- Modifications that duplicate existing accessibility (for example, second accessible bathroom, a second means of egress from home and so forth)
- 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 home modifications rests with the facility owner or operator)
- Individuals living in a provider owned or controlled residence are not eligible to receive this service. (Note: The responsibility for home modifications rests with the facility owner or operator)
- This service must not be used for living arrangements that are owned or leased by providers of waiver services.
- 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.
- Adaptations that have not been approved on a request for approval
- Home modification services are limited to additional services not otherwise covered under the state plan but consistent with waiver objectives of avoiding institutionalization.

The following activities are not allowed under Home Modification Assessment services:

- Home Modification Assessment services shall not be performed by the same provider that performs the subsequent Home Modifications.
- Home Modification Assessment services must not be used for living arrangements that are owned or leased by providers of waiver services.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	FSSA/OMPP Approved Home Modification – Plumber
Individual	FSSA/OMPP approved Home Modification – Architect
Individual	FSSA/OMPP approved Home Modification –Individual Contractor
Agency	FSSA/OMPP approved Home Modification - Agency Contractor
Individual	FSSA/OMPP Approved Home Modification Assessment – Home Inspector

Provider Category	Provider Type Title
Individual	FSSA/OMPP Approved Home Modification Assessment – Architect

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Modifications and Assessments (Effective 12/31/2025)

Provider Category:

Individual

Provider Type:

FSSA/OMPP Approved Home Modification – Plumber

Provider Qualifications

License (specify):

IC 25-28.5

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 455 IAC 2 Provider Qualifications: Becoming an approved provider; maintaining approval
 - 455 IAC 2 Provider qualifications: General requirements
 - 455 IAC 2 Protecting Individuals: Procedures for protecting individuals
 - 455 IAC 2 Protecting Individuals: Unusual occurrence; reporting
 - 455 IAC 2 Protecting Individuals: Transfer of individual's record upon change of provider
 - 455 IAC 2 Protecting Individuals: Notice of termination of services
 - 455 IAC 2 General Administrative Requirements for Providers: Collaboration and quality control
 - 455 IAC 2 General Administrative Requirements for Providers: Resolution of disputes
 - 455 IAC 2 General Administrative Requirements for Providers: Data collection and reporting standards
 - 455 IAC 2 General Administrative Requirements for Providers: Quality assurance and quality improvement system
 - 455 IAC 2 Financial Information: Disclosure of Financial information
 - 455 IAC 2 Property and Personal Liability Insurance: Liability insurance
 - 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
 - 455 IAC 2 Personnel Records: Maintenance of personnel records
 - 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
 - 455 IAC 2 Maintenance of Records of Services Provided: Individual's personal file; site of service delivery
 - 455 IAC 2 Warranty Required: Warranty required
 - 455 IAC 2 Services: Coordination of services and plan of care
- Architects rendering waiver-funded services must obtain/maintain Indiana registration/licensure.
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service**Service Type: Other Service****Service Name: Home Modifications and Assessments (Effective 12/31/2025)****Provider Category:**

Individual

Provider Type:

FSSA/OMPP approved Home Modification – Architect

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

IC 25-4: Certificate of registration with effect of license

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 455 IAC 2 Provider Qualifications: Becoming an approved provider; maintaining approval
 - 455 IAC 2 Provider Qualifications: General requirements
 - 455 IAC 2 Protecting Individuals: Procedures for protecting individuals
 - 455 IAC 2 Protecting Individuals: Unusual occurrence; reporting
 - 455 IAC 2 Protecting Individuals: Transfer of individual's record upon change of provider
 - 455 IAC 2 Protecting Individuals: Notice of termination of services
 - 455 IAC 2 General Administrative Requirements for Providers: Collaboration and quality control
 - 455 IAC 2 General Administrative Requirements for Providers: Resolution of disputes
 - 455 IAC 2 General Administrative Requirements for Providers: Data collection and reporting standards
 - 455 IAC 2 General Administrative Requirements for Providers: Quality assurance and quality improvement system
 - 455 IAC 2 Financial Information: Disclosure of Financial information
 - 455 IAC 2 Property and Personal Liability Insurance: Liability insurance
 - 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
 - 455 IAC 2 Personnel Records: Maintenance of personnel records
 - 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
 - 455 IAC 2 Maintenance of Records of Services Provided: Individual's personal file; site of service delivery
 - 455 IAC 2 Warranty Required: Warranty required
 - 455 IAC 2 Services: Coordination of services and plan of care
- Architects rendering waiver-funded services must obtain/maintain Indiana registration/licensure.
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.

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

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Home Modifications and Assessments (Effective 12/31/2025)**

Provider Category:

Individual

Provider Type:

FSSA/OMPP approved Home Modification –Individual Contractor

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

- Enrolled as an active Medicaid provider
- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 455 IAC 2 Provider Qualifications: Becoming an approved provider; maintaining approval
 - 455 IAC 2 Provider qualifications: General requirements
 - 455 IAC 2 Protecting Individuals: Procedures for protecting individuals
 - 455 IAC 2 Protecting Individuals: Unusual occurrence; reporting
 - 455 IAC 2 Protecting Individuals: Transfer of individual's record upon change of provider
 - 455 IAC 2 Protecting Individuals: Notice of termination of services
 - 455 IAC 2 General Administrative Requirements for Providers: Collaboration and quality control
 - 455 IAC 2 General Administrative Requirements for Providers: Resolution of disputes
 - 455 IAC 2 General Administrative Requirements for Providers: Data collection and reporting standards
 - 455 IAC 2 General Administrative Requirements for Providers: Quality assurance and quality improvement system
 - 455 IAC 2 Financial Information: Disclosure of financial information
 - 455 IAC 2 Property and Personal Liability Insurance: Liability insurance
 - 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
 - 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
 - 455 IAC 2 Personnel Records: Maintenance of personnel records
 - 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
 - 455 IAC 2 Maintenance of Records of Services Provided: Individual's personal file; site of service delivery
 - 455 IAC 2 Warranty Required: Warranty required
 - 455 IAC 2 Services: Coordination of services and plan of care
- Individual contractors rendering waiver-funded services must obtain/maintain Indiana registration/licensure, as applicable.
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.

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

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Home Modifications and Assessments (Effective 12/31/2025)****Provider Category:**

Agency

Provider Type:

FSSA/OMPP approved Home Modification - Agency Contractor

Provider Qualifications**License (specify):**

Any applicable licensure, including but not limited to:
 IC 25-20.2 Home inspector
 IC 25-28.5 Plumber

Certificate (specify):

Any applicable certification, including but not limited to:
 IC 25-4 Architect: Certificate of registration with effect of license

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 455 IAC 2 Provider Qualifications: Becoming an approved provider; maintaining approval
 - 455 IAC 2 Provider qualifications: General requirements
 - 455 IAC 2 General Administrative Requirements for Providers: Provider organizational chart
 - 455 IAC 2 General Administrative Requirements for Providers: Collaboration and quality control
 - 455 IAC 2 General Administrative Requirements for Providers: Resolution of disputes
 - 455 IAC 2 General Administrative Requirements for Providers: Data collection and reporting standards
 - 455 IAC 2 General Administrative Requirements for Providers: Quality assurance and quality improvement system
 - 455 IAC 2 Financial Information: Disclosure of financial information
 - 455 IAC 2 Property and Personal Liability
- Insurance: Liability insurance
 - 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
 - 455 IAC 2 Personnel Records: Maintenance of personnel records
 - 455 IAC 2 Personnel Policies and Manuals: Adoption of personnel policies
 - 455 IAC 2 Personnel Policies and Manuals: Operations manual
 - 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
 - 455 IAC 2 Maintenance of Records of Services Provided: Individual's personal file; site of service delivery
 - 455 IAC 2 Warranty Required: Warranty required
 - 455 IAC 2 Services: Coordination of services and plan of care
- Individual contractors rendering waiver-funded services must obtain/maintain Indiana registration/licensure, as applicable.
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.

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

OMPP

Frequency of Verification:

Up to three years

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

Service Type: Other Service

Service Name: Home Modifications and Assessments (Effective 12/31/2025)

Provider Category:

Individual

Provider Type:

FSSA/OMPP Approved Home Modification Assessment – Home Inspector

Provider Qualifications**License (specify):**

IC 25-20.2 Home Inspector

Certificate (specify):

In addition to the licensure standard, home modification assessor must:

- Be a Certified Aging-In-Place Specialist (CAPS Certification – National Association of Home Builders)
- OR
- Hold an Executive Certificate in Home Modifications (University of Southern California)

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 455 IAC 2 Provider Qualifications: Becoming an approved provider; maintaining approval
 - 455 IAC 2 Provider Qualifications: General requirements
 - 455 IAC 2 Protecting Individuals: Procedures for protecting individuals
 - 455 IAC 2 Protecting Individuals: Unusual occurrence; reporting
 - 455 IAC 2 Protecting Individuals: Transfer of individual's record upon change of provider
 - 455 IAC 2 Protecting Individuals: Notice of termination of services
 - 455 IAC 2 General Administrative Requirements for Providers: Collaboration and quality control
 - 455 IAC 2 General Administrative Requirements for Providers: Resolution of disputes
 - 455 IAC 2 General Administrative Requirements for Providers: Data collection and reporting standards
 - 455 IAC 2 General Administrative Requirements for Providers: Quality assurance and quality improvement system
 - 455 IAC 2 Financial information: Disclosure of financial information
 - 455 IAC 2 Property and Personal Liability Insurance: Liability insurance
 - 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
 - 455 IAC 2 Personnel Records: Maintenance of personnel records
 - 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
 - 455 IAC 2 Maintenance of Records of Services Provided: Individual's personal file; site of service delivery
 - 455 IAC 2 Warranty Required: Warranty required
 - 455 IAC 2 Services: Coordination of services and plan of care
- Home Inspectors rendering waiver-funded services must obtain/maintain Indiana licensure.
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to 3 years

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Modifications and Assessments (Effective 12/31/2025)

Provider Category:

Individual

Provider Type:

FSSA/OMPP Approved Home Modification Assessment – Architect

Provider Qualifications

License (specify):

Certificate (specify):

IC 25-4: Certificate of registration with effect of license

Other Standard (specify):

- Enrolled as an active Medicaid provider

- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 455 IAC 2 Provider Qualifications: Becoming an approved provider; maintaining approval
 - 455 IAC 2 Provider Qualifications: General requirements
 - 455 IAC 2 Protecting Individuals: Procedures for protecting individuals
 - 455 IAC 2 Protecting Individuals: Unusual occurrence; reporting
 - 455 IAC 2 Protecting Individuals: Transfer of individual's record upon change of provider
 - 455 IAC 2 Protecting Individuals: Notice of termination of services
 - 455 IAC 2 General Administrative Requirements for Providers: Collaboration and quality control
 - 455 IAC 2 General Administrative Requirements for Providers: Resolution of disputes
 - 455 IAC 2 General Administrative Requirements for Providers: Data collection and reporting standards
 - 455 IAC 2 General Administrative Requirements for Providers: Quality assurance and quality improvement system
 - 455 IAC 2 Financial information: Disclosure of financial information
 - 455 IAC 2 Property and Personal Liability Insurance: Liability insurance
 - 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
 - 455 IAC 2 Personnel Records: Maintenance of personnel records
 - 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
 - 455 IAC 2 Maintenance of Records of Services Provided: Individual's personal file; site of service delivery
 - 455 IAC 2 Warranty Required: Warranty required
 - 455 IAC 2 Services: Coordination of services and plan of care
- Architects rendering waiver-funded services must obtain/maintain Indiana registration/licensure.
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.

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

OMPP

Frequency of Verification:

Up to three years

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

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

Service Type:

Other Service

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

Service Title:

Integrated Health Care Coordination

HCBS Taxonomy:**Category 1:**

05 Nursing

Sub-Category 1:

05020 skilled nursing

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

11 Other Health and Therapeutic Services

11010 health monitoring

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Integrated Health Care Coordination (IHCC) is to promote improved health status and quality of life, delay/prevent deterioration of health status, manage chronic conditions in collaboration with the individual's provider and circle of support, and integrate medical and social services when this is unavailable through any other Medicaid authority, including an individual's health coverage provider.

REIMBURSABLE ACTIVITIES

- Development and oversight of a healthcare support plan which includes coordination of medical care and proactive care management of both chronic diseases and complex conditions such as falls, depression, and dementia.
- Skilled nursing services are provided within the scope of the Indiana State Nurse Practice Act.
- Collaboration across all service providers: waiver, state plan, mental health, dental, medical.
- Collaboration across social supports: housing, food, Medicare/Medicaid system navigation, finances, transportation.
- Medication review
- Transitional support from hospital or nursing facility to home/assisted living
- Advance care planning

SERVICE STANDARDS

- IHCC services must be included on the individual's service plan
- IHCC services must address needs identified in the person-centered planning process

IHCC services must include:

- Weekly consultations or reviews that include consultations with the individual or members of their care team or review and updates of healthcare support plan and/or updated information from care team as determined necessary through the person centered planning process to ensure effective delivery of service.
- A minimum of one (1) face-to-face visit per month with the individual receiving services.

DOCUMENTATION STANDARDS

Evidence of a consultation including complete date and signature; consultation can be with the participant, informal caregivers, other staff, other professionals, as well as health care professionals.

The provider will provide a written report to pertinent parties at least quarterly. Pertinent parties include the participant, guardian, service coordinator/case manager, all waiver service providers including mental health providers, State Plan services, and physicians.

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

IHCC services are limited to a maximum of sixteen (16) hours per month.

Services provided under IHCC will not duplicate services provided under the Medicaid State Plan, Medicare or any Medicare plan (e.g. advantage and DSNP), or any other waiver service.

IHCC services will not be reimbursed when provided by the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED

Skilled nursing services available under the Medicaid State Plan.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person**Relative****Legal Guardian****Provider Specifications:**

Provider Category	Provider Type Title
Agency	FSSA/OMPP Approved IHCC Agency
Agency	Adult Day Facility
Agency	FSSA/OMPP Approved Physician Practice
Agency	Assisted Living Facility

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Integrated Health Care Coordination****Provider Category:**

Agency

Provider Type:

FSSA/OMPP Approved IHCC Agency

Provider Qualifications**License (specify):**

IC 25-23-1 RN

IC 25-23-1 LPN

IC 25.23.6 LSW

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

- Enrolled as an active Medicaid provider
- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 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 Protecting Individuals: Procedures for protecting individuals
 - 455 IAC 2 Protecting Individuals: Unusual occurrence; reporting
 - 455 IAC 2 Protecting Individuals: Transfer of individual's record upon change of provider
 - 455 IAC 2 Protecting Individuals: Notice of termination of services
 - 455 IAC 2 General Administrative Requirements for Providers: Provider organizational chart
 - 455 IAC 2 General Administrative Requirements for Providers: Collaboration and quality control
 - 455 IAC 2 General Administrative Requirements for Providers: Resolution of disputes
 - 455 IAC 2 General Administrative Requirements for Providers: Data collection and reporting standards
 - 455 IAC 2 General Administrative Requirements for Providers: Quality assurance and quality improvement system
 - 455 IAC 2 Financial Information: Disclosure of financial information
 - 455 IAC 2 Property and Personal Liability Insurance: Liability insurance
 - 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
 - 455 IAC 2 Personnel Records: Maintenance of personnel records
 - 455 IAC 2 Personnel Policies and Manuals: Adoption of personnel policies
 - 455 IAC 2 Personnel Policies and Manuals: Operations manual

- 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
- 455 IAC 2 Maintenance of Records of Services Provided: Individual's personal file; site of service delivery
- 455 IAC 2 Services: Coordination of services and plan of care
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.
- Individuals providing IHCC services must be employed by the specified agency and must be:
 - A Registered Nurse licensed in accordance with IC 25-23-1; or
 - A Licensed Practical Nurse licensed in accordance with IC 25-23-1; or
 - A Licensed Social Worker licensed in accordance with IC 25-23.6, have a master's degree in social work, and have at least two years of experience providing health care coordination.

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

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Integrated Health Care Coordination****Provider Category:**

Agency

Provider Type:

Adult Day Facility

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

- Enrolled as an active Medicaid provider
- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 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 Protecting Individuals: Procedures for protecting individuals
 - 455 IAC 2 Protecting Individuals: Unusual occurrence; reporting
 - 455 IAC 2 Protecting Individuals: Transfer of individual's record upon change of provider
 - 455 IAC 2 Protecting Individuals: Notice of termination of services
 - 455 IAC 2 General Administrative Requirements for Providers: Provider organizational chart
 - 455 IAC 2 General Administrative Requirements for Providers: Collaboration and quality control
 - 455 IAC 2 General Administrative Requirements for Providers: Resolution of disputes
 - 455 IAC 2 General Administrative Requirements for Providers: Data collection and reporting standards
 - 455 IAC 2 General Administrative Requirements for Providers: Quality assurance and quality improvement system
 - 455 IAC 2 Financial Information: Disclosure of financial information
 - 455 IAC 2 Property and Personal Liability Insurance: Liability insurance
 - 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
 - 455 IAC 2 Personnel Records: Maintenance of personnel records

- 455 IAC 2 Personnel Policies and Manuals: Adoption of personnel policies
- 455 IAC 2 Personnel Policies and Manuals: Operations manual
- 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
- 455 IAC 2 Maintenance of Records of Services Provided: Individual's personal file; site of service delivery
- 455 IAC 2 Services: Coordination of services and plan of care
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.
- Individuals providing IHCC services must be employed by the specified agency and must be:
 - A Registered Nurse licensed in accordance with IC 25-23-1; or
 - A Licensed Practical Nurse licensed in accordance with IC 25-23-1; or
 - A Licensed Social Worker licensed in accordance with IC 25-23.6, have a master's degree in social work, and have at least two years of experience providing health care coordination.

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

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Integrated Health Care Coordination****Provider Category:**

Agency

Provider Type:

FSSA/OMPP Approved Physician Practice

Provider Qualifications**License (specify):**

IC 25-23-1 RN

IC 25-23-1 LPN

IC 25.23.6 LSW

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

- Enrolled as an active Medicaid provider
- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 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 Protecting Individuals: Procedures for protecting individuals
 - 455 IAC 2 Protecting Individuals: Unusual occurrence; reporting
 - 455 IAC 2 Protecting Individuals: Transfer of individual's record upon change of provider
 - 455 IAC 2 Protecting Individuals: Notice of termination of services
 - 455 IAC 2 General Administrative Requirements for Providers: Provider organizational chart
 - 455 IAC 2 General Administrative Requirements for Providers: Collaboration and quality control
 - 455 IAC 2 General Administrative Requirements for Providers: Resolution of disputes
 - 455 IAC 2 General Administrative Requirements for Providers: Data collection and reporting standards
 - 455 IAC 2 General Administrative Requirements for Providers: Quality assurance and quality improvement system
 - 455 IAC 2 Financial Information: Disclosure of financial information

- 455 IAC 2 Property and Personal Liability Insurance: Liability insurance
- 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
- 455 IAC 2 Personnel Records: Maintenance of personnel records
- 455 IAC 2 Personnel Policies and Manuals: Adoption of personnel policies
- 455 IAC 2 Personnel Policies and Manuals: Operations manual
- 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
- 455 IAC 2 Maintenance of Records of Services Provided: Individual's personal file; site of service delivery
- 455 IAC 2 Services: Coordination of services and plan of care
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.
- Individuals providing IHCC services must be employed by the specified agency and must be:
 - A Registered Nurse licensed in accordance with IC 25-23-1; or
 - A Licensed Practical Nurse licensed in accordance with IC 25-23-1; or
 - A Licensed Social Worker licensed in accordance with IC 25-23.6, have a master's degree in social work, and have at least two years of experience providing health care coordination.

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

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Integrated Health Care Coordination****Provider Category:**

Agency

Provider Type:

Assisted Living Facility

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

- Enrolled as an active Medicaid provider
- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 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 Protecting Individuals: Procedures for protecting individuals
 - 455 IAC 2 Protecting Individuals: Unusual occurrence; reporting
 - 455 IAC 2 Protecting Individuals: Transfer of individual's record upon change of provider
 - 455 IAC 2 Protecting Individuals: Notice of termination of services
 - 455 IAC 2 General Administrative Requirements for Providers: Provider organizational chart
 - 455 IAC 2 General Administrative Requirements for Providers: Collaboration and quality control
 - 455 IAC 2 General Administrative Requirements for Providers: Resolution of disputes
 - 455 IAC 2 General Administrative Requirements for Providers: Data collection and reporting standards

- 455 IAC 2 General Administrative Requirements for Providers: Quality assurance and quality improvement system
- 455 IAC 2 Financial Information: Disclosure of financial information
- 455 IAC 2 Property and Personal Liability Insurance: Liability insurance
- 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
- 455 IAC 2 Personnel Records: Maintenance of personnel records
- 455 IAC 2 Personnel Policies and Manuals: Adoption of personnel policies
- 455 IAC 2 Personnel Policies and Manuals: Operations manual
- 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
- 455 IAC 2 Maintenance of Records of Services Provided: Individual's personal file; site of service delivery
- 455 IAC 2 Services: Coordination of services and plan of care
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.
- Individuals providing IHCC services must be employed by the specified agency and must be:
 - A Registered Nurse licensed in accordance with IC 25-23-1; or
 - A Licensed Practical Nurse licensed in accordance with IC 25-23-1; or
 - A Licensed Social Worker licensed in accordance with IC 25-23.6, have a master's degree in social work, and have at least two years of experience providing health care coordination.

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

OMPP

Frequency of Verification:

Up to three years

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

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

Service Type:

Other Service

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

Service Title:

Nutritional Supplements

HCBS Taxonomy:**Category 1:**

14 Equipment, Technology, and Modifications

Sub-Category 1:

14032 supplies

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:**

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

Service Definition (Scope):

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

ALLOWABLE ACTIVITIES

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

SERVICE STANDARDS

- Nutritional Supplement services must be included on the individual's service plan
- Nutritional Supplement services must address needs identified in the person-centered planning process
- Supplements must be ordered by a physician, physician assistant, or nurse practitioner.
- For FFS enrollees, reimbursement for approved Nutritional Supplement expenditures are reimbursed through the local AAA or an approved OMPP provider, who maintains all applicable receipts and verifies the delivery of services.

DOCUMENTATION STANDARDS

Date of delivery, how many meals were provided, care professional or service coordinator/case manager that involved the participant also needs to be documented.

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

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

Nutritional Supplement services are limited to a maximum of \$1,200.00 per plan year.

Nutritional Supplement services will not duplicate services provided under the Medicaid State Plan or any other waiver service. The services under Nutritional Supplements are limited to additional services not otherwise covered under the state plan but consistent with waiver objectives of avoiding institutionalization.

The meals provided as part of these services shall not constitute a full nutritional regimen.

Nutritional Supplement services will not be reimbursed when provided by the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/OMPP approved Nutritional Supplements Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Nutritional Supplements

Provider Category:

Agency

Provider Type:

FSSA/OMPP approved Nutritional Supplements Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 455 IAC 2 Provider Qualifications: Becoming an approved provider; maintaining approval
 - 455 IAC 2 Provider qualifications: General requirements
 - 455 IAC 2 Protecting Individuals: Transfer of individual's record upon change of provider
 - 455 IAC 2 Property and Personal Liability Insurance: Liability insurance
 - 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
 - 455 IAC 2 Personnel Records: Maintenance of personnel records
 - 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Participant Directed Home Care Service (Terminated as of 12/30/2025)

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

AS OF THE PATHWAYS IN.2407 THIRD AMENDMENT EFFECTIVE 12.31.2025, PARTICIPANT-DIRECTED HOME CARE SERVICES ARE NO LONGER AVAILABLE UNDER THE PATHWAYS WAIVER.

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

Service Requirements:

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

Limitations:

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

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

AS OF THE PATHWAYS IN.2407 THIRD AMENDMENT EFFECTIVE 12.31.2025, PARTICIPANT-DIRECTED HOME CARE SERVICES ARE NO LONGER AVAILABLE UNDER THE PATHWAYS WAIVER.

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

Participant must be able to direct their own care.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person**Relative****Legal Guardian****Provider Specifications:**

Provider Category	Provider Type Title
Individual	Aide/Paid Caregiver
Agency	Home Health Agency

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Participant Directed Home Care Service (Terminated as of 12/30/2025)****Provider Category:**

Individual

Provider Type:

Aide/Paid Caregiver

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

OMPP Approved

The caregiver applicant must enter into the IHCP agreement in order to become a paid caregiver; the caregiver authorized to provide home care attendant services to consumers if the individual must

(1) Either meet the personnel qualifications specified in IC.16-27-1 or successfully completed, as applicable, the following, as verified by the fiscal intermediary:

(a) If applicable, a competency evaluation program or training and competency evaluation program approved or conducted under section of 10.2.2 the American Association of Respiratory Care (AARC) Clinical Practice Guideline; and/or

(b) A program that includes CPR, basic first aid, and any applicable DME training.

(2) The paid caregiver must identify and document participant need in the provider service plan.

- Services must be outlined in the provider service plan.

- Data record of services must be provided and maintained, including: – Complete date and time of service (in and out). – Specific services or tasks provided. – Signature of paid caregiver providing the service (minimally the last name and first initial).

- Each paid caregiver providing direct care or supervision of care to the participant must make at least one entry on each day of service. All entries must describe an issue or circumstance offered to the individual.

- Daily documentation of service delivery is to be signed by the participant. If the participant cannot sign, then the paid caregiver must self-attest and sign in lieu of the participant. The paid caregiver is required to coordinate information about the participant's care, including backup plan, with any and all other providers and care manager rendering services to the participant. Provider coordination shall occur among providers/paid caregivers during shift changes for the participant and at any other time where the participant experiences a healthcare change.

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

OMPP

Frequency of Verification:

No more than every three years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Participant Directed Home Care Service (Terminated as of 12/30/2025)****Provider Category:**

Agency

Provider Type:

Home Health Agency

Provider Qualifications**License (specify):**

IC 16-27-1

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

OMPP Approved Provider

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

OMPP

Frequency of Verification:

No longer than every three years

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

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System

HCBS Taxonomy:**Category 1:****Sub-Category 1:**

14 Equipment, Technology, and Modifications

14010 personal emergency response system (PERS)

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Personal Emergency Response System (PERS) is an electronic device which enables individuals 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 button is activated. The response center is staffed 24 hours daily/ 7 days per week by trained professionals.

REIMBURSABLE ACTIVITIES

- Device Installation service
- Ongoing monthly maintenance of device
- Electronic service that is usually a portable help button; however, it can also be an electronic device that includes, but is not limited to GPS or video monitoring service.

SERVICE STANDARDS

- PERS must be included on the individual's service plan
- PERS must address needs identified in the person-centered planning process
- The monitor positions must be determined during the person-centered service planning process. Remote monitors will not be placed in bedrooms or bathrooms.
- The persons responsible for monitoring must be determined during the person-centered service planning process including the provider.
- The mainframe location must be determined by the provider.
- A back-up plan must be in place in the event of equipment failure.
- Compliance with applicable building codes and permits

DOCUMENTATION STANDARDS

- Date of installation
- Documentation of expense for installation
- Documentation of monthly rental fee
- Ongoing monthly maintenance of device
- Monthly written notification to Service Coordinators/Care Managers of any participant who experienced a fall within a one month timeframe

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

PERS will not be reimbursed when provided by the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED

- Services to individuals receiving Assisted Living waiver service
- Services to individuals receiving Adult Family Care Services
- Replacement cost or lost or damaged equipment

Service Delivery Method (check each that applies):**Participant-directed as specified in Appendix E****Provider managed****Remote/via Telehealth**

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/OMPP approved Personal Emergency Response System Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Personal Emergency Response System

Provider Category:

Agency

Provider Type:

FSSA/OMPP approved Personal Emergency Response System Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 455 IAC 2 Provider Qualifications: Becoming an approved provider; maintaining approval
 - 455 IAC 2 Provider Qualifications: General requirements
 - 455 IAC 2 Protecting Individuals: Procedures for protecting individuals
 - 455 IAC 2 Protecting Individuals: Unusual occurrence; reporting
 - 455 IAC 2 Protecting Individuals: Transfer of individual's record upon change of provider
 - 455 IAC 2 Protecting Individuals: Notice of termination of services
 - 455 IAC 2 General Administrative Requirements for Providers: Provider organizational chart
 - 455 IAC 2 General Administrative Requirements for Providers: Collaboration and quality control
 - 455 IAC 2 General Administrative Requirements for Providers: Resolution of disputes
 - 455 IAC 2 General Administrative Requirements for Providers: Data collection and reporting standards
 - 455 IAC 2 General Administrative Requirements for Providers: Quality assurance and quality improvement system
 - 455 IAC 2 Financial Information: Disclosure of financial information
 - 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
 - 455 IAC 2 Personnel Records: Maintenance of personnel records
 - 455 IAC 2 Personnel Policies and Manuals: Adoption of personnel policies
 - 455 IAC 2 Personnel Policies and Manuals: Operations manual
 - 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
 - 455 IAC 2 Maintenance of Records of Services Provided: Individual's personal file; site of service delivery
 - 455 IAC 2 Warranty Required: Warranty required
 - 455 IAC 2 Services: Coordination of services and plan of care
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/DDRS HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.
 - 455 IAC 2 Property and Personal Liability Insurance: Liability insurance

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three years

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

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

Service Type:

Other Service

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

Service Title:

Pest Control

HCBS Taxonomy:**Category 1:**

17 Other Services

Sub-Category 1:

17010 goods and services

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Pest Control services are designed to prevent, suppress, or eradicate anything that competes with humans for food and water, injures humans, spreads disease to humans and/or annoys humans and is causing or is expected to cause, more harm than is reasonable to accept. Pests include but are not limited to, insects such as roaches, mosquitoes, fleas; bed bugs insect-like organisms, such as mites and ticks; and vertebrates, such as rats and mice.

REIMBURSABLE ACTIVITIES

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

SERVICE STANDARDS

- Pest control services must be included on the individual's service plan.
- Pest control services must address needs identified in the person-centered planning process and are added to the service plan when the service coordinator/case manager determines, either through direct observation or by individual report that a pest is present that is causing or is expected to cause more harm than is reasonable to accept.

• For FFS enrollees, reimbursement for approved Pest Control expenditures is reimbursed through the local AAA or other approved OMPP provider, who maintain all applicable receipts and verifies the delivery of services.

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

Pest Control services are limited to a maximum of \$4,000.00 per plan year.

Pest Control services may not be used solely as a preventative measure. There must be documentation of a need for this service either through service coordinator/case manager direct observation or individual report that a pest is causing or is expected to cause more harm than is reasonable to accept.

Pest Control services will not be reimbursed when provided by the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED

• Services to individuals receiving Adult Family Care waiver service or Assisted Living waiver service. • Preventive measures or on-going need for services, or eradication or prevention of mold or mold like substances.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/OMPP approved Pest Control Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Pest Control

Provider Category:

Agency

Provider Type:

FSSA/OMPP approved Pest Control Agency

Provider Qualifications

License (specify):

IC 15-3-3.6

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 455 IAC 2 Provider Qualifications: Becoming an approved provider; maintaining approval
 - 455 IAC 2 Provider Qualifications: General requirements

- 455 IAC 2 Property and Liability Insurance: Liability insurance
 - 455 IAC 2 Professional Qualifications and Requirements; Documentation of qualifications
 - 455 IAC 2 Personnel Records: Maintenance of personnel records
 - 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
- Pesticide applicators must be certified or licensed through the Purdue University Extension Service and the Office of the Indiana State Chemist.
 - Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.

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

OMPP

Area Agencies on Aging verify license number

Frequency of Verification:

Up to three years

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

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:**Category 1:**

14 Equipment, Technology, and Modifications

Sub-Category 1:

14031 equipment and technology

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Specialized medical equipment and supplies include:

- Devices, controls, or appliances, specified in the service plan that enable individuals to increase their ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

- Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items.
- Other durable and non-durable medical equipment not available under the State plan that is necessary to address the individual's functional limitations.

Professional Evaluation Requirements

- Any individual item expected to cost more than \$500 requires an evaluation by a qualified professional such as a physician, nurse, occupational therapist, physical therapist, speech and language therapist, or rehabilitation engineer.

Bid Requirements

- At least two (2) bids must be obtained for any individual item expected to exceed \$1,000.00. Bids must be the most cost effective or conservative means to meet the individual's specific needs.
- If only one bid is obtained the service coordinator/case manager must document the date of contact, the provider name, and why the bid was not obtained from that provider.
- Each bid must be itemized and include:
 - Picture of equipment; and
 - Written warranty for new products.

Prior Request for Approval to Authorize Services Requirements

- All Specialized Medical Equipment and Supplies must be approved by the MCE (OMPP or its designee for FFS enrollees) prior to the service being rendered.
- Requests for Specialized Medical Equipment and Supplies may be partially approved or denied in their entirety if the MCE (OMPP or its designee for FFS enrollees) determines that:
 - Requestor did not first exhaust eligibility of the desired equipment or supplies through Indiana Medicaid State Plan, which may require Prior Authorization (PA); or
 - For requests made to OMPP or its designee for FFS enrollees, the request for Specialized Medical Equipment and Supplies did not include documentation of Indiana Medicaid State Plan PA request and denial decision and reason for denial, if requested item is covered under State Plan; or
 - Requested Specialized Medical Equipment and Supplies duplicate equipment or supplies covered under the Indiana Medicaid State Plan; or
 - Specialized Medical Equipment and Supplies are being requested because a Medicaid vendor refused to accept the Medicaid reimbursement through the Medicaid State Plan; or
 - Specialized Medical Equipment and Supplies are being requested because requestor prefers a specific brand name but the Indiana Medicaid State Plan covers like equipment but does not cover the specific brand requested (When this occurs, the individual is limited to the Medicaid State Plan covered service/brand); or
 - The provider claim did not follow the correct Medicaid billing practices.
- Requests for Specialized Medical Equipment and Supplies may be partially approved or denied in their entirety if the MCE (OMPP or its designee for FFS) determines the documentation does not support the service requested.

REIMBURSABLE ACTIVITIES/ITEMS

- Self-help devices - including over the bed tables, reachers, adaptive plates, bowls, cups, drinking glasses, and eating utensils
- Voice activated smart devices
- Lift chairs -The HCBS program will cover the chair. State Plan should be pursued first for prior approval of the lift mechanism.
- 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.
- Medication Dispensers
- Toileting and/or incontinence supplies
- Slip resistant socks
- Maintenance and repair of the items provided through a HCBS waiver
- Items requested which are not listed above, will be submitted in the service plan and will be reviewed and approved by the MCE (or OMPP or its designee for FFS), if the request meets the individual's need.
- Interpreter service - provided in circumstances where the interpreter assists the individual in communication during specified scheduled meetings for service planning (e.g. waiver case conferences, team meetings) and is not available to facilitate communication for other service provision.

SERVICE STANDARDS

- Specialized Medical Equipment and Supplies must be included on the individual's service plan and authorized on the

request for approval and linked to the individual's service plan.

- Specialized Medical Equipment and Supplies must address needs identified in the person-centered planning process and must be of direct medical or remedial benefit to the participant. The service plan must also describe the how the equipment is expected to improve the individual's quality of ADL.
- All items shall meet applicable standards of manufacture, design and service specifications.

DOCUMENTATION STANDARDS

- Date of installation
- Documentation of expense for installation
- Provider of services must maintain receipts for all incurred expenses related to this service

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

Up to \$1,000.00 is allowable per plan year for the maintenance and repair of previously obtained specialized medical equipment that was funded by a Home and Community Based Services (HCBS) waiver. Requests for maintenance/repair services must detail cost of part(s) and cost of labor. If the need for maintenance exceeds \$1000.00, the service coordinator/case manager will work with other available funding streams and community agencies to fulfill the need. If maintenance/repair 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.

If the requested Specialized Medical Equipment or supplies are covered under Medicaid State Plan, the reimbursement amount is limited to the Medicaid State Plan fee schedule.

The services under specialized medical equipment and supplies are limited to additional services not otherwise covered under the Indiana Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

Specialized Medical Equipment and Supplies will not be reimbursed when provided by the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES/ITEMS NOT ALLOWED

- Unallowable items include, but are not limited to the following:
 - Hospital beds, air fluidized suspension mattresses/beds
 - Therapy mats
 - Parallel bars
 - Scales
 - Paraffin machines or baths
 - Therapy balls
 - Books, games, toys
 - Electronics - such as CD players, radios, cassette players, tape recorders, television, VCR/DVDs, cameras or film, videotapes and other similar items
 - Computers and software
 - Exercise equipment such as treadmills or exercise bikes
 - Furniture
 - Appliances - such as refrigerator, stove, hot water heater
 - Indoor and outdoor play equipment such as swing sets, swings, slides, bicycles adaptive tricycles, trampolines, play houses, merry-go-rounds
 - Swimming pools, spas, hot tubs, portable whirlpool pumps
 - Adjustable mattresses (such as, but not limited to, Tempur-Pedic), positioning devices, pillows
 - Motorized scooters
 - Barrier creams, lotions, personal cleaning cloths
 - Essential oils
 - Totally enclosed cribs and barred enclosures used for restraint purposes
 - Manual wheelchairs
 - Vehicle modifications
- Equipment and services available through Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before reimbursement is available through the Medicaid waiver for this service).
- Equipment and services that are not of direct medical or remedial benefit to the individual
- Any equipment or items purchased or obtained by the individual, their family members, or other non- waiver providers

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/ OMPP approved Specialized Medical Equipment and Supplies Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

FSSA/ OMPP approved Specialized Medical Equipment and Supplies Agency

Provider Qualifications

License (specify):

IC 25-26-21 - Home Medical Equipment Services Providers

Certificate (specify):

IC 6-2.5-8-1- Registered retail merchant's certificate; application; filing fee

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 455 IAC 2 Provider Qualifications: Becoming an approved provider; maintaining approval
 - 455 IAC 2 Provider qualifications: General requirements
 - 455 IAC 2 Property and Personal Liability Insurance: Liability insurance
 - 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
 - 455 IAC 2 Warranty Required: Warranty required
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications

Entity Responsible for Verification:

OMPP

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Structured Family Caregiving

HCBS Taxonomy:

Category 1:

02 Round-the-Clock Services

Sub-Category 1:

02023 shared living, other

Category 2:

02 Round-the-Clock Services

Sub-Category 2:

02033 in-home round-the-clock services, other

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Structured Family Caregiving means a caregiving arrangement in which an individual lives with a principal caregiver who provides daily care and support to the individual based on the individual's daily care needs. The person responsible for providing day-to-day support (hereafter known as principal caregiver) may be a non-family member or a family member (except as limited below) who lives with the individual in the private home of the individual or the principal caregiver. Structured Family Caregiving agencies (hereafter known as provider agencies) are the Medicaid provider of this service and are responsible for identifying principal caregivers (and substitute caregivers as needed), assessing the home setting, and providing ongoing oversight and support.

Necessary support services are provided by the principal caregiver as part of Structured Family Caregiving. Principal caregivers must be qualified to meet all federal and state regulatory guidelines and be able to provide care and support to an individual based on their assessed needs as identified in the person-centered planning process. Principal caregivers receive training based on their assessed needs and are paid a per diem stipend for the care and support they provide to individuals.

Structured Family Caregiving preserves the dignity, self-respect, and privacy of the individual by ensuring high quality care in a non-institutional setting. The goal of this service is to provide necessary care while fostering and emphasizing the individual's independence through a range of care options as the needs of the individual change. The goal is reached through a cooperative relationship between the individual (or the individual's legal guardian), the principal caregiver, service coordinator/case manager, and the provider agency. Individual needs shall be addressed in a manner that support and enable the individual to maximize abilities to function at the highest level of independence possible while principal caregivers receive initial and ongoing support in order to provide high quality care. The service is designed to provide options for alternative long-term care to waiver participants whose needs can be met in Structured Family Caregiving.

Only agencies may be Structured Family Caregiving providers, with the home settings being assessed and accessible, and all paid caregivers (including principal caregivers) being qualified as able to meet the individual's needs. The provider agency

must conduct a minimum of one home visit per quarter. Home visits are conducted in accordance with the person-centered plan of care and by any of the following support professionals as determined by the assessed need:

- a registered nurse (RN)
- a licensed practical nurse (LPN)
- a caregiver trainer
- a SFC home manager who is employed by the agency and who does not live in the home.

In addition to conducting one home visit per quarter, one of the support professionals (specified above) must also attend each separate quarterly case management monitoring meeting. Additional home visits and ongoing communication with the principal caregiver may occur based on the identified needs of the individual and the principal caregiver.

The provider agency must make a substitute caregiver available to allow opportunities for principal caregiver wellness and skill development in alignment with the needs of the principal caregiver as identified by the caregiver trainer, up to 15 days per year. The provider agency must capture daily notes that are completed by the principal caregiver in an electronic format, and use the information collected to monitor the individual's health and principal caregiver support needs. The agency provider must make such notes available to waiver service coordinators/case managers, MCEs, and the State, upon request.

SERVICE LEVELS

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

The breakdown is as follows:

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

REIMBURSABLE ACTIVITIES

- Structured Family Caregiving includes (Levels 1-3)
- Services provided by a principal caregiver. Principal caregiver may also be the spouse of the participant (Legally Responsible Persons).
- Personal care support.
- Homemaker or chore support.
- Companion care.
- Medication oversight (to the extent permitted under state law).
- Support by a substitute caregiver who has met all principal caregiver qualifications.
- Escorting for necessary appointments, whenever possible, such as transporting individuals to doctor. When provided, such transportation is incidental and not duplicative of any other State Plan or waiver service.
- Appointments and community activities that are therapeutic in nature or assist with maintaining natural supports.
- Other appropriate supports as described in the individual's service plan.

SERVICE STANDARDS

- SFC services must be included on the individual's service plan.
- SFC services must address needs identified in the person-centered planning process and the AFC/SFC LOS Assessment Form.
- Structured Family Caregiving provider agencies develop, implement, and provide ongoing management and support of a person-centered service plan that addresses the individual's level of service needs.
- The supports provided within the home and community are managed and completed by the principal caregiver throughout the day based on the individual's daily needs.
- Structured Family Caregiving is provided in a private residence and affords all of the rights, dignity and qualities of living in a private residence including privacy, comfortable surroundings, and the opportunity to modify one's living area to suit one's individual preferences.
- Provider agencies must conduct, at a minimum, one home visit per quarter based on the individual's needs and caregiver training needs identified in the person-centered planning process. Additionally, an agency support professional must attend each separate quarterly case management monitoring meeting.
- The Provider Agency must identify the skill development and wellness needs of the principal caregiver and provide access to a qualified substitute caregiver as needed for up to 15 days per year.

- Principal caregivers receive a minimum of eight hours in annual training that reflects the individual's and principal caregiver's assessed needs. Training may be delivered during in-person during home visits, virtually, or in another manner that is flexible and meaningful for the caregiver.
- Provider agencies must work with individuals and principal caregivers to establish backup plans for emergencies and other times when the principal caregiver is unable to provide care.
- Structured Family Caregiving emphasizes the individual's independence in a setting that protects and encourages the individual's dignity, choice, and decision-making while preserving self-respect.
- Provider agencies who provide medication oversight, as addressed under Reimbursable Activities, must receive necessary instruction from a doctor, nurse, or pharmacist regarding medications prescribed to the individual.

DOCUMENTATION STANDARDS

Documentation to support service rendered, including:

- Training outlined in the service plan that provider agency will provide to the principal caregiver
- Electronic caregiver notes that record and track the participant's status, and updates or significant changes in the participant's health status or behaviors and participation in community based activities and other notable or reportable events
- Medication management records, if applicable

Regular review of caregiver notes by provider agency in order to:

- Understand and respond to changes in the participant's health status and identify potential new issues in an effort to better communicate changes with the participant's doctors or healthcare providers and avoid unnecessary hospitalizations or emergency room use.
- Document and investigate and refer reportable events to the service coordinator/case manager.
- Documentation of home visits conducted by the provider agency.
- Documentation of education, skills training and coaching conducted with the principal caregiver.
- Documentation demonstrating collaboration and communication with other service providers and healthcare professionals (as appropriate), service coordinators/case managers and other caregivers or individuals important to the participant regarding changes in the participant's health status and reportable events.
- Documentation of all qualified caregivers (including paid substitute caregivers).

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

Not more than four waiver participants may reside in a single structured family caregiving household. When participants have a familial relationship, this maximum may be exceeded on a case-by-case basis as approved by the state.

Separate payment will not be made for Home and Community Assistance or Attendant Care services furnished to an individual receiving Structured Family Caregiving as these activities are integral to and inherent in the provision of Structured Family Caregiving.

Structured Family Caregiving will be reimbursed when provided by the spouse of a participant (also known as a Legally Responsible Individual), Relative or a Legal Guardian ONLY when all conditions specified in Appendix C-2-d and Appendix C-2-e of this waiver are met.

ACTIVITIES NOT ALLOWED

- Services to individuals receiving Assisted Living, or Adult Family Care waiver services.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/OMPP approved Structured Family Caregiving Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Structured Family Caregiving

Provider Category:

Agency

Provider Type:

FSSA/OMPP approved Structured Family Caregiving Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 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 Protecting Individuals: Procedures for protecting individuals
 - 455 IAC 2 Protecting Individuals: Unusual occurrence; reporting
 - 455 IAC 2 Protecting Individuals: Transfer of individual's record upon change of provider
 - 455 IAC 2 Protecting Individuals: Notice of termination of services
 - 455 IAC 2 General Administrative Requirements for Providers: Provider organizational chart
 - 455 IAC 2 General Administrative Requirements for Providers: Collaboration and quality control
 - 455 IAC 2 General Administrative Requirements for Providers: Data collection and reporting standards
 - 455 IAC 2 General Administrative Requirements for Providers: Quality assurance and quality improvement system
 - 455 IAC 2 Financial Information: Disclosure of financial information
 - 455 IAC 2 Property and Personal Liability Insurance: Liability insurance
 - 455 IAC 2 Transportation of an Individual: Transportation of an individual
 - 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
 - 455 IAC 2 Personnel Records: Maintenance of personnel records
 - 455 IAC 2 Personnel Policies and Manuals: Adoption of personnel policies
 - 455 IAC 2 Personnel Policies and Manuals: Operations manual
 - 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
 - 455 IAC 2 Maintenance of Records of Services Provided: Individual's personal file; site of service delivery
 - 455 IAC 2 Services: Coordination of services and plan of care
 - 455 IAC 2 Residential Day Services: Safety and security policies and procedures
 - 455 IAC 2 Residential Day Services: Emergency telephone numbers
- Provider agencies must demonstrate 3 years of delivering services to older adults or adults with disabilities and their caregivers in Indiana or as a Medicaid participating provider in another State or have a national accreditation.
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP Waivers provider reference module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

Up to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transportation

HCBS Taxonomy:
Category 1:

15 Non-Medical Transportation

Sub-Category 1:

15010 non-medical transportation

Category 2:
Sub-Category 2:
Category 3:
Sub-Category 3:
Category 4:
Sub-Category 4:
Service Definition (Scope):

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

SERVICE TYPES

Transportation services are reimbursed at three types of service:

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

SERVICE STANDARDS

- Transportation must be included on the individual's service plan
- Transportation must address needs identified in the person-centered planning process
- This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them.
- Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

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:

Adult Day service transportation is limited to a maximum of two (2) one-way trips per day to or from a non-medical community service or resource as specified on the service plan and provided by an approved provider of adult day services.

Services provided under Transportation service will not duplicate services provided under the Medicaid State Plan or any other waiver service. Service coordinators/case managers must assure that coverage of services provided under the State Plan or a responsible third-party continues until the plan limitations have been reached or a determination of non-coverage has been established prior to this service's inclusion in the service plan.

Transportation services will not be reimbursed when provided by the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED

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

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/OMPP approved Transportation Agency

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

Service Type: Other Service

Service Name: Transportation

Provider Category:

Agency

Provider Type:

FSSA/OMPP approved Transportation Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 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 Protecting Individuals: Procedures for protecting individuals
 - 455 IAC 2 Protecting Individuals: Unusual occurrence; reporting
 - 455 IAC 2 Protecting Individuals: Transfer of individual's record upon change of provider
 - 455 IAC 2 Protecting Individuals: Notice of termination of services
 - 455 IAC 2 General Administrative Requirements for Providers: Provider organizational chart
 - 455 IAC 2 General Administrative Requirements for Providers: Collaboration and quality control
 - 455 IAC 2 General Administrative Requirements for Providers: Resolution of disputes
 - 455 IAC 2 General Administrative Requirements for Providers: Data collection and reporting standards
 - 455 IAC 2 General Administrative Requirements for Providers: Quality assurance and quality improvement system
 - 455 IAC 2 Financial Information: Disclosure of financial information
 - 455 IAC 2 Property and Personal Liability Insurance: Liability insurance
 - 455 IAC 2 Transportation of an Individual: Transportation of an individual
 - 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
 - 455 IAC 2 Personnel Records: Maintenance of personnel records
 - 455 IAC 2 Personnel Records: Adoption of personnel policies
 - 455 IAC 2 Personnel Records: Operations manual
 - 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
 - 455 IAC 2 Maintenance of Records of Services Provided: Individual's personal file; site of service delivery
 - 455 IAC 2 Services: Coordination of services and plan of care
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.
- Individuals providing Transportation services must be employed by the specified agency and must comply with applicable vehicle/driver licensure for vehicle being utilized.

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

OMPP

Frequency of Verification:

Up to three years

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

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

Service Type:

Other Service

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

Service Title:

Vehicle Modifications

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Vehicle Modifications (VMOD) are the addition of adaptive equipment or structural changes to a motor vehicle that will provide the individual with a safe and accessible mode of transportation that increases their ability to access their home and community.

Bid Requirements

- At least two (2) bids must be obtained for any vehicle modification expected to exceed \$1,000.00. Bids must be the most cost effective or conservative means to meet the individual's specific needs.
- If only one bid is obtained the case manager must document the date of contact, the provider name, and why the bid was not obtained from that provider.
- Each bid must be itemized and include:
 - Picture of equipment; and
 - Written warranty for new products.

Prior Request for Approval to Authorize Services Requirements

- All vehicle modifications must be approved by the MCE (OMPP or its designee for FFS enrollees) prior to the service being rendered.
- The vehicle to be modified must meet all of the following:
 - The individual or primary caregiver (including a family member with whom the individual lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the individual and is not a paid provider of such services) is the titled owner.
 - The vehicle is registered and/or licensed under state law.
 - The vehicle has appropriate insurance as required by state law.
 - The vehicle is the individual's sole or primary means of transportation.
 - The vehicle is less than 10 years old and has less than 100,000 miles on the odometer
 - The vehicle is not registered to or titled by an FSSA approved provider
- 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.
- Requests for vehicle modifications may be partially approved or denied in their entirety if the MCE (OMPP or its designee for FFS enrollees) determines that the documentation does not support the service requested.

REIMBURSABLE ACTIVITIES/ITEMS

- Wheelchair lifts
- Wheelchair tie-downs (if not included with lift)
- Wheelchair/scooter hoist
- Wheelchair/scooter carrier for roof or back of vehicle
- Raised roof and raised door openings
- Power transfer seat base
- Lowered floor and lowered door openings
- Wheelchair ramp for vehicle
- Maintenance and repair of the items provided through a HCBS waiver
- Items requested which are not listed above, will be reviewed and approved by the MCE (or OMPP or its designee for FFS)

if the request meets the medical or social needs of the individual.

SERVICE STANDARDS

- Vehicle modifications must be included on the individual's service plan, identify the direct medical or remedial benefit for the individual, and authorized on the request for approval and linked to the individual's service plan.
- Vehicle modifications must address needs identified in the person-centered planning process.
- Pricing must be consistent with the fair market price for such modification(s).
- Many automobile manufacturers offer a rebate for waiver participants 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.
- All products shall meet applicable standards of manufacture, design and installation.

DOCUMENTATION STANDARDS

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

All bids must be itemized

Must be in compliance with MCE and OMPP specific guidelines and/or policies

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

Vehicle Modification services are limited to a 10-year cap of \$15,000.00 for one vehicle per every ten year period for an individual's household.

In addition to the applicable 10-year cap for vehicle modifications, up to \$1,000.00 is allowable per plan year for the maintenance and repair to an existing vehicle modification that was funded by a Home and Community Based Services (HCBS) waiver. Requests for maintenance/repair services must detail cost of part(s) and cost of labor. If the need for maintenance/repair services exceeds \$1000.00, the service coordinator/case manager will work with other available funding streams and community agencies to fulfill the need. If maintenance/repair 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.

Vehicle modifications will not be reimbursed when provided by the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED

- Unallowable items include, but are not limited to the following:
 - Repair or replacement of modified equipment damaged or destroyed in an accident
 - Alarm systems
 - Auto loan payments
 - Insurance coverage
 - Driver's license, title registration, or license plates
 - Emergency road service
 - Routine maintenance and repairs related to the vehicle itself
 - Specialized Medical Equipment or Home Modification items
 - Leased vehicles
- Vehicle modifications that are available under the Rehabilitation Act of 1973 or PL 94-142.

Payment may not be made to adapt the vehicles that are owned or leased by paid providers of waiver services. The cost of purchasing or leasing of a vehicle is excluded from the service.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian**Provider Specifications:**

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

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

Agency

Provider Type:

FSSA/OMPP approved Vehicle Modification Agency

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

- Enrolled as an active Medicaid provider
- Must be FSSA/OMPP (or its designee) approved
- Must comply with Indiana Administrative Code, 455 IAC 2, including but not limited to:
 - 455 IAC 2 Provider Qualifications: Becoming an approved provider; maintaining approval
 - 455 IAC 2 Provider Qualifications: General requirements
 - 455 IAC 2 Property and Personal Liability Insurance: Liability insurance
 - 455 IAC 2 Professional Qualifications and Requirements: Documentation of qualifications
 - 455 IAC 2 Personnel Records: Maintenance of personnel records
 - 455 IAC 2 Maintenance of Records of Services Provided: Maintenance of records of services provided
 - 455 IAC 2 Warranty Required: Warranty required
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/OMPP HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications**Entity Responsible for Verification:**OMPP**Frequency of Verification:**Up to three years**Appendix C: Participant Services****C-1: Summary of Services Covered (2 of 2)**

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

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

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

Check each that applies:

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

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

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

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

As a primary care case management system service under a concurrent managed care authority. Complete item C-1-c.

As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management). 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 and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

PathWays MCEs provide service coordination as an administrative function. FFS waiver enrollees receive an equivalent service, case management, as a waiver service as defined in Appendix C-3. All service coordinators must complete "Person-Centered Thinking Training" through a state approved curriculum for person-centered practices or a state approved certified trainer within 90 days of their hire date. A service coordinator who has not yet completed the training must have each service plan reviewed and signed off on prior to the plan's effective date by a service coordinator supervisor who has completed the training. All service coordinators must complete this training on an annual basis. Additionally, the MCEs are contractually required to provide orientation and training to newly hired service coordinators on a variety of topics, including the HCBS Settings Rule.

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

Service
Integrated Health Care Coordination

1. Will any in-person visits be required?

Yes.

No.

2. By checking each box below, the state assures that it will address the following when delivering the service remotely/via telehealth.

The remote service will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. Explain:

"Telehealth" means the delivery of health care services using interactive electronic communications and information technology (including secure videoconferencing, store and forward technology, or remote patient monitoring technology) between a provider in one (1) location and a patient in another location.

Telehealth services must be provided in compliance with Indiana Code 25-1-9.5 and the federal Health Insurance Portability and Accountability Act (HIPAA). Individuals must have an informed choice between in-person and telehealth services.

The appropriateness of telehealth services, equipment locations and providers must be determined during the person-centered service planning process. Equipment related to remote service delivery will not be placed by providers in bedrooms or bathrooms except in such instances where it has been reviewed and approved by a Human Rights Committee and been shown to be necessary to ensure health and safety. Any equipment related to remote service delivery will only enter the home under full agreement of all adults who reside in the home, and their guardians (when applicable) and use of remote monitoring must be documented in the individual's person-centered service plan prior to use. The individual maintains the ability to turn off the device independently and may do so when they so choose.

How the telehealth service delivery will facilitate community integration. *Explain:*

For individuals who are sufficiently medically fragile that in-person service delivery would put them at risk, or who geographically are too far from a provider of the service to be able to realistically obtain the service the availability of telehealth services offer opportunity to obtain needed coordination of the individual's full health care needs which promotes positive health outcomes. When a person is in good health and has their healthcare needs adequately met they are more able to participate in community activities and have greater connectivity to their community.

How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service can be rendered without someone who is physically present or is separated from the individual. *Explain:*

Prior to commencing any telehealth service the service coordinator/case manager will lead the person's team through a conversation regarding how to ensure the service can be maximally effective given the person's specific needs. In some circumstances, the individual and their team may identify that due to the need for hands on assistance telehealth delivery may not be a good fit. In other circumstances the team may identify ways that natural supports can be maximized to offer any hands-on physical assistance that may be needed during the delivery of the telehealth service.

How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service. *Explain:*

The providers or vendors who supply the technology necessary for the telehealth delivery of services provide training and guidance on how to use the technology to the individual, their family, support staff, and others who may need to interface with the technology. The person's service coordinator/case manager is also responsible for helping to identify additional available resources regarding technology training and support for the individual when needed. Prior to adding a telehealth service to the person-centered plan the team will discuss the types and amounts of support the individual will likely require with the technological aspects of the service. This will extend to establishing the willingness and capacity of the person's family, guardian, and/or residential support provider to provide ongoing technology support.

Monitoring will be completed by the provider who is offering the service as they are required to ensure all service elements are met and the goals and purpose of the service are being effectuated.

Where the telehealth or remote service is essential to health and safety of the individual, back-up plans in the circumstances of technology failure or power loss are discussed and incorporated into the person's plan. The individual has full control of the device. The individual can turn off the device and end services at any time they wish. The person's service coordinator/case manager is also responsible for informing the individual of this option.

How the telehealth will ensure the health and safety of an individual. *Explain:*

Telehealth can help to ensure the health and safety of the individual in that it offers options for service provision in circumstances where the individual might otherwise go without the identified service or where obtaining an in-person service would put the person at risk.

A provider may refuse at any time to provide telehealth services if the provider believes:

- (1) that the individual's health quality may be negatively impacted by the use of telehealth services; or
- (2) the provider would be unable to provide the same standards of care as those provided in an in-person setting.

If the provider determines that telehealth services (which have been approved in the individual's service plan) are no longer appropriate, the provider will notify the individual, their legal guardian (if applicable) and the individual's service coordinator/case manager.

Appendix C: Participant Services

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

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

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

Yes. Criminal history and/or background investigations are required.

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

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

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

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

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

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

No. The state does not conduct abuse registry screening.

Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. 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):

a) The State of Indiana has a registry of professional licenses that is available online at <https://mylicense.in.gov/eVerification/>

b) FSSA requires each provider or prospective provider conduct and document the screening against this license verification website.

c) FSSA staff reviews applications for approval to provide waiver services as submitted by the prospective provider. In the absence of the license verification for each direct care staff employed by the provider, the application shall not be approved.

Indiana's abuse registry is hosted by the Indiana Professional Licensing Agency (IPLA) at <https://www.in.gov/pla/> but information is maintained by the Indiana Department of Health (IDOH). If a registered aide has an abuse finding, IDOH places a finding on their certification within <https://www.in.gov/health/lrc/aide-training-and-certification/> so the aide will not show up as active on the registry.

d) If an individual's waiver provider is added to the registry, the MCE (FSSA staff for FFS) and service coordinator/case manager work together to ensure transition to new provider and continuity of care. Provider agencies are responsible for coordinating new direct care staff with oversight by FSSA.

Appendix C: Participant Services

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

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *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 types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is "*extraordinary care*", exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

In accordance with the federal description, Legally Responsible Individuals (LRIs) include ONLY the spouse of a participant. LRIs DO NOT include the parent of an adult participant (including a parent who also may be a legal guardian) or other types of relatives.

The state allows payment to be made to LRIs for the provision of Attendant Care Services and Structured Family Caregiving ONLY when the conditions outlined below are met but will not allow payment to be made to LRIs for the provision of participant-directed attendant care or any other waiver service.

LRIs may be paid by an FSSA-approved provider for the provision of Attendant Care services (ATTC) ONLY when the following conditions are met:

- the ATTC services are not participant-directed;
- the ATTC services are provided as “extraordinary care.” Extraordinary care in the provision of Attendant Care services means care that the individual is unable to perform independently to meet his or her intensive nursing care needs under the supervision of an interdisciplinary team. Intensive nursing care needs includes continuous ventilator care, tracheostomy care, Total Parenteral Nutrition (TPN), or other comparable nursing services approved by the Family and Social Services Administration (FSSA). The care must exceed the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person of the same age without a disability or chronic illness;
- the ATTC services are provided in alignment with the ATTC waiver service definition and limitations found in Appendix C of this waiver;
- the LRI is qualified to provide ATTC services in alignment with the qualifications found in Appendix C of this waiver; and
- the LRI is employed by or contracts with an FSSA-approved provider agency. Payment for ATTC services provided by an LRI is only made to an FSSA-approved provider agency. Payment for such ATTC services is never made directly to the LRI.

LRIs may be paid by an FSSA-approved provider for the provision of Structured Family Caregiving services (SFC) ONLY when the following conditions are met:

- the SFC services are provided as “extraordinary care.” Extraordinary care in the provision of Structured Family Caregiving means the day-to-day care or support activities provided by a legally responsible individual principal caregiver (spouse who meets the established waiver provider qualifications) that exceed the daily care that a legally responsible individual ordinarily would provide or perform in the household on behalf of a person of the same age without a disability or chronic illness;
- the SFC services are provided in alignment with the SFC waiver service definition and limitations found in Appendix C of this waiver;
- the LRI is qualified to provide SFC services in alignment with the qualifications found in Appendix C of this waiver; and
- the LRI is employed by or contracts with an OMPP-approved provider agency. Payment for SFC services provided by an LRI is only made to an OMPP-approved provider agency. Payment for such SFC services is never made directly to the LRI.

Limitations:

The maximum number of hours of ATTC services that may be reimbursed when provided by LRIs must not exceed an aggregate of forty (40) hours per week per waiver participant.

- Attendant Care services will not be reimbursed when provided by a LRI if the participant is self-directing this service per Indiana Code 12-10-17.1-10.

Safeguards:

The State tracks service plans that include the provision of ATTC and SFC by an LRI for monitoring purposes. Additionally, provider agencies and their employed/contracted LRIs who receive payment for the provision of ATTC and SFC services will be subject to service plan monitoring by the service coordinator/case manager as described in Appendix D-2-a. These practices will ensure that selection of service providers during the planning meeting is based on an understanding of what the individual wants in accordance with Appendix D-1 and that services delivered will continue to meet the needs and goals as well as the best interest of the individual.

For FFS enrollees, as with all other waiver-funded services, ATTC and SFC service delivery is authorized via the Notice of Action (NOA) issued by the state upon approval of the individual's service plan. Providers are required to

ensure that waiver services are provided as authorized and to document service delivery, allowing access to that documentation at any time by the MCE, state or its agents, including the service coordinator/care manager. As explained in Appendix I-2-d of the waiver application, the state uses a billing validation process to ensure FFS claims are paid only for necessary services that were properly authorized and actually provided to the individual within the authorized timeframe. MCEs are responsible for ensuring compliance with these policies, including ensuring claims are paid only for necessary services that were properly authorized and actually provided to the participant within the authorized timeframe. OMPP provides oversight of MCE compliance practices with billing subject to audit in look behind efforts of OMPP and by the FSSA's surveillance and utilization unit.

The state ensures that the legally responsible individual uses substituted judgement on behalf of the individual by requiring that (1) the decision for the relative to provide services to a waiver individual is part of the PCISP planning process, which indicates that the relative is the best choice of persons to provide services from the State-approved provider agency, and this decision is recorded and explained in the PCISP, (2) there is detailed justification as to why the relative is providing service, and (3) the decision for a relative to provide services is evaluated periodically (for example, at least annually) to determine whether it continues to be in the best interest of the waiver individual.

- 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 types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures 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.*

In accordance with the federal description, Legally Responsible Individuals (LRIs) include ONLY the spouse of a participant. LRI's DO NOT include the parent of an adult participant (including a parent who also may be a legal guardian) or other types of relatives. Except as specified in Appendix C-2-d above for Attendant Care and Structured Family Caregiving, the state does not make payments to legally responsible individuals for furnishing any other waiver services.

Policies Regarding Relatives:

The state allows payment to be made to Relatives (as defined below in this Appendix C-2-e) for the provision of the following waiver services ONLY when the conditions outlined below are met:

- Adult Day Services
- Attendant Care (including participant-directed ATTC services)
- Home and Community Assistance (including participant-directed HCA services)
- Skilled Respite (including participant-directed Skilled Respite services)
- Assisted Living
- Structured Family Caregiving Services

The state will not allow payment to be made to Relatives for the provision of any other waiver services.

Relatives may be paid by an FSSA-approved provider agency (or by the financial management services (FMS) vendor when services are authorized to be participant-directed) for the provision of the services (specified above) ONLY when the following conditions are met:

- the services are provided in alignment with the waiver service definitions and limitations found in Appendix C of this waiver;
- the individual providing such services is qualified to provide such services in alignment with the qualifications found in Appendix C of this waiver; and
- the individual providing such services is employed by or contracts with (i) a FSSA-approved provider agency, or (ii) an individual who self-directs their services. Payment for such services provided by a Relative is only made to an (i) FSSA-approved provider agency, or (ii) the FMS vendor for participant-directed services. Payment for such services is never made directly to the Relative.

“Relatives” means the following types of relatives (natural, adoptive and/or step relationships, whether by blood or by marriage, inclusive of half and/or in-law status):

- Parent of an Adult (natural, step, adopted, in-law)
- Grandparent (natural, step, adopted)
- Uncle (natural, step, adopted)
- Aunt (natural, step, adopted)
- Brother (natural, step, half, adopted, in-law)
- Sister (natural, step, half, adopted, in-law)
- Child (natural, step, adopted)
- Grandchild (natural, step, adopted)
- Nephew (natural, step, adopted)
- Niece (natural, step, adopted)
- First cousin (natural, step, adopted)

Policies Regarding Legal Guardians:

The state allows payment to be made to Legal Guardians for the provision of the following waiver services ONLY when the conditions outlined below are met:

- Attendant Care Services (excluding participant-directed ATTC services)
- Structured Family Caregiving

The state will not allow payment to be made to Legal Guardians for the provision of participant-directed attendant care or any other waiver services.

Legal Guardians may be paid by an FSSA-approved provider agency for the provision of the services (specified above) ONLY when the following conditions are met:

- the ATTC services are not participant directed;
- the services are provided in alignment with the waiver service definitions and limitations found in Appendix C of this waiver;
- the individual providing such services is qualified to provide such services in alignment with the qualifications

found in Appendix C of this waiver; and

- the individual providing such services is employed by or contracts with a FSSA-approved provider agency. Payment for such services provided by a Legal Guardian is only made to an FSSA-approved provider agency. Payment for such services is never made directly to the Legal Guardian.

Limitations:

The maximum number of hours of ATTC services that may be reimbursed when provided by Relatives and Legal Guardians (who are NOT LRIs) must not exceed forty (40) hours per week per paid Relative caregiver and/or paid Legal Guardian caregiver.

- ATTC services will not be reimbursed when provided by a Legal Guardian if the participant is self-directing this service per Indiana Code 12-10-17.1-10.

Safeguards:

Relatives and Legal Guardians who receive payment for waiver services (as specified above in this Appendix C-2-e) will be subject to service plan monitoring as described in Appendix D-2-a. These practices will ensure that the selection of service providers during the planning meeting is based on an understanding of what the individual wants in accordance with Appendix D-1 and that services delivered will continue to meet the needs and goals as well as the best interest of the individual.

For FFS enrollees, as with all other waiver-funded services, service delivery is authorized via the Service Authorization/Notice of Action (SA/NOA) issued by the state upon approval of the individual's person-centered service plan. Providers (including Relatives and Legal Guardians) are required to ensure that waiver services are provided as authorized and to document service delivery, allowing access to that documentation at any time by the MCE, state or its agents, including the service coordinator/case manager. As explained in Appendix I-2-d of the waiver application, the state uses a billing validation process to ensure FFS claims are paid only for necessary services that were properly authorized and actually provided to the individual within the authorized timeframe. MCEs are responsible for ensuring compliance with these policies, including ensuring claims are paid only for necessary services that were properly authorized and actually provided to the participant within the authorized timeframe. OMPP provides oversight of MCE compliance practices with billing subject to audit in look behind efforts of OMPP and by the FSSA's surveillance and utilization unit.

The state ensures that the relative/legal guardian uses substituted judgement on behalf of the individual by requiring that (1) the decision for the relative to provide services to a waiver individual is part of the PCISP planning process, which indicates that the relative is the best choice of persons to provide services from the OMPP-approved provider agency, and this decision is recorded and explained in the PCISP, (2) there is detailed justification as to why the relative is providing service, and (3) the decision for a relative to provide services is evaluated periodically (for example, at least annually) to determine whether it continues to be in the best interest of the waiver individual.

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:

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

The OMPP is dedicated to increasing HCBS providers for the waiver. The OMPP is dedicated to focusing on recruitment, certification, and timely enrollment of providers by the fiscal agent, and retention of waiver providers. Information regarding HCBS services is posted on the FSSA website. The OMPP has open enrollment meaning any provider can apply at any time.

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

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one:*

No, the state does not choose the option to provide HCBS in acute care hospitals.

Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions. *By checking the boxes below, the state assures:*

The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;

The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;

The HCBS must be identified in the individual's person-centered service plan; and

The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.

And specify: (a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting; (b) How the 1915(c) HCBS will assist the individual in returning to the community; and (c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.

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

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. Sub-Assurance: *The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance,

complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

C.1.a Number and percentage of waiver services providers who met certification standards. Numerator: Number of waiver service providers who were certified by the State. Denominator: Number of waiver services providers who requested certification from the State.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider Relations Tracking Database

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

--	--	--

Data Aggregation and Analysis:

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

Performance Measure:

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

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

If 'Other' is selected, specify:

Provider Relations Tracking Database

Responsible Party for data collection/generation <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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative

		Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Fiscal Agent Reporting

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

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:

C.2 Number and percent of newly enrolled non-licensed/non-certified providers that met the provider qualifications prior to providing waiver services. Numerator: Number of newly enrolled non-licensed/non-certified providers that met the provider qualifications prior to providing waiver services. **Denominator:** Number of newly enrolled non-licensed/non-certified providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider Relations Tracking Database

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

MCE Reports

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

MCE		
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

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

--

b. Methods for Remediation/Fixing Individual Problems

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

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

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

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

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

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

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

C.3

MCEs are contractually required to provide orientation and training to all newly hired service coordinators. If OMPP identifies MCE non-compliance with this requirement, written notice of non-compliance is sent to the MCE with expected

remediation activities. OMPP then monitors the corrective actions implemented through to resolution. In the event remediation is not achieved in accordance with the required corrective action plan, OMPP may implement escalating corrective action, the nature and severity of which is based on the scope of non-compliance.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

No

Yes

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

Not applicable- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Applicable - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies

that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. *(check each that applies)*

Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

Other Type of Limit. The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 §§ CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings in which 1915(c) HCBS are received. *(Specify and describe the types of settings in which waiver services are received.)*

The Indiana Family and Social Services Administration (FSSA) attests that all settings are compliant with the HCBS Settings requirements at 42 CFR 441.301(c)(4)-(5).

Individuals receiving HCBS under the PathWays waiver may reside in the following settings:

- Privately owned or rented homes by themselves or with family members, friends, or roommates.
- Adult family care (AFC) homes: Residential services provided in a family-like setting. The AFC homes are approved to serve not more than four waiver participants in a home-like setting in a residential community with a live-in caregiver.
- Assisted living facilities: Residential services offering an increased level of support in a home or apartment-like setting.
- Structured Family Caregiving (SFC) homes: Residential service arrangement in which a waiver participant lives together with a related or non-related principal caregiver who provides daily care and support.

PathWays1915(c) waiver services are provided in the individual's home and community, based upon their preference. Additionally, Adult Day Services are activities provided in a group setting, outside the individual's home. Settings for service delivery are chosen by the individual during the service planning process, identified in the individual's service plan, reviewed, and approved by the MCE, and subject to OMPP review. To ensure compliance of all settings, HCBS questions are addressed and recorded in the service plan.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

FSSA has developed and utilizes a variety of tools to establish HCBS settings criteria compliance and monitor on-going compliance for all provider-owned or controlled settings as well as any other settings where HCBS services are provided. These tools include the following:

- Provider application/reverification process that is conducted at least every 4 years.
- Service plan development/review process that is conducted at least annually.
- Provider Compliance Review (PCR) process that is conducted at least every 3 years.
- Complaint Investigation Process that is conducted on a continuously and on-going basis.

Provider Application and Reverification Process: The provider application process assesses for compliance by ensuring providers fully embrace person-centered values, practices, and planning by requiring new providers to demonstrate an understanding of the purpose of HCBS by articulating how they will support individuals in a way that complies with the HCBS Settings requirements at 42 CFR 441.301(c)(4)-(5). MCEs may only contract with providers certified by OMPP as a PathWays waiver provider and enrolled as a Medicaid provider.

Service Plan Development Process: HCBS settings questions are addressed and recorded in the service plan. For provider owned or controlled residential settings a systemic verification process has been embedded within the service plan development process to ensure ongoing monitoring of HCBS settings compliance.

Provider Compliance Review Process: The oversight process for continuous compliance with HCBS settings requirements is conducted through the Provider Compliance Review. The Provider Compliance Review process includes an assessment tool that includes indicators to support determining if individual outcomes are being achieved as well as the providers compliance with the HCBS Settings requirements. Through this process FSSA reviews providers compliance with state and federal rules as well as speaks directly to individuals to make sure they are receiving person-centered quality services.

Complaint Investigation Process: Individuals can report any instances of non-compliance directly to their service coordinator/case manager, MCE, or OMPP. FSSA provides an online complaint form as well as a complaint hotline to submit reports of non-compliance.

3. By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:

The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access

as individuals not receiving Medicaid HCBS.

The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. (see Appendix D-1-d-ii)

Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

Facilitates individual choice regarding services and supports, and who provides them.

Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.

Provider-owned or controlled residential settings. (Specify whether the waiver includes provider-owned or controlled settings.)

No, the waiver does not include provider-owned or controlled settings.

Yes, the waiver includes provider-owned or controlled settings. (By checking each box below, the state assures that each setting, in addition to meeting the above requirements, will meet the following additional conditions):

The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

Each individual has privacy in their sleeping or living unit:

Units have entrance doors lockable by the individual.

Only appropriate staff have keys to unit entrance doors.

Individuals sharing units have a choice of roommates in that setting.

Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

Individuals have the freedom and support to control their own schedules and activities.

Individuals have access to food at any time.

Individuals are able to have visitors of their choosing at any time.

The setting is physically accessible to the individual.

Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan(see Appendix D-1-d-ii of this waiver application).

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. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. (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:

MCEs must employ service coordinators experienced in meeting the needs of people with disabilities regardless of age and vulnerable populations with chronic and/or complex conditions. A service coordinator must have an undergraduate and/or graduate degree in social work or a related field, or be a Registered Nurse, Licensed Practical Nurse, Advanced Nurse Practitioner, or a Physician Assistant.

All service coordinators must complete "Person-Centered Thinking Training" through a state approved curriculum for person-centered practices or a state approved certified trainer within 90 days of their hire date. A service coordinator who has not yet completed the training must have each service plan reviewed and signed off on prior to the plan's effective date by a service coordinator supervisor who has completed the training. All service coordinators must complete this training on an annual basis. Additionally, the MCEs are contractually required to provide orientation and training to newly hired service coordinators on a variety of topics, including the HCBS Settings Rule.

Social Worker

Specify qualifications:

Other

Specify the individuals and their qualifications:

Area Agencies on Aging (AAAs) may also develop an initial service plan for newly eligible PathWays enrollees enrolled in the FFS delivery system. AAA staff completing these initial service plans must meet the following criteria:

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *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. *Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:*

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;

An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;

Direct oversight of the process or periodic evaluation by a state agency;

Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and

Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

- d. **i. 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; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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

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

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

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

Unless otherwise assessed as part of the MCE's care coordination processes or included in the member's CHAT results, the MCE's LTSS-specific assessment process may also include, but is not limited to, the following explorations and assessments based on the member's specific health and social needs:

- An exploration with the member of their understanding of self-directed supports and any desire to self-manage the allowable portions of their Service Plan.
- An exploration with the member of their preferences in regard to privacy, services, caregivers, and daily routine, including, if appropriate, an evaluation of the member's need and interest in acquiring skills to perform activities of daily living to increase their capacity to live independently in the most integrated setting.
- An assessment of mental health and alcohol and other drug abuse (AODA) issues, including risk assessments of mental health and AODA status as indicated.
- An assessment of the member's overall cognition and evaluation of risk of memory impairment.
- An assessment of the availability and stability of natural supports and community supports for any part of the member's life. This includes an assessment of what it will take to sustain, maintain and/or enhance the member's existing supports and how the services the member receives from such supports can best be coordinated with the services provided by the MCE.
- An exploration with the member of their preferences and opportunities for community integration including opportunities to engage in community life, control personal resources, and receive services in the community.
- An exploration with the member of their preferred living situation and a risk assessment for the stability of housing and finances to sustain housing as indicated.
- An exploration with the member of their preferences for educational and vocational activities.
- An assessment of the member's understanding of their rights, preferences for executing advance directives, and whether the member has a guardian, protective order, durable power of attorney or activated power of attorney for health care.

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

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

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

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

The person-centered planning process includes the following components to assist the participant in identifying waiver and non-waiver services that will best meet their goals, needs, and preferences:

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

e. How waiver and other services are coordinated

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

The Care Coordinator has primary responsibility for coordination of the member's physical and behavioral health. The member's Service Coordinator collaborates with the member's Care Coordinator and is a core participant in the member's Interdisciplinary Care Team (ICT). The ICT also includes any member-selected supports, including informal caregivers and incorporates additional expertise as needed based on the member's medical and behavioral health conditions, disabilities, pharmacy, environmental needs, and other urgent management needs. Through a person-centered planning approach, MCEs assist the member, their family, and physician to develop a strengths-based Individualized Care Plan (ICP) with specific objectives, goals, and action protocols to meet identified needs. The Service Plan is a component of the ICP. Additionally, MCEs must engage the member's PMP or other significant practitioner(s) in care coordination activities through ongoing, direct interaction between the practitioner and the ICT. This involvement includes semi-annual care conferences based on the member's assessment and evaluation.

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

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

MCEs must ensure services outlined on the Service Plan are initiated within 20 business days of receiving the NFLOC determination. When the initial Service Plan is activated, the service coordinator/case manager must either call or visit the member within 30 days from initial Service Plan activation to ensure implementation of services. Additionally, service coordinators/case managers are responsible for monitoring and assessing the quality and effectiveness of the member's Service Plan in a face-to-face contact every 90 days. At least two of these face-to-face contacts per year will be in the member's home setting, consistent with the member's preference. Additionally, members are contacted by their service coordinator/case manager at least monthly either in person or by telephone, unless the member specifically requests to opt out or otherwise reduce the frequency of these monthly contacts. The service coordinator/case manager may also meet more frequently with the member when appropriate based on the member's needs and/or request.

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

Service Plans must be updated when there is a change in the member's condition or recommended services. The service coordinator/case manager must monitor and assess the quality and effectiveness of the Service Plan during each 90 day visit and initiate updates as needed. MCEs are contractually required to establish a process, subject to OMPP review and approval, for identifying and addressing the following events that trigger reassessment of the member as expeditiously as possible in accordance with the circumstances, and as clinically indicated by the member's health status and needs, but in no case more than five business days after the occurrence of any of the following:

- A significant healthcare event, including but not limited to, hospital admission, transition between healthcare settings, or hospital discharge.
- A change or loss of informal caregiver.
- A decline in social status (e.g., increased isolation/loneliness).
- A change in the home setting or environment if the change impacts one or more areas of health or functional status.
- A change in diagnosis that is not temporary or episodic and that impacts one or more area of health status or functioning.
- As requested by the member or member's designee, caregiver, provider, the member's ICT, or OMPP.

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

Case managers and supervisors monitor service plans that are due to expire through the case management system. In addition, supervisors run monthly reports of the number of service plans that are about to expire for case management monitoring and quality assurance purposes.

- ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:

A specific and individualized assessed need for the modification.

Positive interventions and supports used prior to any modifications to the person-centered service plan.

Less intrusive methods of meeting the need that have been tried but did not work.

A clear description of the condition that is directly proportionate to the specific assessed need.

Regular collection and review of data to measure the ongoing effectiveness of the modification.

Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

Informed consent of the individual.

An assurance that interventions and supports will cause no harm to the individual.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Risks are assessed during both the NFLOC and service planning processes. During the initial and renewal NFLOC processes, the level of care assessment tool is used to identify potential risks and vulnerabilities. Service Plan development takes into account risks identified during the assessment. The person-centered service planning process must include protecting a member's health, welfare, and safety, including developing an emergency plan. Service plans must address member's assessed needs, including health and safety risks factors and documentation of appropriate interventions to mitigate risk while balancing the member's overall quality of life and individual choice. The person-centered service plan will clearly identify any activities that pose a significant level of risk which require restricting the person's ability to engage in the activity. Such restrictions will have a targeted modification plan, proportional to the risk itself, including support necessary for the person to engage in the activity, and a plan to restore the person's unrestricted right to that activity. The service provider must document the assessed risk, including when and how often the risk occurs, and develop a strategic plan to attempt to restore the person's right to that activity. The State recognizes that risk tolerance varies greatly from participant to participant and encourages service coordinators/case managers to recognize and respect the participant's participant desires and preferences when formulating risk mitigation strategies.

Additionally, the Service Coordinator works with the informal caregiver and Informal Caregiver Coach, as applicable, on the creation of a crisis management/emergency plan to support unplanned events that could impact the member and environment. The plan is reviewed and updated at the time of reassessment, or as needed, and provided to the MCE and listed entities on the plan. Permissions from the member to share this information is necessary. The plan includes but is not limited to the following:

- Health conditions
- Advance Care Planning: advance directives, will planning, physician orders for life sustaining treatment (POST) form, etc.
- Medications and/or medication management/assistance to prevent medication errors, if part of the Service Plan
- Fall prevention interventions, as necessary
- Healthcare providers including contact information
- Emergency contacts - Identification and contact information for back-up informal caregiver(s)
- Contact information for Informal Caregiver Coach and MCE Care Team
- Informal caregiver resources available within the caregiver's/member's community of choice

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from

among qualified providers of the waiver services in the service plan.

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Additionally, OMPP's care management team conducts monthly audits of service plans, based on a statistically significant random sample, developed in accordance with the National Committee for Quality Assurance (NCQA) "8-30 methodology" for file review. OMPP has developed a standardized audit template to ensure consistent application of review standards. To be considered compliant, the following elements must be included:

- Developed by a person trained in person-centered planning using a person-centered process
- Identifies the setting where the member lives
- Addresses member's strengths and preferences
- Identifies member's specific individualized assessed needs including clinical and support needs as identified through an assessment of functional need
- Individually identified goals and outcomes
- Services and supports (paid and unpaid) that will assist the member to achieve the goals
- Identifies the individual and/or entity who is responsible for monitoring the plans
- Identifies services for which the individual elects to self-direct, meeting the requirements of 42 CFR 441.740
- Reflects risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed
- Contains the electronic or written signature of the member, member's designated representative (if applicable) and any others involved in the service planning process
- Is written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b)

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

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

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a

minimum period of 3 years as required by 45 CFR § 92.42. Service plans are maintained by the following (*check each that applies*):

Medicaid agency

Operating agency

Case manager

Other

Specify:

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

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

MCEs must ensure services outlined on the Service Plan are initiated within 20 business days of receiving the NFLOC determination. When the initial Service Plan is activated, the Service Coordinator/Case Manager must either call or visit the member within 30 days to ensure implementation of services. Additionally, Service Coordinators/Case Managers are responsible for monitoring and assessing the quality and effectiveness of the member's Service Plan in a face-to-face contact every 90 days. At least two of these face-to-face contacts per year will be in the member's home setting, consistent with the member's preference. Additionally, members are contacted by their Service Coordinator/Case Manager at least monthly either in person or by telephone, unless the member specifically requests to opt out or otherwise reduce the frequency of these monthly contacts. The Service Coordinator/Case Manager may also meet more frequently with the member when appropriate based on the member's needs and/or request. MCEs must use the OMPP-developed person-centered monitoring tool (PCMT), or OMPP-approved equivalent tool, which supports monitoring to ensure participants can exercise free choice of provider, services meet participants' needs, effectiveness of back-up plans, participant health and welfare, and access to non-waiver services.

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

- b. Monitoring Safeguard.** Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation. (*Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation.*)

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. By checking each box, the state attests to having a process in place to ensure:

Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;

An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;

Direct oversight of the process or periodic evaluation by a state agency;

Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and

Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

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

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

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

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

Performance Measure:

D.1.a Number and percentage of service plans that address the participants needs and personal goals. Numerator: Number of service plans that address the participants needs and personal goals. Denominator: Number of service plans audited by the State.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Audit Reports

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

Data Aggregation and Analysis:

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

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

Performance Measure:

D.1.b Number and percent of sampled individuals who report that their long-term services meet all of their current needs and goals. Numerator: Number of sampled individuals who report that their long-term services meet all of their current needs and goals. Denominator: Total number of sampled individuals who responded.

Data Source (Select one):

Other

If 'Other' is selected, specify:

National Core Indicators Aging and Disabilities (NCI-AD)

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

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

Data Aggregation and Analysis:

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

Performance Measure:

D.1.c Number and percent of sampled individuals who responded that the service coordinator/CM talked to them about services/resources that may help their unmet needs/goals. Numerator: Number of sampled individuals who responded the service coordinator/CM talked to them about services/resources that may help their unmet needs/goals. **Denominator:** Total number of sampled individuals who responded

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

If 'Other' is selected, specify:

National Core Indicators Aging and Disabilities (NCI-AD)

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

Data Aggregation and Analysis:

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

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

- b. *Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.*

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Audit Reports

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

Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: MCE	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

- c. **Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.**

Performance Measures

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

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

Performance Measure:

D.3.a Number and percentage of service plans audited that were updated or revised annually. Numerator: Number of service plans that were updated annually.

Denominator: Number of service plans that were due for annual update.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Audit Report

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

	Other Specify: 	
--	--	--

Data Aggregation and Analysis:

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

Performance Measure:

D.3.b Number and percentage of service plans with evidence the plan was updated in response to a participant's needs. Numerator: Number of service plans audited that include evidence that the plan was updated in response to a participant's needs.

Denominator: Number of service plans audited for participants who had a change in condition or change in needs.

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

If 'Other' is selected, specify:

Audit Report

Responsible Party for data collection/generation <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>
State Medicaid Agency	Weekly	100% Review

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

Data Aggregation and Analysis:

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

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

d. Sub-assurance: Participants are afforded choice between/among waiver services and providers.

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Audit Report

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

MCE		
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

e. Sub-assurance: *The state monitors service plan development in accordance with its policies and procedures.*

Performance Measures

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

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

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Audit Report

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

Data Aggregation and Analysis:

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Audit Report

Responsible Party for data collection/generation <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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

Other Specify: MCE	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Audit Reports

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

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

In addition, service plans are reviewed to confirm compliance with the following timeliness requirements:

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

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

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

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

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

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

c. Timelines

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

No

Yes

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

Appendix E: Participant Direction of Services

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

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

- Attendant Care
- Home and Community Assistance
- Skilled Respite

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

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

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Select one:

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

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

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

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

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

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

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

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

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

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

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

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

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

The service coordinator/case manager must discuss what support is chosen by the individual to assist them to self-direct their services; if no support is needed or desired, case managers and service coordinators must, at a minimum, provide training on the following:

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

MCEs are contractually required to educate enrollees on the opportunity to self-direct services. Service coordinators/case managers are responsible for assessing enrollee interest in participant-direction and providing them with information regarding the philosophy and availability of self-direction. The information provided must include:

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

Information about the self-directed option will be provided in advance of service planning and at least annually. The self-directed services toolkit will be provided to individuals, their families, and representatives (if applicable), which includes descriptions of benefits and responsibilities to help them make an informed choice. Annually, the service coordinator must obtain a dated signature from the enrollee or their representative on a form that states: "My service coordinator has explained the self-direction option to me. I understand that under this option I can choose to self-direct services." Affirm one of the two statements below: "I accept the offer of self-direction and my service coordinator is helping me explore that option." "I decline self-direction at this time but understand I can choose this option at any time in the future by asking my service coordinator."

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

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

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

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

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

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

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

participant:

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

- Be at least 18 years of age;
- Have a personal relationship with the member and understand his/her support needs;
- Know the member’s daily schedule and routine, medical and functional status, medication regimen, likes and dislikes, and strengths and weaknesses; and
- Be physically present in the member’s residence on a regular basis or at least at a frequency necessary to supervise and evaluate each self-directed worker. This frequency can be determined through the person-centered service planning process.

Representatives have decision-making authority related to the role of employer of record for self-directed services included in the plan.

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Waiver Service	Employer Authority	Budget Authority
Home and Community Assistance Service		
Attendant Care		
Participant Directed Home Care Service (Terminated as of 12/30/2025)		
Skilled Respite		

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

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

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

Governmental entities

Private entities

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

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

The waiver service entitled:

FMS are provided as an administrative activity.

Provide the following information

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

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

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

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

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

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

Assist participant in verifying support worker citizenship status

Collect and process timesheets of support workers

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

Other

Specify:

Administers limited criminal history background check.

Supports furnished when the participant exercises budget authority:

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

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

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

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

Other services and supports

Specify:

Additional functions/activities:

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

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

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

Other

Specify:

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

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

- j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their

services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

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

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

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

Waiver Service Coverage.

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

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Case Management	
Home and Community Assistance Service	
Nutritional Supplements	
Attendant Care	
Assisted Living	
Specialized Medical Equipment and Supplies	
Pest Control	
Adult Family Care	
Personal Emergency Response System	
Participant Directed Home Care Service (Terminated as of 12/30/2025)	
Skilled Respite	
Home Modification Assessment (Terminated as of 12/30/2025)	
Vehicle Modifications	
Home Delivered Meals	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Community Transition	
Transportation	
Caregiver Coaching	
Structured Family Caregiving	
Integrated Health Care Coordination	
Adult Day Service	
Home Modifications (Terminated as of 12/30/2025)	
Home Modifications and Assessments (Effective 12/31/2025)	

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

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (select one).

- No. Arrangements have not been made for independent advocacy.
- Yes. Independent advocacy is available to participants who direct their services.

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

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

MCEs must forward to OMPP any cases in which the MCE plans to involuntarily terminate a member from participant-direction. If OMPP approves the request, the MCE notifies the member which initiates the right to appeal the determination. The service coordinator/case manager assists the individual with accessing needed and appropriate services through the traditional waiver services option, ensuring that no lapse in necessary services occurs for which the individual is eligible. The service coordinator/case manager will provide information regarding other service options and assure selected services are able meet the individual's needs and assure their health and safety during transition. This process will not circumvent the participant's right to a fair hearing as detailed in Appendix F-1.

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

When an individual or self-directed worker is involuntarily terminated, they shall be ineligible to reapply for participant-directed services as either a waiver participant or self-directed worker for 24 months following the date of termination. The service coordinator/case manager must work with the FMS vendor to ensure that the issues previously identified as reasons for termination have been adequately addressed prior to reinstatement.

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		211
Year 2		797
Year 3		1594
Year 4		2391
Year 5		3187

Appendix E: Participant Direction of Services

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

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

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

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

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

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

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

Recruit staff

Refer staff to agency for hiring (co-employer)

Select staff from worker registry

Hire staff common law employer

Verify staff qualifications

Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

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

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

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

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

Determine staff wages and benefits subject to state limits

Schedule staff

Orient and instruct staff in duties

Supervise staff

Evaluate staff performance

Verify time worked by staff and approve time sheets

Discharge staff (common law employer)

Discharge staff from providing services (co-employer)

Other

Specify:

Appendix E: Participant Direction of Services

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

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

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

Reallocate funds among services included in the budget

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

Substitute service providers

Schedule the provision of services

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

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

Identify service providers and refer for provider enrollment

Authorize payment for waiver goods and services

Review and approve provider invoices for services rendered

Other

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

Individuals who decide to self-direct their services will have a budget for each self-directed service in their service plan. During the person-centered planning process, units of service will be approved, based on assessed need, and those units will then be converted into a dollar amount that the individual can use to hire their own staff to provide the identified service. A percentage will be deducted from the resulting budget amount for the administrative costs associated with participant-direction. Individuals will determine the wage paid to their self-directed workers within a specified range according to the service. The service coordinator/case manager is responsible for determining the appropriate and necessary number of hours through the person-centered planning process. That number of hours is then entered into the spend plan tool within the case management system and calculated consistently for each individual when determining the self-directed budget. Information about the self-directed budgets will be made publicly available on the state's website.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

The service coordinator/case manager will assess the needs and preferences of the individual through a person-centered planning process. The service coordinator/case manager and support team will develop a person-centered plan to meet those needs and service requests. The total allowance of self-directed service budget is determined with the assessed need identified during the person-centered planning process. The service coordinator/case manager will explain how the budget is determined, the total amount of the budget, how an individual can request a change in the budget, and what the ramifications are if the individual exceeds the budget. The service coordinator/case manager and FMS vendor are responsible for monitoring the allocation of funds to the individual and the individual's self-directed worker. Individuals will receive monthly financial statement detailing the funds spend and remaining for the year. Adjustments to the self-directed budget may be made through the person-centered planning process. Participants retain fair hearing rights in accordance with 42 CFR Part 431, Subpart E as further described in Appendix F.

Appendix E: Participant Direction of Services

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

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

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

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

MCEs operate a grievance and appeal system in accordance with 42 CFR 438 Subpart F and as detailed in the Grievance System section of the PathWays 1915(b) Waiver. PathWays enrollees are notified in writing, by their MCE, of all adverse benefit determinations, as defined in 42 CFR 438.400(b). The MCE notice must meet the requirements of 42 CFR 438.404 and explain the:

- Adverse benefit determination the MCE has taken or intends to take
- Reason for the adverse benefit determination
- Right of the enrollee to be provided access to all information relevant to the determination
- Right to request an appeal
- Procedures for requesting an appeal, including an external review by an Independent Review Organization (IRO) and Fair Hearing following exhaustion of the MCE appeals process
- Circumstances under which an appeal process may be expedited, and how to request
- Right to have benefits continue pending resolution of the appeal, how to request continuation of benefits, and any circumstances under which the enrollee may be required to pay for the cost of such services

MCEs must maintain records of all grievance and appeals in accordance with 42 CFR 438.416. Within 120 days of exhausting the MCE grievance and appeal process, in accordance with 42 CFR 438.408, PathWays enrollees may access the State Fair Hearing process. This may run concurrent to an external review by an IRO.

MCEs must provide PathWays enrollees any reasonable assistance in completing forms and taking other procedural steps related to appeals. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. Oral interpretation services do not substitute for written translation of vital materials in accordance with 42 CFR 438.408(d)(1) and 42 CFR 438.10. In addition to MCE assistance, OMPP contracts with a Member Support Services Contractor to provide beneficiary support system services per 42 CFR 438.71(d). They are an access point for enrollee grievances and appeals, and provide education on grievance, appeal, and State Fair Hearing rights. The Contractor also provides assistance in navigating the process and appealing MCE adverse benefit determinations.

Additionally, MCEs are contractually required to annually provide enrollees written information including a description of grievance, appeal, external review by an IRO, and State Fair Hearing procedures and timeframes. Information must also be included in the PathWays Member Handbook, in accordance with 42 CFR 438.10(g)(2)(xi). All MCE generated enrollee materials are subject to advanced OMPP review and approval.

For PathWays Waiver participants receiving services through the FFS delivery system, the following processes apply: Waiver applicants and their legal representatives are provided oral explanations of the Medicaid Fair Hearing process (including an explanation of the types of decisions they may appeal) at the time of the waiver participant's initial eligibility assessment by the Level of Care Assessment Representative (LCAR) contractor.

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

- Denying functional level of care

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

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

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

The notice will include the following information:

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

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

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

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

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

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

The MCE grievance and appeals process operates in accordance with 42 CFR Part 438 Subpart F and is described in the Pathways 1915(b) Waiver.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

No. This Appendix does not apply

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

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

Do not complete this item.

- **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).

Do not complete this item.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

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

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

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

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

All individuals with direct monitoring responsibilities for PathWays enrollees (including, but not limited to MCEs, providers, Service Coordinators/Case Managers, and FSSA staff) are responsible for reporting incidents. Incident reports are submitted through the FSSA web-based incident reporting system. If web access is unavailable, incidents can be reported by telephone and e-mail. Additionally, all cases of suspected abuse, neglect, or exploitation (ANE), and unexpected death of a member, must be reported to an Adult Protective Services (APS) unit or law enforcement. APS reports can be made via a 24-hour hotline, online reporting system, or to an APS field office. Providers are also required to notify the member's service coordinator/case manager of all incident reports.

In accordance with 455-IAC-2, incidents are unusual occurrences affecting the health and safety of PathWays enrollees and include the following:

1. Alleged, suspected, reported, observed, or actual abuse/battery, assault, neglect, or exploitation of a member
2. The unexpected death of a member
3. Significant injuries to the member requiring emergent medical intervention, including, but not limited to, the following: (a) fracture; (b) a burn greater than first degree; (c) choking that requires intervention; or (d) contusions or lacerations.
4. Injuries of unknown origin
5. Any threat or attempt of suicide made by the member
6. Any unusual hospitalization due to significant change in health and/or mental status may require a change in service provision OR admission of an individual to a nursing facility, excluding respite stays
7. Member elopement or missing person
8. Inadequate formal or informal support for a member, including inadequate supervision which endangers the member
9. Medication errors resulting in outcomes that require medical treatment beyond an ER/physician evaluation or monitoring vital signs
10. A residence that compromises the health and safety of a member due to any of the following: (a) a significant interruption of a major utility; or (b) an environmental, structural, or other significant problem.
11. Environmental or structural problems associated with a dwelling where individuals reside that compromise the health and safety of the individuals
12. A residential fire resulting in any of the following: (a) relocation; (b) personal injury; or (c) property loss.
13. Suspected or observed criminal activity by: (a) provider's staff when it affects or has the potential to affect the member's care; (b) a family member of a member receiving services when it affects or has the potential to affect the member's care or services; or (c) the member receiving services.
14. Police arrest of a member or any person responsible for the care of the member
15. A major disturbance or threat to public safety created by the member. The threat can be toward anyone, including staff, and in an internal setting, and need not be outside the individual's residence.
16. Any instance of restrictive intervention (including chemical or physical restraints, or seclusion)
17. Falls with injury, in accordance with the U.S. Center for Disease Control's (CDC) Behavioral Risk Factor Surveillance System (BRFSS)

Reports regarding an incident, allegation, or suspicion of ANE, or the death of a member must be submitted within 24 hours of the occurrence or knowledge of the occurrence (whichever is sooner). All other incidents must be reported

within 48 hours of the occurrence or knowledge of the occurrence (whichever is sooner).

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Information pertaining to protections from abuse, neglect, and exploitation (including how to notify the appropriate authorities) is shared with participants annually. MCEs are contractually required to provide educational materials and training opportunities to members, families, informal caregivers, and guardians which cover the prevention, identification, reporting, management, and mitigation of abuse, neglect, and exploitation. MCEs must communicate this information via a variety of mechanisms such as alerts and messages via member portals, websites, text messaging, social media campaigns, and online videos.

At minimum, MCEs must also include in its member welcome packet, member handbook, and member website the following information:

- A detailed description of critical incidents and instructions about how to report an incident
- A description of what the member should expect if they submit a critical incident report to the MCE and if one is submitted on their behalf
- Member rights related to the reporting, management, and mitigation of all critical incident types
- Information about where at-risk members and caregivers can find education, support, and strategies to reduce member and informal caregiver isolation
- A description of the member's role in mitigating future critical incidents

All MCE materials are reviewed and approved by OMPP.

Additionally, as part of the person-centered service planning process, the service coordinator/case manager provides information on who to contact, when to contact, and how to report incidents with all persons involved in service plan development. Information is regularly reviewed during each 90 day visit.

For FFS enrollees, as a part of the service plan process, participants, family members and/or legal guardians are advised by the case manager via written materials of OMPP'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.

Additionally, case managers are required to provide each waiver participant with a link to the Indiana Health Coverage Programs (IHCP) Office of Medicaid Policy and Planning (OMPP) HCBS Module, a resource document for participants and support teams. When requested by the participant, guardian and/or family, a paper/hard copy of the IHCP OMPP HCBS Module will be provided by the case manager. Participants are required to sign and date that they received the grievance procedure and a link and/or copy of the above mentioned IHCP OMPP HCBS Module.

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

Incidents are reported to the FSSA web-based incident reporting system. Additionally, all cases of suspected abuse, neglect, or exploitation (ANE) are reported to an Adult Protective Services (APS) unit or law enforcement. Upon receipt of a report through the web-based system, OMPP routes it to the participant's MCE. The MCE must intake the report into its critical incident tracking system as soon as possible, but no later than four business hours after receipt. Then, the MCE must review and triage all reports within one business day of receipt to:

- Determine if ANE has occurred. If ANE is reasonably suspected, the MCE must file a critical incident report with APS if one has not already been submitted.

- Assess and address any immediate potential threats to member health, safety, and welfare. If the MCE identifies a risk of harm or potential harm, the MCE must take immediate action to ensure the safety of the member. These steps may include communication with service coordinators, other providers, family members and informal caregivers to verify or ensure that immediate threats to the individual's health and welfare are addressed and resolved. The MCE must document the actions taken as part of their weekly report to OMPP until the critical incident investigation is closed.

- Determine whether additional information is required from the provider.

- Notify the member and, as needed, other service providers about the critical incident report and related issues and concerns, about what to expect, and, as appropriate, how to mitigate future risk.

If the MCE determines that additional information is required from the provider or other reporter, the MCE must notify them within no more than 24-hours and provide guidance and technical assistance to support them in successfully completing the report. After returning the report to the provider or other reporter, the MCE must follow up with them within one business day to obtain confirmation that they are submitting the necessary updates to the MCE.

The MCE is responsible for analyzing each critical incident report (except for ANE reports investigated by APS, as described further below) and determining how to proceed. The MCE must analyze each report to determine if the report meets the threshold to be a critical incident as defined in Appendix G-1-b. If a report meets the defined criteria to be a critical incident, the MCE must take the following steps:

1. Conduct a full investigation. The MCE shall ensure that the investigation and resolution of critical incidents are conducted timely based on the nature and severity of each case. All investigations must be completed within 30 days, and:

- a. Incidents not resolved within 21 days of the date of the initial incident must be referred to the MCE's Quality Manager or designee for additional action. The MCE must have the ability to flag such incidents in its incident management system. Follow-up reporting must continue every seven days until the incident is deemed resolved.

- b. For incidents that occurred when the member was enrolled with a different MCE, the member's prior MCE must cooperate with the investigating MCE.

- c. The MCE must clearly define responsibilities for implementation of its critical incident policies and procedures, to assure that a thorough investigation is completed timely. These policies are reviewed and approved by OMPP.

2. Submit to the member or the member's legal guardian as well as to the individual's case manager and service coordinator all information required by the MCE's investigator to be submitted.

3. Submit required reports to FSSA.

If a report does not meet the threshold to be a critical incident, the MCE must:

1. Respond to the reporter and route the complaint through the MCE's complaints, grievances, and appeals process.

2. Follow its quality of care and/or quality of service investigation process.

If a critical incident has been confirmed (i.e., a substantiated critical incident), the MCE is responsible for ensuring follow-up care is in place for the impacted member. The MCE must require all staff and contracted providers to

document updates regarding initiated action(s) taken for the member and all follow-up activities related to the intervention(s) implemented as a result of the incident. Such follow-up may include updating the member's service plan to reflect enhanced care needs and conducting necessary follow up visits. The MCE's process must include a holistic review of the circumstances of the critical incident and preventing future occurrences. For example, if multiple critical incidents are filed for a network provider, the MCE must evaluate the implications for inclusion of that provider in its network or the application of additional oversight and reporting requirements, sanctions, or other requirements. The MCE is required to align its response with 455 IAC 2-6 and take comparable actions with providers who have egregious or repeated violations.

The MCE is responsible for implementing corrective actions to ensure that the conditions that led to the critical incident no longer exist. These may include but are not limited to:

- Enhancing provider oversight activities for a single provider, a group of providers, or all providers
- Establishing corrective action plans with network providers, within the MCE itself, or in other areas
- Modifying or terminating contracts with providers or vendors
- Transferring all or subgroups of members to be served by other providers

The MCE must document its corrective action process including steps taken to address the conditions that led to the critical incident, timeframe for resolution, staff members involved, member perspective, and plan for continuous monitoring. Upon a determination that the report does not need further documentation or review, the MCE shall mark the report as closed.

For reports of ANE, after the report is submitted to APS, it is sent to the director of the local APS unit who determines appropriate next steps. If APS conducts an investigation, an investigator may contact the MCE and/or other reporter for additional information. Once a report of an ANE critical incident has been made, the MCE must proactively provide interventions to members regarding the ANE. For cases where APS may need to be involved, the MCE must:

1. Invite APS to participate in the member-centered planning process, including plan development and updates, comprehensive assessment, and reassessment.
2. Invite APS to participate on the interdisciplinary team to the extent that the staff person makes recommendations as necessary to fulfill their APS responsibilities.
3. Designate a staff person to serve as a member advocate and liaison between APS and the member to assist in developing service options.

The MCE must ensure that members are immediately separated from an alleged abuser. This transition must uphold continuity of care and connect the individual with appropriate providers and other services in their community. The MCE will consult with human services agencies, as needed, to identify appropriate providers in the community. The MCE must then follow up to ensure that member needs are addressed on an ongoing basis. Follow-up on the success of an intervention must be completed within a week and reported to OMPP. All follow-up activities and referrals must be documented in the MCE's tracking systems.

Additionally, the OMPP Mortality Review Committee will review all participant deaths that:

- Are due to alleged, suspected or known abuse or neglect
- Are from trauma or accident
- Are alleged or known suicide or homicide
- Occur unexpectedly following transition from a nursing facility
- Occurs when participant has gone missing from normal care setting

The OMPP Mortality Review Committee may:

- Request additional information and review the case a second time when the requested information is in the file;
- Close a case with recommendations for the provider(s) or service coordinator/case manager, a referral to another entity, or a systemic recommendation; or
- Close a case with no recommendation(s).

MCEs are required to participate in the OMPP Mortality Review Committee.

OMPP is responsible for review and response to critical incidents or events for PathWays FFS enrollees in accordance with the methods and timeframes implemented by MCEs for PathWays managed care enrollees.

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

Oversight of reporting and response to critical incidents is the responsibility of OMPP. To assist in this oversight, MCEs are required to submit weekly critical incident reports to OMPP. These reports document data such as:

- Date the critical incident occurred
- Date the critical incident was identified
- Confirmation of report made to APS for incidents involving ANE
- Date initial action was taken
- Incident type
- Relevant provider information
- Current status of the investigation
- Closure information (e.g., date closed, final disposition, service plan updates made, provider changes initiated, education provided, other actions taken, etc.)

OMPP reviews the MCE reports against incidents reported to the FSSA web-based incident reporting system to validate all reported incidents are being investigated by the MCE. Data is also monitored to ensure the MCEs are closing cases timely. As applicable, corrective action is implemented with the MCE when performance or non-compliance issues are identified.

MCEs are also subject to semi-annual audits by OMPP of their critical incident processes. OMPP collects a sample of reports received by the MCE to confirm whether critical incidents were accurately identified and reported timely; whether appropriate investigations and/or follow-up actions were conducted; and whether corrective actions were implemented where necessary. OMPP may obtain feedback from members who experienced a critical incident, and the providers involved in the incident, to assure appropriate follow-up occurred. OMPP may also review the MCE's internal policies and procedures and related documents and data and to observe the MCE's workflows related to critical incidents as part of the audit process.

Additionally, OMPP has a critical incident workgroup that reviews data provided by the MCEs, refers cases to the OMPP Mortality Review Committee, and aggregates data across the PathWays MCEs to identify programmatic trends and necessary remediation. For example, the workgroup reviews the number and types of incidents for patterns such as across and within settings, provider, or provider type.

The MCEs, with oversight of OMPP, have an obligation to implement and maintain systems to prevent and mitigate critical incidents from occurring, such as:

- Conducting screenings to identify members who are at risk of experiencing a critical incident, as well as follow-up protocols to implement interventions for those members who are at risk.
- Making reasonable efforts through member interactions, education, and interventions to ensure that members are free from ANE.
- Referring members at risk to the appropriate resource including the LTC Ombudsman or other appropriate agency, such as the Area Agency on Aging.
- Processes to develop and update members' care plans and/or service plans, as needed, to balance member needs for safety, protection, physical health and freedom from harm with overall quality of life and individual choice.
- Using trend reports to identify potentially vulnerable members and develop systemic or operational interventions. This includes developing a screening or algorithm to identify individuals at higher risk of incidents. This also includes identifying areas where critical incidents are underreported.

- In cases where a participant has more than three critical incidents in a 12-month period, the MCE must perform an analysis of that participant's situation and take action as necessary to prevent or mitigate further incidents.
- Identifying, remediating, and resolving systemic issues based on a review of program data including:
 - o Developing and implementing initiatives to mitigate critical incident risks.
 - o Developing and implementing initiatives to reduce levels of underreporting.
 - o Imposing corrective actions with network providers, within the MCE itself, or in other areas, as needed.
 - o Terminating contracts with providers or vendors that, based on MCE analysis, pose risks that cannot be mitigated or that the provider has failed to mitigate.
 - o Other MCE actions, as needed.
- Using coordinated, creative, and effective methods for conducting outreach and education for all parties involved in critical incident reporting, management and mitigation, for example:
 - o Providing outreach and educational information about critical incidents to members and their family, guardian, and informal or unpaid caregivers to address particular trends or issues.
 - o Communicating timely with MCE staff and contractors about trends and issues, and updating the MCE's training materials.
 - o Communicating with providers about trends and issues identified through critical incident data analysis.
- Implementing policies and processes to assist in identifying unreported incidents.

OMPP also works in collaboration with the Bureau of Disability Services (BDS), the FSSA agency responsible for administration and operation of Indiana's other four 1915(c) waivers. OMPP and BDS meet to identify cross-waiver issues such as provider trends requiring system-wide remediation across waiver programs. These meetings occur on a bi-annual basis, and ad hoc as needed to respond to identified issues.

Appendix G: Participant Safeguards

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

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

The state does not permit or prohibits the use of restraints

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

OMPP prohibits the use of restraints in the provision of services regardless of the waiver setting. Reporting of prohibited restraint usage by a provider is reported through the FSSA web-based incident reporting system.

Service coordinators/case managers are responsible for monitoring and assessing the quality and effectiveness of the member's service plan through monthly contact, including face-to-face contact every 90 days. These reviews are utilized as opportunities to monitor for any prohibited restraint usage. MCEs are responsible for tracking, reviewing, and analyzing all incidents of prohibited use of restraints and reporting incidents to OMPP. OMPP has ultimate responsibility for oversight that these prohibitions are enforced.

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

OMPP prohibits the use of restrictive interventions in the provision of services regardless of the waiver setting. Reporting of prohibited usage of restrictive interventions by a provider is reported through the FSSA web-based incident reporting system.

Service coordinators/case managers are responsible for monitoring and assessing the quality and effectiveness of the member's service plan through monthly contact, including face-to-face contact every 90 days. These reviews are utilized as opportunities to monitor for any prohibited usage of restrictive interventions. MCEs are responsible for tracking, reviewing, and analyzing all incidents of prohibited use of restrictive interventions and reporting incidents to OMPP. OMPP has ultimate responsibility for oversight that these prohibitions are enforced.

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

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

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

Appendix G: Participant Safeguards

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

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

The state does not permit or prohibits the use of seclusion

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

OMPP prohibits the use of seclusion in the provision of services regardless of the waiver setting. Reporting of prohibited usage of seclusion by a provider is reported through the FSSA web-based incident reporting system.

Service coordinators/case managers are responsible for monitoring and assessing the quality and effectiveness of the member's service plan through monthly contact, including face-to-face contact every 90 days. These reviews are utilized as opportunities to monitor for any prohibited usage of seclusion. MCEs are responsible for tracking, reviewing, and analyzing all incidents of prohibited use of seclusion and reporting incidents to OMPP. OMPP has ultimate responsibility for oversight that these prohibitions are enforced.

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

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

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

Appendix G: Participant Safeguards

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

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

- a. **Applicability.** Select one:

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

Yes. This Appendix applies (complete the remaining items)

• **Medication Management and Follow-Up**

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

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

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

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

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

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

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

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

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

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

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

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

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

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

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).

Complete the following three items:

- (a) Specify state agency (or agencies) to which errors are reported:

All approved waiver providers that are responsible for medication administration are required to report specific medication errors as defined in OMPP's incident reporting policy. Licensed AL waiver service providers must also report medication errors to the Indiana Department of Health (IDOH).

(b) Specify the types of medication errors that providers are required to *record*:

AL waiver service providers, by IDOH regulation, 410 IAC 16.2-5-4(e)(7), are required to record any error in medication shall be noted in the resident's record. All approved waiver providers that are responsible for medication administration are required to record medication errors, including refusal to take medications, in the individual's record as per OMPP's IR policy. This includes the following:

- a) Medication given that was not prescribed or ordered for the individual;
- b) Failure to administer medication as prescribed, including:
 - Incorrect dosage;
 - Medication administered incorrectly;
 - Missed medication; and
 - Failure to give medication at the appropriate time.

(c) Specify the types of medication errors that providers must *report* to the state:

For licensed AL waiver providers, the facilities are required to report to IDOH any unusual occurrences if it directly threatens the welfare, safety or health of a resident as per 410 IAC 16.2-5-1.3(g)(1). The current IDOH policy on unusual occurrences includes the reporting of medication errors to IDOH that caused resident harm or require extensive monitoring for 24-48 hours. Waiver providers that are responsible for medication administration must report medication errors in accordance with the OMPP's IR policy.

Any medication error, except for refusal to take medications, must be reported to the state via the incident reporting process detailed within Appendix G-1-a of this application. Such errors including the following:

- a) Medication given that was not prescribed or ordered for the individual;
- b) Failure to administer medication as prescribed, including:
 - Incorrect dosage;
 - Medication administered incorrectly;
 - Missed medication; and
 - Failure to give medication at the appropriate time

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

- **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The IDOH has responsibility for monitoring licensed providers through the survey and compliance review processes. Additionally, OMPP gathers data through incident reporting, complaints, provider surveys, and mortality review. Identified problems with medication administration involving licensed waiver providers are referred to IDOH. OMPP staff reviews and reports medication administration error trends to the OMPP executive staff for further remedial action as deemed necessary.

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

i. Sub-Assurances:

a. Sub-assurance: *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.*

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

G.1.a Number and percentage of Critical Incident Reports received from MCEs within the stipulated timeframe. Numerator: Number of Critical Incident Reports received. Denominator: Number of Critical Incident Reports due.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify:	Annually	Stratified Describe Group:

MCE		
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

G.1.b Number and percentage of instances of abuse, neglect, exploitation, and unexplained death. Numerator: Number of Critical Incidents reflecting instances of abuse, neglect, exploitation or unexplained death. Denominator: Number of Critical Incidents reports received.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: MCE	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Continuously and Ongoing
	Other Specify:

Performance Measure:

G.1.c Number and percent of sampled individuals who reported that paid staff are respectful. Numerator: Number of sampled individuals who reported paid staff are respectful. Denominator: Total number of sampled individuals who responded.

Data Source (Select one):

Other

If 'Other' is selected, specify:

National Core Indicators Aging and Disabilities (NCI-AD)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: NCI-AD Survey Contractor	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:

		Representative Sample; Confidence Interval = 95%; Proportional and stratified across state districts
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: NCI-AD Survey Contractor	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

G.1.d Number and percent of sampled individuals who reported they feel safe around their paid support staff. Numerator: Number of sampled individuals who reported they feel safe around their paid support staff. Denominator: Total number of sampled individuals who responded.

Data Source (Select one):

Other

If 'Other' is selected, specify:

National Core Indicators Aging and Disabilities (NCI-AD)

Responsible Party for	Frequency of data	Sampling Approach
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data collection/generation (check each that applies):	collection/generation (check each that applies):	(check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: NCI-AD Survey Contractor	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify: Representative Sample; Confidence Interval = 95%; Proportional and stratified across state districts
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Other Specify: NCI-AD Survey Contractor	Annually
	Continuously and Ongoing
	Other Specify:

- b. *Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

G.2.a Number and percentage of Critical Incident Reports reviewed by Critical Incident team that included cases sent to Mortality Review Committee. Numerator: Number of Critical Incident reports reviewed with recommendation to send to Mortality Review Committee. Denominator: Number of Critical Incident reports received.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative

		Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

G.2.b Number and percentage of waiver individuals (or families/legal guardians) who received information on how to report abuse, neglect, and/or exploitation (ANE) via the service planning process. Numerator: Number of participants, family members, or legal guardians who received information on reporting ANE as part of the service plan. Denominator: Number of service plans audited.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Audit Report

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: MCE	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

G.2.c Number and percentage of incidents of abuse, neglect and exploitation individually remediated. Numerator: Number of incidents of abuse, neglect and exploitation remediated. Denominator: Number of incidents of abuse, neglect and exploitation.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other	Annually	Stratified

Specify: MCE		Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

G.2.d Number and percentage of unexpected deaths reviewed by the mortality review committee according to policy. Numerator: Number of unexpected deaths reviewed by the mortality review committee according to policy. Denominator: Total number of unexpected deaths.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Continuously and Ongoing
	Other Specify:

- c. **Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

G.3 Number and percentage of Critical Incident Reports that include instances of restrictive interventions. Numerator: Number of Critical Incident reports that include usage of restrictive intervention (seclusion and restraints). Denominator: Number of Critical Incident reports received.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

Other Specify: MCE	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

d. *Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

G.4.a Number & percentage of members with a care plan that was transmitted to their PCP or other documented medical care practitioner identified by the member within 30 days of its development (HEDIS MEASURE). Numerator: Number of members whose care plan was transmitted to practitioner within 30 days

Denominator: Number of care plans reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Annual LTSS HEDIS Audit

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: MCE	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify: HEDIS specifications
	Other	

	Specify: 	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

G.4.b Number and percentage of sampled individuals having a complete physical exam or wellness visit in the past year. Numerator: Number of sampled individuals who report having a complete physical exam or wellness visit in the past year. Denominator: Total number of sampled individuals who responded.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

National Core Indicators Aging and Disabilities (NCI-AD)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review

Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: NCI-AD Survey Contractor	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify: Representative Sample; Confidence Interval = 95%; Proportional and stratified across state districts
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: NCI-AD Survey Contractor	Annually
	Continuously and Ongoing
	Other

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify:

Performance Measure:

G.4.c Number and percentage of HCBS participants who received an ambulatory or preventive health visit during the year. Numerator: Number of HCBS participants who received an ambulatory or preventive health visit during the measurement year.
Denominator: Number of HCBS participants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic Data Warehouse (EDW)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: MCE, EDW	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify: HEDIS Specifications
	Other Specify:	

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

G.4.d Number and percent of sampled individuals who report the ability to get an appointment to see their primary care doctor when they need to. Numerator: Number of sampled individuals who report the ability to get an appointment to see their primary care doctor when they need to. **Denominator:** Total number of sampled individuals.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

National Core Indicators Aging and Disabilities (NCI-AD)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review

Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: NCI-AD Survey Contractor	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify: Representative Sample; Confidence Interval = 95%; Proportional and stratified across state districts
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: NCI-AD Survey Contractor	Annually
	Continuously and Ongoing
	Other

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

All HCBS providers are required to report critical incidents (CI) to the FSSA web-based incident reporting system (and APS as applicable). The MCE must include CI reporting requirements for providers in all network provider agreements. The MCEs receive CI reports from the web-based incident reporting system and are responsible for reviewing/remediating the CI. The MCEs are also responsible for logging all reported incidents on the CI report that goes to OMPP weekly. OMPP is responsible for verifying that all web-based incident reporting system reported incidents appear on the MCE reports.

The MCEs must have a system for accepting and analyzing CI reports. They are responsible for remediating the CIs and sending status updates to OMPP via the weekly CI report. In the web-based incident reporting system, there is a field for providers to indicate if an incident was reported to APS; providers are required to report to APS, but the MCE is responsible for identifying and reporting instances when the provider did not report to APS.

OMPP's CI Team reviews all CI reports and performs data analysis to identify trends and cases to send to the Mortality Review Committee. Part of the service plan review will include whether information on reporting A-N-E was included in the service planning process. Data is also monitored to ensure the MCEs are closing cases timely. Corrective action is implemented when performance or non-compliance issues are identified.

If a report meets the defined criteria to be a CI, the MCE must follow the steps identified in the CI Management section of the MCE Policy and Procedure Manual. If a CI has been confirmed (i.e., a substantiated critical incident), the MCE is responsible for ensuring follow-up care is in place for the impacted member. The MCE shall require all staff and contracted providers to document updates regarding initiated action(s) taken for the member and all follow-up activities related to the intervention(s) implemented as a result of the incident. Such follow-up may include updating the member's service plan to reflect enhanced care needs and conducting necessary follow up visits. The MCE's process must include a holistic review of the circumstances of the CI and preventing future occurrences. For example, if multiple CIs are filed for a network provider, the MCE should evaluate the implications for inclusion of that provider in its network or the application of additional oversight and reporting requirements, sanctions, or other requirements. The MCE must also report to OMPP decisions to exclude the provider from network participation based on founded allegations. The MCE should align its response with 455 IAC 2-6, Provider Qualifications, and take comparable actions with providers who have egregious or repeated violations. The MCE is also responsible for implementing corrective actions to ensure that the conditions that led to the CI no longer exist.

The MCE must document its corrective action process including steps taken to address the conditions that led to the CI, time frame for resolution, staff members involved, member perspective, and plan for continuous monitoring. Upon a determination that the report does not need further documentation or review, the MCE shall mark the report as closed.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of health and welfare that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 1915(c) of the Social Security Act and 42 CFR § 441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver quality improvement strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a quality improvement strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the quality improvement strategy.

Quality Improvement Strategy: Minimum Components

The quality improvement strategy (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the QIS spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

DISCOVERY and ANALYSIS

OMPP will utilize the information gathered during the discovery and remediation efforts identified throughout this waiver application in conjunction with the information gathered through Indiana's other four 1915(c) waivers to ensure a seamless approach to system improvement. In support of these activities, FSSA will convene a quality team comprised of representatives from OMPP, BDS, each MCE, and others as appropriate. This team will assist OMPP in identifying areas requiring system improvements through the review of information gathered through the discovery and remediation processes. Systems improvement strategies used by OMPP will be tailored to address the specific issues identified through discovery and remediation data, and can include targeted technical assistance and training with the MCEs (and, as needed with their provider panels), data system improvements, or contract clarifications or adjustments.

The 1915(c) waiver data sources identified throughout the appendices in this application will form the basis of information upon which systems improvement will be undertaken. Initial analysis of discovery data is conducted by the appropriate OMPP staff as part of their day-to-day activities. This discovery data is obtained from the following activities and sources:

- Regular reporting — OMPP conducts regular reporting activities to include the collection of the following information: claims, encounters, member grievances and appeals, independent external reviews, translation and interpretation services, provider helpline performance, provider claims, credentialing, outcome measures, utilization, service authorizations, administrative, financial, network development and access, quality management and improvement, program integrity, and critical incidents.
- Electronic Database queries—OMPP utilizes several electronic database applications which provide routine reports on various performance indicators in addition to allowing for on-demand report generation. These reports provide some of the performance measurement data for the waiver sub- assurances.
- On site reviews — OMPP conducts bi-monthly onsite reviews of all PathWays MCEs. Site visits are utilized to review MCE compliance with federal, state, and contract requirements through strategies such as onsite demonstrations of operational procedures, meetings and interviews with MCE personnel, and monitoring helpline calls.
- Incident Review— OMPP requires all waiver service providers to report critical incidents via a web-based submission tool. All reports are processed by incident review staff within the time period stipulated in the MCE manual. All reports of actual or alleged ANE are designated as critical incidents and forwarded to OMPP for additional review in addition to any submission to APS.
 - o Mortality Review— All incident reports of waiver participants' deaths are forwarded to OMPP for review. Death events which may have been impacted by the provision or non-provision of waiver services are referred to designated Mortality Review staff for further investigation.

Reporting and management of critical incidents will be an area of heightened focus during the early implementation of the PathWays program. The state expects a high degree of collaboration to reduce the risk of critical incidents as members transition into the MCE and transition to new Service Coordinators. This period may involve activities such as increased reporting frequency and detail, ad hoc workgroups to identify trends, and required interventions to address those trends. The state may also require the submission of the MCE's methodology for identifying individuals at high risk for critical incidents.

- Provider Compliance/Licensure Monitoring —The Provider Compliance Tool (PCT) review involves a service review visit to each non-licensed/noncertified provider at least one time every three years to establish that the provider continues to meet all provider requirements contained in 455 IAC 2. If found deficient the provider will be required to submit and fulfill the requirements of an acceptable CAP. Failure to successfully complete the CAP process may result in corrective action up to and including decertification as a waiver provider. IDOH is responsible for assuring licensed providers continue to meet license requirements. If found deficient the provider will be required to submit and fulfill the requirements of an acceptable CAP. Failure to successfully complete the CAP process may result in corrective action up to and including decertification as a waiver provider.

COMPILATION and TRENDING OF PERFORMANCE MEASURES

OMPP identified key performance measures and present these in numerator/denominator format. These measures

are derived from other discovery activities but serve as both discovery and analytical tools. Each of these measures corresponds with a sub-assurance identified in the waiver application.

Data obtained from all of these sources, as well as data generated through remediation processes, is disseminated to the appropriate agency staff. Remediation of participant findings is initiated immediately at the program and service level.

OMPP will meet at least quarterly to review and evaluate the QIS performance measures, sampling strategies, and processes for remediation and improvement. The evaluation compares current performance to past or anticipated performance, analyzes trends in performance improvement/decrement, and analyzes remediation reports to identify systemic deficiencies. OMPP also reviews reports and descriptions of best-practice quality improvement approaches from other states. OMPP recommendations for system improvements will be researched and developed into proposals for consideration by the Quality Strategy Committee.

SYSTEM IMPROVEMENT and DESIGN

OMPP can include upper management personnel from MCES, other FSSA agencies, and other areas within OMPP, and it may also include legal representation. The purpose is to provide leadership and direction for quality improvement projects, policy revision or development, and actions leading to refinement of quality operations and system management.

OMPP may assign research, design or implementation activities back to appropriate agencies, MCE staff, other OMPP personnel, or contracted entities.

Prioritization of system improvement activities will be subject to several factors:

- regulatory requirements as specified by law or funding sources;
- potential to reduce risk or negative outcomes for program participants;
- potential to effect positive outcomes for a substantial number of participants;
- potential for implementation success;
- cost and feasibility of implementation activities; and
- ability to measure results and outcomes of system improvements.

OMPP is sensitive to the complexities of the service delivery system and the impact that change can have on both that system and on the participants we serve. While the scope of any given system improvement initiative will determine the implementation processes, when appropriate the state will:

- seek and consider stakeholder input;
- communicate changes and timelines to stakeholders, clearly identifying how the change may impact them;
- use beta testing and limited roll-out strategies; and
- abide by existing State protocols for approval, development and implementation of new policies, technologies and general practices.

Outcomes of all system changes and improvements will be monitored using the discovery and analysis tools and process described above. Measures obtained from these tools and processes will be compared to past and anticipated measures in continuation of the quality improvement cycle. In addition to the data and information related to the measures specifically identified in this waiver, OMPP will utilize information from the following sources to achieve a coordinated, effective system improvement strategy: external quality review (EQR) reports, managed care quality strategy, and performance improvement projects (PIPs).

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
Quality Improvement Committee	Annually
Other Specify: MCEs	Other Specify:

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

OMPP is committed to making sound, data driven design changes based upon information gathered from discovery and remediation, and from the waiver monitoring activities. OMPP utilizes several electronic database applications and MCE reports which provide routine reports on various performance indicators in addition to allowing for on-demand report generation. These reports provide key data and allow OMPP to monitor and assess the outcome and effects of system design changes. OMPP identified key performance measures which are compiled in numerator/denominator format. These measures are derived from a variety of discovery activities and serve as both discovery and analytical tools. Data gathered from these discovery activities is compiled and trend lines are developed by the OMPP. This information is disseminated throughout the agency and is provided to other areas within OMPP as well as other agencies and MCE staff for review and analysis. These entities assess the outcome of system design changes through a comparison of current and past performance measure results. Findings are then used to assess the need for additional changes or refinement, in the continuation of the quality improvement cycle.

The State will use this data to inform future QIS considerations. The State will utilize formalized processes, including solicitation of input from CMS, to monitor the efficacy of the intervention to ensure that the areas targeted for improvement are positively impacted. Areas of non-compliance are addressed through a progressive sanctioning process that may include corrective action plans developed by the MCEs or by the LCAR contractor, as appropriate, and such interventions will further inform overall system design changes to prevent future issues. Lessons learned from these activities will be communicated internally by the OMPP, and externally to MCEs and provider entities.

- ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

While the QIS is designed to identify opportunities for improvement in the service delivery system, the QIS itself must be monitored and improved upon. Improvements in the QIS will be necessary to keep up with changes in the regulatory and service delivery environments, and due to data or tools which the operators find to be inconsistent, incomplete or not conducive to obtaining desired measures or outcomes.

As many of the data collection and analysis tools are electronic in nature, OMPP will review opportunities to integrate new technology into the QIS. OMPP staff will also actively seek input into QIS component performance from staff and contract entities who work with the various components on a day-to-day basis. Any complaints received from service recipients regarding QIS activities will be reviewed by OMPP staff. OMPP staff will formally review the QIS at least annually and make recommendations for changes or improvements.

OMPP has engaged with stakeholders and advocates throughout the design and development phases of the waiver. In order to ensure success and maintain a truly collaborative process, the state will continue reaching out to providers, advocates, and individuals throughout the implementation and operational phases of the demonstration.

In addition to the ongoing incorporation of a continuous quality improvement process for the quality and oversight process as a whole, OMPP will, at least once during the initial term of the waiver engage in a critical assessment of the performance of both the system improvement and the QIS and revise it as necessary and appropriate. Modifications to the Quality Improvement Strategy will also be submitted annually with the 372 report.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

- a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

- b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Waiver services are furnished through MCEs; therefore, 1915(b) waiver financial accountability requirements apply. MCEs are contractually required to reconcile eligibility and capitation payments on a monthly basis and return overpayments within 45 days.

For services delivered via FFS, FSSA's Audit Unit is responsible for annual review of services/billing performed by AAAs with reporting to OMPP. FSSA PI has an agreement with FSSA Audit to investigate allegations of fraud, waste and abuse (FWA). PI receives allegations of provider FWA, tracks in its case management system, and forwards to FSSA Audit to begin research/audit. FSSA Audit works with PI to vet providers with the Indiana Medicaid Fraud Control Unit (MFCU). Once MFCU's clearance is determined, FSSA Audit determines means to validate the accuracy of the allegation.

FSSA Audit conduct a statistically valid random sample of consumers and then PI's Fraud & Abuse Detection System (FADS) vendor will pull a sample for their audit. The size of a random sample audit is dependent upon the universe(s) size, claim/claim line payments, and other statistical criteria. The sample size is ultimately determined utilizing a FADS contractor tool that generates a statistically valid random sample size. Depending on the concerns identified during the risk assessment FADS will recommend an approach and/or scope for the audit:

- **Targeted Probe Audit Sample**- A sample of sufficiently small size designed to focus on specific services, members, timeframes or other scenarios identified as higher risk for FWA to determine potential outcomes of audit findings or payment error issues. If the probe identifies material issues, statistical sampling is used to expand testing and quantify overpayments.
- **Random Sample Audit** - Identify potential payment errors and extrapolate those to the entire universe of claims. FSSA Audit conducts its audit activities, develops a findings report for the provider which may include a CAP and request for overpayment, and shares findings with PI. Audits are performed onsite utilizing a probe test that includes a review of:
 - **Providers' source documents.** This includes documents that support paid claims, e.g. employee signed service notes, logs, evidence of supervisory approvals.
 - **Payroll records.** Dates/times/locations of service per claims are compared to related time cards and payroll registers.
 - **Employee background and qualifications.** Supporting documents, found in in HR files, are reviewed, including background checks, licenses, and search of the HHS/OIG exclusions list.

The FSSA PI section regularly utilizes random-sampling and extrapolation in conducting audits of IHCP providers. If the focus of the audit is narrow, and the number of potentially erroneous claims is manageable, the review will be conducted on all identified claims. In the event the issue involves a large number of claims, or if the review is a provider-focused, comprehensive review, PI has the ability to utilize statistically-valid random sampling and extrapolation to determine any potential overpayments from the IHCP. The frequency of utilizing this approach is fluid, based upon the providers in queue for audit as well as the proposed audits included in the yearly FADS Audit Workplans. On-going monitoring of IHCP providers is supported by utilization of Truven Health Analytic's Provider Peer Comparison Tool, J-SURS, which compares providers to peers of like specialty to identify outliers. All provider types are profiled at least yearly, while higher-risk provider types are profiled quarterly. The results of the profiles are reviewed by PI staff to determine which providers may need further investigation and these results are discussed in weekly FADS team meetings.

Provider records are reviewed to ensure compliance with applicable state and federal guidelines, as well as policies published by the IHCP. Review scope may vary depending on provider type/specialty and/or concerns identified through pre-audit activities (e.g., data mining, complaints, etc.). Review scopes typically include (at a minimum) procedures to determine provider compliance with applicable documentation requirements and review of provider credentials/qualifications to ensure they are practicing within the scope of their licensure or certification (if applicable). When appropriate, these reviews may include reconciliation of the records to timesheet and/or other payroll records, as well as vehicle insurance and/or health records of servicing providers (e.g., TB test records for waiver and home health providers). A detailed claim-level review checklist is prepared for each review that lists all claims included in the review, outlines the scope of the review, and identifies all findings or educational items noted during the review.

FADS investigations/audits can be initiated based on referrals received from different sources/agencies. PI receives information from the following sources which could potentially lead to additional action including audit action:

1. IHCP Provider and Member Concerns Line
2. Other agencies (MFCU)
3. Analyses/Analytics performed by the PI Investigations team
4. Analytics performed by FADS contractors

Depending on the allegations/information received regarding the provider(s), PI may conduct a Preliminary Investigation, utilizing the Credible Allegation of Fraud (CAF) tool developed by FADS contractors to determine next steps.

In certain instances, PI refers the provider in question to FADS contractors for additional analysis which may include

performing a Risk Assessment. The Risk Assessment tool, developed by FADS contractors, is utilized to gather information on a specific provider's background as well as billing patterns utilizing claims data and other research databases, focusing on any potential issues identified during the referral process. FADS contractors utilize this tool to assist in the decision making process when recommending the next appropriate action to be taken for the provider(s) in question.

There are differences in post-payment review methods, scope and frequency based upon audit type, provider type/specialty, background information, and state rules/regulations. PI can audit IHCP providers through either an algorithmic approach or a provider-specific full review. Algorithms processed by the PI FADS contractor, focus on specific codes, diagnoses, or program limitations to identify potentially erroneous claims across the IHCP. These reviews can involve hundreds of IHCP providers, but are limited in scope. The providers are notified of the potential errors upon receipt of the Draft Audit Findings letter, where no medical records are reviewed prior to identification of the claims. If PI decides to conduct a more comprehensive review of a provider, PI request a full medical record review. The audit can be conducted through a medical record request desk audit, or as an on-site review. The on-site audit can be announced or unannounced, based upon the circumstances.

Depending on multiple factors, risk assessments typically result in one of the following recommended actions (dependent upon the severity of the allegations and other information uncovered during the risk assessment):

- No further action: No issues uncovered warranting further action.
- Provider education: No issues identified that would result in patient harm or overpayments; however, it may be apparent that the provider as well as the Medicaid Program would benefit from additional education for the provider on proper/best billing practices.
- Provider self-audit: Specific concern(s) were identified resulting in a recommended limited-scope audit; however, the concern(s) are in an area which the State is comfortable with the provider conducting the audit to ensure compliance. FADS contractors perform validation review of the provider self-audit results. If FADS contractors determine they are not in agreement with a high percentage of the provider's self-audit results during the validation review, they will recommend the audit be escalated to a desk review and all records within the provider self-audit sample are evaluated by the contractor.
- Provider desk audit: Concern(s) were identified resulting in the need for medical record review (full or limited scope). However, the severity of the concerns do not currently warrant an on-site review. Certain provider records, including medical records, are requested for selected claims and clinical staff (if necessary) conduct a review of the services billed to ensure compliance with IHCP guidelines. Providers are allowed 30 days to submit the requested information.
- Provider on-site audit (announced or unannounced): Severity of the concern(s) has resulted in a recommendation of an on-site audit. Providers are generally given shorter notice (or no notice) of the pending on-site audit. If notice is provided, it can range from a few days to a few weeks depending on several factors (type of facility, audit concerns, etc.). Requested information is collected on-site. A facility tour as well as provider/staff interviews are also conducted during on-site reviews. FADS contractors, including clinical staff, are included in on-site reviews and assist with conducting interviews. State Program Integrity personnel often also participate in on-site reviews.
- Referral to MFCU: Payment suspension recommended as the potential intent of fraudulent behavior was identified. Depending on the allegations/information received regarding the provider(s), the SUR Unit may conduct a Preliminary Investigation, utilizing the Credible Allegation of Fraud (CAF) tool developed by FADS contractors to determine the appropriate next steps, if any.

*Audit reports containing accuracy-related issues, missing documentation, internal control deficiencies, and training issues are prepared. Providers submit corrective action plans. Any overpayments are set up for recoupment. Audit reports are distributed to provider leadership and appropriate FSSA executives. Periodically, PI is advised of any systemic issues identified. FSSA Audit Services seeks PI's advice on audit reporting and direction on technical questions. For audits performed based on referrals such as incorrect billing, the reporting varies. If the audit finds the provider made unintentional errors, the typical audit reporting process is followed. However, if the referred audit identifies potential, intentional errors that may be credible allegations of fraud, the provider is referred to Program Integrity for further action. Select analytics are periodically rerun in an attempt to identify if provider billing patterns have changed/improved based on previous audit and/or provider education. Additional audit action may be taken for providers who continue to be identified as potential issues in these algorithms. If providers are again selected for audit, a similar audit process as previously described would occur.

The State implemented an Electronic Visit Verification (EVV) system, known as the Sandata EVV System, that complies with the requirements of the federal 21st Century Cures Act. The IHCP CoreMMIS claim-processing system has been configured to integrate with the Sandata EVV system. IHCP requires that providers use the EVV system to document the following: Date of the service; Location of service delivery; Individual providing the service; Type of service performed; Individual receiving the service; Time the service begins and ends. Providers may choose to use an EVV system other than Sandata. However, those providers will be required to export data from their alternate system to the Sandata "Aggregator" for integration with CoreMMIS.

Appendix I: Financial Accountability**Quality Improvement: Financial Accountability**

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

i. Sub-Assurances:

a. Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

I.1 Number and percentage of claims paid for services that have a matching EVV record. Numerator: Number of claims paid for services that have a matching EVV record. Denominator: Number of claims submitted subject to EVV.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MCE Report

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify:	Annually	Stratified Describe Group:

MCE		
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

- b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

I.2. Number and percentage of claims per MCE which are not paid at the State minimum fee schedule. Numerator: Number of waiver claims which were not paid at the State minimum fee schedule. Denominator: Number of waiver claims paid.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MCE Encounter Data

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: MCE & State Fiscal Agent	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

For PM I.1: MCEs provide quarterly reports to OMPP documenting claims adjudication for services subject to EVV. This reporting allows OMPP and the MCEs to monitor the volume of claims for which an associated EVV record is not present. MCEs are expected to monitor provider compliance with EVV requirements and to conduct outreach and education as necessary to resolve claims non-compliance and ensure provider understanding of submission requirements. OMPP monitors MCE reports to identify any trends that require remediation. For example, OMPP would outreach to MCEs with high EVV denial rates to understand MCE processes for provider education and resolution. In the event of an identified deficiency in MCE remediation process, a corrective action plan, liquidated damages, or other contractually agreed upon remedy is required. OMPP provides the MCE written notice of non-compliance with expected remediation action and monitors the corrective actions implemented through to resolution. In the event remediation is not achieved in accordance with the required corrective action plan, OMPP may implement escalating corrective action.

Additionally, OMPP may determine additional policy guidance or contractual modifications are necessary to clarify expectations and ensure performance in accordance with state expectations. In such cases, OMPP may initiate contract amendment or policy clarification through updates to the MCE Policy and Procedure Manual. Trends are also monitored for the potential development of new Performance Improvement Projects.

For PM I.2: The Fiscal Agent runs all encounter claims through an adjudication process that calculates the amount that should be paid under the state fee schedule. The process also captures the amount paid by the MCE, and the data is placed in the Electronic Data Warehouse (EDW). OMPP will compare the two amounts to verify for each MCE the number of waiver claims that were not paid at the state minimum fee schedule. If it is determined that an MCE is paying less than the state minimum fee schedule, OMPP will investigate the root cause(s) and develop a remediation plan as appropriate. MCEs will be required to identify reasons why the minimum fee schedule was not paid and adjust their systems to correct and re-adjudicate prior claims as needed.

ii. Remediation Data Aggregation**Remediation-related Data Aggregation and Analysis (including trend identification)**

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability**I-2: Rates, Billing and Claims (1 of 3)**

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The method of determining capitation rates for the PathWays program is subject to the 1915(b) requirements and criteria. FSSA has contracted with an actuarial firm to develop the actuarially sound capitation payment rates on an annual basis.

For FFS rate setting, a rate review occurs at least every five years.

In state fiscal year (SFY) 2023, FSSA completed a rate review (rate study) for all waiver services. FSSA conducted a provider survey to capture the current provider experience of delivering the applicable waiver services, service specific workgroups, and all provider meetings.

Data sources: To develop revised payment rates, FSSA used the following primary data sources:

Bureau of Labor Statistics (BLS) data – Data elements from the BLS incorporated in the rates include Indiana wage data for applicable occupation codes, healthcare industry benefits, and healthcare wages, which were used to project the costs out to the effective rate period.

Provider survey data – Data collected from providers informed public source gaps and provided corroborating support for key BLS inputs. FSSA collected provider surveys related to provider costs (for employee salaries, benefits, administration and program support), average wages per hour, staffing information (such as number of employees relative to waiver participants served, and the average number of service hours per employee), mileage, and operational structure.

Service specific workgroups – Service specific interested party meetings were held to contextualize provider survey information and to further capture the provider experience with hiring/retaining staff, delivering services, and sufficiency of current payment rates.

Other public and proprietary data sources – Other data sources were used to develop assumptions in the rate models, including but not limited to, transportation mileage reimbursement, fleet vehicle costs, and food costs (limited to adult day).

Methodologies: To develop prospective payment rate methodologies for this waiver's program services, FSSA selected the following approaches:

Traditional cost model build-up - This approach reflects the program-related cost per unit of providing each covered service. The foundation of this model is the labor cost per unit, which includes projected wages and benefits costs, allocated to the service unit level. Administration and program support costs are calculated as a percentage of the labor cost per unit component. Self-directed and non-agency service rates follow the cost model build-up but do not include a supervisory component. Select services also include "other" cost components for unique requirements such as food for adult day services. All services using this build-up approach have supporting rate models.

Key default rate inputs under this approach were as follows:

Direct care staff and supervisory wages: based on BLS Indiana wages and percentiles, but were also informed by provider surveys and interested party feedback

Wage inflation: based on changes in Consumer Price Index (CPI) for employment earnings of medical professionals

Training and Paid Time Off (PTO) factors: training and PTO ranges between 60 and 70 hours per employee per year

Benefits factor ("employee related expenses" or ERE): varies by wages and is based on BLS national benchmarks for insurance costs as well as federal and state taxes

Administration and program support factor: 15% combined administration and program support factor

Indirect service time: ranges between 1 minute and 3 minutes per 15-minute unit for timed individual services

Staffing ratios: group services vary by staffing ratios that align with group service standards; group services include adult day

Caseload size: case management services reflect a waiver specific caseload size

Transportation: some services include mileage for onsite staff travel or reimbursement for a fleet

Rate composite approach - This approach was used for Assisted Living only, and is based on a composite of rates for service components to reflect the value for the package of services. It includes tiered and bundled rates for Assisted Living, where the tiers are assigned based on the level of service assessment for each individual. The rate composite for each level includes the following components:

Attendant Care

Home Maker

Skilled Nursing
 Adult Day Service
 Emergency Response
 Non-Medical Transportation

Participant levels 1-3 are assigned based on an Indiana-specific Level of Service tool. Level 2 has the highest projected utilization and is the starting point of the Assisted Living tiered rates. Under tiered rate adjustments, the Level 2 Attendant Care, Home Maker and Skilled Nursing rate components are adjusted upwards by 17% for the level 3 rate and adjusted downward by 10% for the level 1 rate. These Assisted Living level differentials are informed by multiple discussions with interested parties, provider survey results, and the state's knowledge of service requirements. Assisted Living services will be paid on a monthly unit basis for all months except admit and discharge months, in which case payment will be based on a daily unit. The monthly rate is equal to the daily rate multiplied by 29.7 days, based on average monthly utilization.

Market-based approach - Based on market prices (up to an annual or lifetime limit) or commercial benchmarks for Community Transition, Home Modifications, Nutritional Supplements, Personal Emergency Response, Pest Control, Specialized Medical Equipment, and Vehicle Modifications.

This waiver's fee schedule can be found on the FSSA webpage at: <https://www.in.gov/fssa/da/medicaid-hcbs/>.

Changes to rates and rate setting methodology require 60 day tribal notice and 30 day public comment period as well as a waiver amendment. Further, Indiana code requires that all providers of Medicaid funded services be made aware of changes 30 days prior to the change effective date. All other providers are notified of rate changes through public notice and public comments, IHCP published banner pages, bulletins, and newsletters as prepared by FSSA and distributed by FSSA's fiscal agent. Once the changes occur, manuals are regularly updated to reflect the changed rates. Information about payment rates is made available to waiver participants by their case manager. Information about payment rates is also available to waiver participants and providers, both verbally and in writing, from FSSA staff.

FSSA will continue to collaborate with the community on any revisions made to the waiver rates. Their valuable input into the waiver rate reviews is necessary to ensure that rates are sufficient to continue provider participation and waiver participant access to waiver services.

At CMS' request, the Home Modification Assessment Service and the Home Modification service have been combined into one service line in the waiver filing. However, the service components are performed by different providers (the assessor is independent of the contractor who does the actual modification), and therefore payment for the service is remitted in two separate components: 1) the independent assessment continues to be paid using a flat fee developed using a traditional cost model build-up, and 2) the modification itself continues to use a market based approach. The payment for the combined service is the sum of these two components.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Waiver services are reimbursed by MCEs. Providers bill the MCE with whom a member is enrolled. Claims are reimbursed in accordance with the terms of the provider's contract with the MCE. Providers may not bill FSSA directly for services provided to MCE enrollees. MCE billings to the State are made in accordance with the provisions of the 1915(b) PathWays Waiver.

For FFS, claims for waiver services flow directly from the providers to the Indiana Medicaid Management Information System (MMIS) and payments are made via FSSA's contracted fiscal agent.

The State implemented an Electronic Visit Verification (EVV) system, known as the Sandata EVV System, that complies with the requirements of the federal 21st Century Cures Act. The IHCP CoreMMIS claim-processing system has been configured to integrate with the Sandata EVV system.

Appendix I: Financial Accountability

c. Certifying Public Expenditures (select one):

No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Waiver services are reimbursed by MCEs. Providers bill the MCE with whom a member is enrolled. Claims are reimbursed in accordance with the terms of the provider's contract with the MCE. Providers may not bill FSSA directly for services provided to MCE enrollees. MCE billings to the State are made in accordance with the provisions of the 1915(b) PathWays Waiver. The MMIS includes system edits to ensure that prior to issuing a capitation payment, the enrollee is eligible for the PathWays 1915(c) waiver and is enrolled with the MCE. MCEs must implement system edits to ensure that claim payments are made only when the individual is eligible for 1915(c) waiver services on the date of service. FSSA monitors MCE compliance and system capability through pre-implementation readiness review and ongoing monitoring (e.g., encounter data audit and validation). The MCEs are also responsible for program integrity functions with OMPP review and oversight.

For FFS enrollees, OMPP approves an individual's service plan within the State's case management database ensuring only services which are necessary and reimbursable under the Waiver. The service plan is sent to the fiscal agent, via systems interface with the MMIS, serving as the authorization for the individual's approved Waiver services. The case management system will not allow the addition of services beyond those services offered under the Waiver. The case management data system has been programmed to alert OMPP staff when a service plan is being reviewed for an individual whose Medicaid eligibility status is not currently open within an acceptable category as described under Appendix B-4-b. When the appropriate Medicaid eligibility status is in place, the service plan will be approved, and the system will generate the Individual Service Authorization, which is sent to each authorized provider of services on the Plan. The Individual Service Authorization identifies the waiver participant, the service that each provider is approved to deliver, and the rate at which the provider may bill for the service.

The case management database transmits data daily containing all new or modified service plans to the Indiana MMIS. The service plan data is utilized by the MMIS as the basis to create or modify Prior Authorization fields to bump against the billing of services for each individual waiver participant.

Providers submit electronic (or paper) claims directly to the MMIS. Claims are submitted with date(s) of service, service code, and billing amount. Reimbursements are only authorized and made in accordance with the Prior Authorization data on file. The MMIS also confirms that the waiver participant had the necessary level of care and Medicaid eligibility for all dates of service being claimed against.

Documentation and verification of service delivery consistent with paid claims is reviewed during the post payment review of the operating agency as well as by the OMPP when executing SUR activities. Additional information about these reviews can be found in the Provider and Member Utilization Review provider reference module at the following link: <http://provider.indianamedicaid.com/media/155481/provider%20and%20member%20utilization%20review.pdf>

RECOUPMENT

If a payment to a provider is identified as paid in error due to error, fraud, policy, system issues, etc., the State can recoup that payment by any of the ways listed below:

1. Create a non-claim specific accounts receivable
2. Claim adjustment
3. Remit payment via check

Non-Claim Specific Accounts Receivable (AR):

When this method is used to recoup payment, an AR is setup under the Medicaid Provider's identification number. Each AR is assigned a reason code. The reason code describes the purpose for the AR. The reason code also maps to various lines on the CMS 64.

Once the AR is setup, a provider's future Medicaid payments will be reduced until the AR is fully satisfied.

Claim Adjustments:

Under this process, a claim specific AR will be created when a claim is adjusted. Either the provider or the State may adjust claims. With claim specific ARs, the AR is attached to a specific claim that was previously paid.

The process is the same; however, as non-claim specific ARs, in that a reason code will also be assign to a claim specific AR, and a provider's future Medicaid payments will be reduced until the AR is satisfied. With claim specific ARs, the CMS 64 line on which the original payment was made, is reduced to reflect returning the federal share. For, example, if an inpatient claim is adjusted to recoup payment, once the recoupment happens, the adjustment would be reflected in line 1A of the CMS 64.9.

Remit Payment Via Check:

Providers may repay overpayments in the form of a check. If a provider remits payment via check, an AR is still necessary to process the check. Under this method, instead of reducing a providers future Medicaid payments until the AR is satisfied, the AR is satisfied with the check.

In summary, the waiver participant's eligibility for Medicaid Waiver services is controlled through the electronic case management system which is linked to the Medicaid claims system. All services are approved within these systems by the operating agency. As part of the 90 day review, the case manager verifies with the individual the appropriateness of services and monitors for delivery of service as prescribed in the plan of care. Modifications to the plan of care are made as necessary.

The State is offering an Open Choice Model for Electronic Visit Verification (EVV). The State is contracting with an EVV vendor that allows providers with existing EVV vendors to continue to use those systems. Existing EVV vendors will report standardized aggregate data to the State operated EVV system. The PathWays waiver services that utilize EVV are all forms of attendant care, unskilled respite care, Home and Community Assistance, and specialized medical equipment.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (select one):

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for PathWays Waiver services for FFS enrollees are made through the MMIS. Capitation payments to MCEs are made by the MMIS. The MMIS contains recipient eligibility and MCE assignment information. When a PathWays 1915(c) waiver recipient is enrolled in an MCE, this is reflected on the eligibility file and monthly payment flows from the MMIS to the MCE via an 837 transaction. FSSA will recover capitation payments for enrollees who were later determined to be ineligible for PathWays.

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

N/A - For enrollees receiving PathWays services via managed care, no 1915(c) waiver services are paid outside the MCE capitation rate.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

The capitation payment to MCEs is reduced by a performance withhold amount as outlined in the contracts between FSSA and the MCEs, and approved by CMS. The MCEs are eligible to receive some or all of the withheld funds based on their performance against contractual requirements. FSSA also recoups excess capitation paid to the MCE in the event its medical loss ratio (MLR) falls below the contractual requirement. Additionally, the MCE contracts and capitation rate certification outline applicable capitation risk mitigation strategies such as risk corridors and risk adjustments.

For FFS enrollees, providers receive and retain 100% of the amount claimed to CMS for waiver services.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the

state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

Appropriation of State Tax Revenues to the State Medicaid Agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as

CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. Select one:

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

In accordance with 42 CFR 441.310(a)(2), FSSA does not pay the cost of room and board and did not include costs associated with room and board in the capitation rate development process. The MCEs are contractually required to comply with federal provisions regarding reimbursement prohibitions for the cost of room and board services in residential settings.

For FFS enrollees, no room and board costs are figured into allowable provider expenses. There are provider guidelines for usual and customary fee, and the provider agreement states that a provider may only provide services for which the provider is certified. Waiver service providers are paid a fee for each type of direct service provided; no room and board costs are included in these fees.

Note: The waiver does not provide services in waiver group home settings. Waiver participants are responsible for all room and board costs.

Based on the method for establishing the fee for each waiver service, the State of Indiana assures that no room and board costs are paid through Medicaid. Indiana provider audit procedures also review provider billing and all allowable costs to further assure no room and board payments are made.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)**

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)**

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)**

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)**

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

MEDWorks members with income between 150% - 350% FPL are responsible for paying a premium based on family size and income; the income standard includes a 50% earned income disregard for all MEDWorks members. Premiums vary from \$0 to \$254.

The included groups are the MEDWorks members with HCBS waivers with income over 150% FPL.

For 2023, the MEDWorks premiums are:

Family Size 1:

Income standard \$1216 - \$1822: Premium \$0
 Income standard \$1823 - \$2127: Premium \$48
 Income standard \$2128 - \$2430: Premium \$69
 Income standard \$2431 - \$3038: Premium \$107
 Income standard \$3039 - \$3645: Premium \$134
 Income standard \$3646 - \$4253: Premium \$161
 Income standard: \$4254 and over: Premium \$187

Family size 2:

Income standard \$1644 - \$2465: Premium \$0
 Income standard \$2465 - \$2876: Premium \$65
 Income standard \$2877 - \$3287: Premium \$93
 Income standard \$3288 - \$4109: Premium \$145
 Income standard \$4110 - \$4930: Premium \$182
 Income standard \$4931 - \$5752: Premium \$218
 Income standard \$5753 and over: Premium \$254

*Income of the non-MEDWorks member is not budgeted in the eligibility determination but does apply to the premium calculation.

Every month, the Premium Vendor sends a bill to MEDWorks members with a premium. The member has 60 days to pay the premium; failure to pay within 60 days can result in the closure of the MEDWorks Medicaid. This results in a 2 year lock out for MEDWorks members. If the member pays the premium in full, the lock out is removed. MEDWorks members between 101-149% FPL are excluded as are other Medicaid categories with HCBS waivers.

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D

tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	38250.71	9383.11	47633.82	90177.64	2879.69	93057.33	45423.51
2	35288.29	14037.05	49325.34	88413.76	3065.33	91479.09	42153.75
3	34479.56	14345.87	48825.43	91154.59	3132.77	94287.36	45461.93
4	34736.50	14661.48	49397.98	93980.38	3201.69	97182.07	47784.09
5	34636.53	14984.03	49620.56	96893.77	3272.13	100165.90	50545.34

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	39842		39842
Year 2	39842		39842
Year 3	39842		39842
Year 4	39842		39842
Year 5	39842		39842

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Projected average length of stay was developed based on slot projections. Slot projections reflect actual experience through October 2024 in WY 1 of the initial filing. They also assume approximately 2.20% of participants lapse each month (between 691 to 715 members per month) while a sufficient number of new entrants are enrolled each month to allow no annual slot growth throughout the remainder of the filing. The 2.20% lapse rate was developed based on historical experience.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Base Year data reflects experience for members 60 and over from Waiver Year 1 of the seventh renewal of the Health & Wellness (H&W waiver): July 1, 2023 – June 30, 2024. This is the last year prior to the PathWays transition. The base year data was projected to WY 2 through WY 5 of the initial waiver filing in the following manner:

- The number of users of each service was adjusted proportionally, based on projected slots and assumptions about the number of slots for capitation vs FFS delivery systems as described in the section J-2-b.
 - Average units per user were projected to vary with average length of stay.
 - The number of Structured Family Caregiving (SFC) users was adjusted to reflect a policy change, under which Legally Responsible Individuals (LRIs) may not be reimbursed for Attendant Care effective July 1, 2024. Under this policy, several hundred members transitioned to SFC as of July 1, 2024, and are therefore no longer able to use Attendant Care concurrently. Appendix J-2-d reflects actual tier placement of the new SFC users.
 - Attendant Care: The utilization has been reduced by 20% in alignment with capitation rate setting assumptions for the PathWays for Aging managed care program.
 - The new Caregiving Coaching and Behavior Management service was effective January 1, 2023. Based on input from the Division of Aging, Factor D projections assume that 95% of the projected 1,500 members from the prior filing or 1,425 individuals age 60 and above were expected to utilize the service for 2 hours every month in SFY 2023. Cost per unit is assumed to be \$15.75 per quarter hour effective July 1, 2023 based on the rate developed using the updated methodology.
 - It is assumed that those in the managed care program will be receiving Case Management services through integrated case management with the managed care entities (MCEs), since it will be part of administrative function performed by the MCEs under the PathWays program. Only those receiving services through the FFS delivery system will receive waiver Case Management services through the PathWays waiver.
 - The following changes are proposed to be effective December 31, 2025:
 - o For Adult Day Services – the number of average units per user and average cost per unit were adjusted to reflect elimination of two different categories for the level of reimbursement.
 - o For Attendant Care – the number of users and the number of average units per user were adjusted to reflect the limitation of the service to 40 hours per week when provided by a family member.
 - o Self-directions – proposed to be implemented and will impact Attendant Care, Home and Community Assistance Service and Respite Care. It is assumed that 2% of members will participate in self-direction of the services and this will reduce their budget by 10%. The average cost per unit was adjusted to decrease by 0.2% for the services listed above. In addition, the Participant-Directed Services will be sunset by December 31, 2025.
 - o Healthcare coordination – the average number of units per user was adjusted to reflect an anticipated reduction in services, accounting for instances where services were identified as duplicative of those already being provided to the member. This adjustment is estimated to have a \$16.5 million impact.
 - o Environmental Modification and Environmental Modification Assessment lines were combined into one line now titled 'Environmental Modification and Assessment' on the Appendix J.
- Cost per unit trend is projected to be 0.0% per year as the state does not expect the rates to change after rate review during the renewal period.

Estimates of Factor D for each waiver year are illustrated in the cost neutrality summary in Appendix J-1.

- ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Base Year data reflects experience from Waiver Year 1 of the seventh renewal of the H&W waiver: July 1, 2023 – June 30, 2024 for enrollees age 60 and above. Base year data was trended at 2.2% per year to reflect Medical CPI-U over the most recent 5 complete years (rounded).

Estimates of Factor D' for each waiver year are illustrated in the cost neutrality summary in Appendix J-1.

- iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Base Year data reflects experience from Waiver Year 1 of the seventh renewal of the H&W waiver for nursing facility residents age 60 and above: July 1, 2023 – June 30, 2024. Factor G for WY1 also includes \$810.3 million in Nursing Facility Upper Payment Limit (UPL) expenditures, contributing \$23,329 to the base year Factor G. Starting with Waiver Year 1, costs are trended at 3.1% per year.

The 3.1% trend was estimated using the average of the Medical CPI-U and CPI-U over the most recent 5 complete years (rounded) as institutional costs tend to trend midway between medical and non-medical costs.

Estimates of Factor G for each waiver year are illustrated in the cost neutrality summary in Appendix J-1.

- iv. Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Base Year data reflects experience for nursing facility residents age 60 and above during Waiver Year 1 of the seventh renewal of the H&W waiver: July 1, 2023 – June 30, 2024. Base year data was trended at 2.2% per year to reflect Medical CPI-U over the recent 5 complete years (rounded).

Estimates of Factor G' for each waiver year are illustrated in the cost neutrality summary in Appendix J-1.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

Waiver Services	
Adult Day Service	
Attendant Care	
Case Management	
Home and Community Assistance Service	
Skilled Respite	
Adult Family Care	
Assisted Living	
Caregiver Coaching	
Community Transition	
Home Delivered Meals	
Home Modification Assessment (Terminated as of 12/30/2025)	
Home Modifications (Terminated as of 12/30/2025)	
Home Modifications and Assessments (Effective 12/31/2025)	
Integrated Health Care Coordination	
Nutritional Supplements	
Participant Directed Home Care Service (Terminated as of 12/30/2025)	
Personal Emergency Response System	
Pest Control	
Specialized Medical Equipment and Supplies	
Structured Family Caregiving	
Transportation	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							9872111.41
Adult Day Services - Capitation	☐	1/4 hour	878	3111.10	3.61	9860880.34	
Adult Day Services - FFS	☐	1/4 hour	1	3111.10	3.61	11231.07	
Attendant Care Total:							839004235.31
Attendant Care - Capitation	☐	1/4 hour	17906	5483.90	8.53	837600905.30	
Attendant Care - FFS	☐	1/4 hour	30	5483.90	8.53	1403330.01	
Case Management Total:							114434.21
Case Management - FFS	☐	monthly	63	9.60	189.21	114434.21	
Home and Community Assistance Service Total:							37022015.84
Home and Community Assistance Service - Capitation	☐	1/4 hour	5963	791.60	7.83	36960033.56	
Home and Community Assistance Service - FFS	☐	1/4 hour	10	791.60	7.83	61982.28	
Skilled Respite Total:							6699360.53
Respite - Capitation	☐	1/4 hour	552	1252.80	9.67	6687245.95	
Respite - FFS	☐	1/4 hour				12114.58	
GRAND TOTAL: 1523984758.95 Total: Services included in capitation: 1521316997.75 Total: Services not included in capitation: 2667761.19 Total Estimated Unduplicated Participants: 39842 Factor D (Divide total by number of participants): 38250.71 Services included in capitation: 38183.75 Services not included in capitation: 66.96 Average Length of Stay on the Waiver: 297							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			1	1252.80	9.67		
Adult Family Care Total:							957106.57
Adult Family Care - Level 1 - Capitation	day		11	128.30	66.21	93442.17	
Adult Family Care - Level 2 - Capitation	day		15	246.00	72.30	266787.00	
Adult Family Care - Level 3 - Capitation	day		27	236.20	90.25	575560.35	
Adult Family Care - Level 1 - FFS	day		0	128.30	66.21	0.00	
Adult Family Care - Level 2 - FFS	day		0	246.00	72.30	0.00	
Adult Family Care - Level 3 - FFS	day		1	236.20	90.25	21317.05	
Assisted Living Total:							283878286.62
Assisted Living - Daily - Capitation	day		5603	107.60	112.76	67981064.53	
Assisted Living - Daily - FFS	day		9	107.60	112.76	109196.78	
Assisted Living - Monthly - Capitation	monthly		7322	8.70	3381.95	215434949.73	
Assisted Living - Monthly - FFS	monthly		12	8.70	3381.95	353075.58	
Caregiver Coaching Total:							2375744.17
Caregiver Coaching - Capitation	1/4 hour		1447	104.10	15.75	2372465.02	
Caregiver Coaching - FFS	1/4 hour		2	104.10	15.75	3279.15	
Community Transition Total:							203602.85
Community Transition - Capitation	unit		160	1.30	972.78	202338.24	
Community Transition - FFS	unit		1	1.30	972.78	1264.61	
Home Delivered							39563487.56
GRAND TOTAL: 1523984758.95 Total: Services included in capitation: 1521316997.75 Total: Services not included in capitation: 2667761.19 Total Estimated Unduplicated Participants: 39842 Factor D (Divide total by number of participants): 38250.71 Services included in capitation: 38183.75 Services not included in capitation: 66.96 Average Length of Stay on the Waiver: 297							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Meals Total:							
Home Delivered Meals - Capitation		meal	15882	321.30	7.74	39496342.28	
Home Delivered Meals - FFS		meal	27	321.30	7.74	67145.27	
Home Modification Assessment (Terminated as of 12/30/2025) Total:							992409.03
Home Modifications - Assessment - Capitation		unit	1959	1.50	337.21	990891.58	
Home Modifications - Assessment - FFS		unit	3	1.50	337.21	1517.44	
Home Modifications (Terminated as of 12/30/2025) Total:							11712498.84
Home Modifications - Capitation		unit	1378	1.40	6062.37	11695524.20	
Home Modifications - FFS		unit	2	1.40	6062.37	16974.64	
Home Modifications and Assessments (Effective 12/31/2025) Total:							0.00
Home Modifications and Assessments - Capitation		unit	0	0.00	0.01	0.00	
Home Modifications and Assessments - FFS		unit	0	0.00	0.01	0.00	
Integrated Health Care Coordination Total:							30792565.12
Integrated Health Care Coordination - Capitation		1/4 hour	5435	400.30	14.13	30741658.96	
GRAND TOTAL: 1523984758.95 Total: Services included in capitation: 1521316997.75 Total: Services not included in capitation: 2667761.19 Total Estimated Unduplicated Participants: 39842 Factor D (Divide total by number of participants): 38250.71 Services included in capitation: 38183.75 Services not included in capitation: 66.96 Average Length of Stay on the Waiver: 297							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Integrated Health Care Coordination - FFS		1/4 hour	9	400.30	14.13	50906.15	
Nutritional Supplements Total:							638558.46
Nutritional Supplements - Capitation		unit	949	28.50	23.56	637215.54	
Nutritional Supplements - FFS		unit	2	28.50	23.56	1342.92	
Participant Directed Home Care Service (Terminated as of 12/30/2025) Total:							478818.25
Participant-Directed Home Care Service - Capitation		1/4 hour	1	32113.90	14.91	478818.25	
Personal Emergency Response System Total:							7247557.14
Personal Emergency Response System - Capitation		unit	16687	9.20	47.13	7235416.45	
Personal Emergency Response System - FFS		unit	28	9.20	47.13	12140.69	
Pest Control Total:							937095.34
Pest Control - Capitation		unit	979	4.30	222.15	935184.86	
Pest Control - FFS		unit	2	4.30	222.15	1910.49	
Specialized Medical Equipment and Supplies Total:							1635896.39
Specialized Medical Equipment and Supplies - Capitation		unit	2128	3.70	207.38	1632827.17	
Specialized Medical Equipment and Supplies - FFS		unit	4	3.70	207.38	3069.22	
GRAND TOTAL: 1523984758.95 Total: Services included in capitation: 1521316997.75 Total: Services not included in capitation: 2667761.19 Total Estimated Unduplicated Participants: 39842 Factor D (Divide total by number of participants): 38250.71 Services included in capitation: 38183.75 Services not included in capitation: 66.96 Average Length of Stay on the Waiver: 297							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
FFS							
Structured Family Caregiving Total:							241606218.26
Structured Family Caregiving - Level 1 - Capitation		day	4084	260.00	77.40	82186416.00	
Structured Family Caregiving - Level 2 - Capitation		day	3128	251.90	99.57	78455504.42	
Structured Family Caregiving - Level 3 - Capitation		day	2415	251.30	132.75	80564581.12	
Structured Family Caregiving - Level 1 - FFS		day	7	260.00	77.40	140868.00	
Structured Family Caregiving - Level 2 - FFS		day	5	251.90	99.57	125408.42	
Structured Family Caregiving - Level 3 - FFS		day	4	251.30	132.75	133440.30	
Transportation Total:							7647152.04
Transportation - Capitation		trip/mileage	965	2196.70	3.60	7631335.80	
Transportation - FFS		trip/mileage	2	2196.70	3.60	15816.24	
Vehicle Modifications Total:							605604.99
Vehicle Modifications - Capitation		unit	100	1.10	5450.99	599608.90	
Vehicle Modifications - FFS		unit	1	1.10	5450.99	5996.09	
GRAND TOTAL: 1523984758.95 Total: Services included in capitation: 1521316997.75 Total: Services not included in capitation: 2667761.19 Total Estimated Unduplicated Participants: 39842 Factor D (Divide total by number of participants): 38250.71 Services included in capitation: 38183.75 Services not included in capitation: 66.96 Average Length of Stay on the Waiver: 297							

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated

payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							8812771.63
Adult Day Services - Capitation	☐	1/4 hour	880	2733.10	3.66	8802768.48	
Adult Day Services - FFS	☐	1/4 hour	1	2733.10	3.66	10003.15	
Attendant Care Total:							770461707.71
Attendant Care - Capitation	☐	1/4 hour	21052	4293.30	8.52	770059339.63	
Attendant Care - FFS	☐	1/4 hour	11	4293.30	8.52	402368.08	
Case Management Total:							32709.22
Case Management - FFS	☐	monthly	19	9.10	189.18	32709.22	
Home and Community Assistance Service Total:							44451701.23
Home and Community Assistance Service - Capitation	☐	1/4 hour	6270	902.70	7.85	44430442.65	
Home and Community Assistance Service - FFS	☐	1/4 hour	3	902.70	7.85	21258.58	
Skilled Respite Total:							4128200.21
Respite - Capitation	☐	1/4 hour	257	1634.40	9.79	4112199.43	
Respite - FFS	☐	1/4 hour	1	1634.40	9.79	16000.78	
Adult Family Care Total:							720112.67
Adult Family Care - Level 1 - Capitation	☐	day	10	167.50	67.93	113782.75	
GRAND TOTAL: 1405956154.25 Total: Services included in capitation: 1405163450.56 Total: Services not included in capitation: 792703.69 Total Estimated Unduplicated Participants: 39842 Factor D (Divide total by number of participants): 35288.29 Services included in capitation: 35268.40 Services not included in capitation: 19.90 Average Length of Stay on the Waiver: 292							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Family Care - Level 2 - Capitation		day	18	178.30	72.34	232168.00	
Adult Family Care - Level 3 - Capitation		day	14	275.20	90.64	349217.79	
Adult Family Care - Level 1 - FFS		day	0	167.50	67.93	0.00	
Adult Family Care - Level 2 - FFS		day	0	178.30	72.34	0.00	
Adult Family Care - Level 3 - FFS		day	1	275.20	90.64	24944.13	
Assisted Living Total:							262698389.02
Assisted Living - Daily - Capitation		day	4903	124.60	118.97	72680414.79	
Assisted Living - Daily - FFS		day	2	124.60	118.97	29647.32	
Assisted Living - Monthly - Capitation		monthly	6525	8.60	3384.14	189901016.10	
Assisted Living - Monthly - FFS		monthly	3	8.60	3384.14	87310.81	
Caregiver Coaching Total:							2415180.60
Caregiver Coaching - Capitation		1/4 hour	1575	97.30	15.75	2413648.12	
Caregiver Coaching - FFS		1/4 hour	1	97.30	15.75	1532.48	
Community Transition Total:							124928.39
Community Transition - Capitation		unit	108	1.20	955.11	123782.26	
Community Transition - FFS		unit	1	1.20	955.11	1146.13	
Home Delivered Meals Total:							42453071.88
Home Delivered Meals - Capitation		meal	18365	298.90	7.73	42432277.40	
Home Delivered Meals - FFS		meal	9	298.90	7.73	20794.47	
GRAND TOTAL: 1405956154.25 Total: Services included in capitation: 1405163450.56 Total: Services not included in capitation: 792703.69 Total Estimated Unduplicated Participants: 39842 Factor D (Divide total by number of participants): 35288.29 Services included in capitation: 35268.40 Services not included in capitation: 19.90 Average Length of Stay on the Waiver: 292							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Modification Assessment (Terminated as of 12/30/2025) Total:							545037.71
Home Modifications - Assessment - Capitation		unit	1256	1.30	333.54	544604.11	
Home Modifications - Assessment - FFS		unit	1	1.30	333.54	433.60	
Home Modifications (Terminated as of 12/30/2025) Total:							8978084.88
Home Modifications - Capitation		unit	819	1.20	9124.07	8967136.00	
Home Modifications - FFS		unit	1	1.20	9124.07	10948.88	
Home Modifications and Assessments (Effective 12/31/2025) Total:							9522943.36
Home Modifications and Assessments - Capitation		unit	1256	2.10	3608.30	9517252.08	
Home Modifications and Assessments - FFS		unit	1	1.40	4065.20	5691.28	
Integrated Health Care Coordination Total:							31703260.84
Integrated Health Care Coordination - Capitation		1/4 hour	7013	318.80	14.17	31680498.15	
Integrated Health Care Coordination - FFS		1/4 hour	4	401.60	14.17	22762.69	
Nutritional Supplements Total:							664174.68
GRAND TOTAL: 1405956154.25 Total: Services included in capitation: 1405163450.56 Total: Services not included in capitation: 792703.69 Total Estimated Unduplicated Participants: 39842 Factor D (Divide total by number of participants): 35288.29 Services included in capitation: 35268.40 Services not included in capitation: 19.90 Average Length of Stay on the Waiver: 292							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nutritional Supplements - Capitation		unit	1037	11.50	55.64	663534.82	
Nutritional Supplements - FFS		unit	1	11.50	55.64	639.86	
Participant Directed Home Care Service (Terminated as of 12/30/2025) Total:							143226.31
Participant-Directed Home Care Service - Capitation		1/4 hour	1	32774.90	4.37	143226.31	
Personal Emergency Response System Total:							7738052.50
Personal Emergency Response System - Capitation		unit	17923	9.10	47.42	7734168.81	
Personal Emergency Response System - FFS		unit	9	9.10	47.42	3883.70	
Pest Control Total:							1070992.16
Pest Control - Capitation		unit	1123	4.00	238.21	1070039.32	
Pest Control - FFS		unit	1	4.00	238.21	952.84	
Specialized Medical Equipment and Supplies Total:							2381046.59
Specialized Medical Equipment and Supplies - Capitation		unit	2320	3.30	310.87	2380020.72	
Specialized Medical Equipment and Supplies - FFS		unit	1	3.30	310.87	1025.87	
Structured Family Caregiving Total:							192128512.28
Structured Family Caregiving -		day	4347	224.50	77.53	75661643.30	
GRAND TOTAL: 1405956154.25 Total: Services included in capitation: 1405163450.56 Total: Services not included in capitation: 792703.69 Total Estimated Unduplicated Participants: 39842 Factor D (Divide total by number of participants): 35288.29 Services included in capitation: 35268.40 Services not included in capitation: 19.90 Average Length of Stay on the Waiver: 292							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Level 1 - Capitation							
Structured Family Caregiving - Level 2 - Capitation		day	2698	213.50	99.61	57377651.03	
Structured Family Caregiving - Level 3 - Capitation		day	2025	218.90	133.11	59004002.48	
Structured Family Caregiving - Level 1 - FFS		day	2	224.50	77.53	34810.97	
Structured Family Caregiving - Level 2 - FFS		day	1	213.50	99.61	21266.74	
Structured Family Caregiving - Level 3 - FFS		day	1	218.90	133.11	29137.78	
Transportation Total:							13940370.86
Transportation - Capitation		trip/mileage	1923	2693.50	2.69	13933125.34	
Transportation - FFS		trip/mileage	1	2693.50	2.69	7245.52	
Vehicle Modifications Total:							841679.52
Vehicle Modifications - Capitation		unit	135	1.10	5626.20	835490.70	
Vehicle Modifications - FFS		unit	1	1.10	5626.20	6188.82	
GRAND TOTAL: 1405956154.25 Total: Services included in capitation: 1405163450.56 Total: Services not included in capitation: 792703.69 Total Estimated Unduplicated Participants: 39842 Factor D (Divide total by number of participants): 35288.29 Services included in capitation: 35268.40 Services not included in capitation: 19.90 Average Length of Stay on the Waiver: 292							

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							8786505.49
Adult Day Services - Capitation		1/4 hour	880	2702.80	3.69	8776532.16	
Adult Day Services - FFS		1/4 hour	1	2702.80	3.69	9973.33	
Attendant Care Total:							756884708.54
Attendant Care - Capitation		1/4 hour	21052	4222.60	8.51	756489430.95	
Attendant Care - FFS		1/4 hour	11	4222.60	8.51	395277.59	
Case Management Total:							32349.78
Case Management - FFS		monthly	19	9.00	189.18	32349.78	
Home and Community Assistance Service Total:							43790156.93
Home and Community Assistance Service - Capitation		1/4 hour	6270	890.40	7.84	43769214.72	
Home and Community Assistance Service - FFS		1/4 hour	3	890.40	7.84	20942.21	
Skilled Respite Total:							4067462.88
Respite - Capitation		1/4 hour	257	1612.00	9.78	4051697.52	
Respite - FFS		1/4 hour	1	1612.00	9.78	15765.36	
Adult Family Care Total:							710394.67
Adult Family Care - Level 1 - Capitation		day	10	165.20	67.93	112220.36	
Adult Family Care - Level 2 - Capitation		day	18	175.90	72.34	229042.91	
Adult Family Care - Level 3 - Capitation		day	14	271.50	90.64	344522.64	
Adult Family Care - Level 1 - FFS		day	0	165.20	67.93	0.00	
GRAND TOTAL: 1373734543.04 Total: Services included in capitation: 1372960290.19 Total: Services not included in capitation: 774252.85 Total Estimated Unduplicated Participants: 39842 Factor D (Divide total by number of participants): 34479.56 Services included in capitation: 34460.12 Services not included in capitation: 19.43 Average Length of Stay on the Waiver: 288							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Family Care - Level 2 - FFS		day	0	175.90	72.34	0.00	
Adult Family Care - Level 3 - FFS		day	1	271.50	90.64	24608.76	
Assisted Living Total:							257288024.49
Assisted Living - Daily - Capitation		day	4903	122.90	118.97	71688787.94	
Assisted Living - Daily - FFS		day	2	122.90	118.97	29242.83	
Assisted Living - Monthly - Capitation		monthly	6525	8.40	3384.14	185484713.40	
Assisted Living - Monthly - FFS		monthly	3	8.40	3384.14	85280.33	
Caregiver Coaching Total:							2382912.00
Caregiver Coaching - Capitation		1/4 hour	1575	96.00	15.75	2381400.00	
Caregiver Coaching - FFS		1/4 hour	1	96.00	15.75	1512.00	
Community Transition Total:							124928.39
Community Transition - Capitation		unit	108	1.20	955.11	123782.26	
Community Transition - FFS		unit	1	1.20	955.11	1146.13	
Home Delivered Meals Total:							41870744.70
Home Delivered Meals - Capitation		meal	18365	294.80	7.73	41850235.46	
Home Delivered Meals - FFS		meal	9	294.80	7.73	20509.24	
Home Modification Assessment (Terminated as of 12/30/2025) Total:							0.00
Home Modifications - Assessment -		unit	0	0.00	0.01	0.00	
GRAND TOTAL: 1373734543.04 Total: Services included in capitation: 1372960290.19 Total: Services not included in capitation: 774252.85 Total Estimated Unduplicated Participants: 39842 Factor D (Divide total by number of participants): 34479.56 Services included in capitation: 34460.12 Services not included in capitation: 19.43 Average Length of Stay on the Waiver: 288							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Capitation							
Home Modifications - Assessment - FFS		unit	0	0.00	0.01	0.00	
Home Modifications (Terminated as of 12/30/2025) Total:							0.00
Home Modifications - Capitation		unit	0	0.00	0.01	0.00	
Home Modifications - FFS		unit	0	0.00	0.01	0.00	
Home Modifications and Assessments (Effective 12/31/2025) Total:							19045833.88
Home Modifications and Assessments - Capitation		unit	2512	2.10	3608.29	19034451.41	
Home Modifications and Assessments - FFS		unit	1	2.80	4065.17	11382.48	
Integrated Health Care Coordination Total:							22928206.35
Integrated Health Care Coordination - Capitation		1/4 hour	7013	230.50	14.17	22905755.40	
Integrated Health Care Coordination - FFS		1/4 hour	4	396.10	14.17	22450.95	
Nutritional Supplements Total:							658399.25
Nutritional Supplements - Capitation		unit	1037	11.40	55.64	657764.95	
Nutritional Supplements - FFS		unit	1	11.40	55.64	634.30	
Participant Directed Home Care Service (Terminated as of							0.00
GRAND TOTAL: 1373734543.04 Total: Services included in capitation: 1372960290.19 Total: Services not included in capitation: 774252.85 Total Estimated Unduplicated Participants: 39842 Factor D (Divide total by number of participants): 34479.56 Services included in capitation: 34460.12 Services not included in capitation: 19.43 Average Length of Stay on the Waiver: 288							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
12/30/2025) Total:							
Participant-Directed Home Care Service - Capitation		1/4 hour	0	0.00	0.01	0.00	
Personal Emergency Response System Total:							7653018.96
Personal Emergency Response System - Capitation		unit	17923	9.00	47.42	7649177.94	
Personal Emergency Response System - FFS		unit	9	9.00	47.42	3841.02	
Pest Control Total:							1044217.36
Pest Control - Capitation		unit	1123	3.90	238.21	1043288.34	
Pest Control - FFS		unit	1	3.90	238.21	929.02	
Specialized Medical Equipment and Supplies Total:							2381046.59
Specialized Medical Equipment and Supplies - Capitation		unit	2320	3.30	310.87	2380020.72	
Specialized Medical Equipment and Supplies - FFS		unit	1	3.30	310.87	1025.87	
Structured Family Caregiving Total:							189494560.57
Structured Family Caregiving - Level 1 - Capitation		day	4347	221.40	77.53	74616872.27	
Structured Family Caregiving - Level 2 - Capitation		day	2698	210.60	99.61	56598282.47	
Structured Family Caregiving -		day	2025	215.90	133.11	58195359.22	
GRAND TOTAL: 1373734543.04 Total: Services included in capitation: 1372960290.19 Total: Services not included in capitation: 774252.85 Total Estimated Unduplicated Participants: 39842 Factor D (Divide total by number of participants): 34479.56 Services included in capitation: 34460.12 Services not included in capitation: 19.43 Average Length of Stay on the Waiver: 288							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Level 3 - Capitation							
Structured Family Caregiving - Level 1 - FFS		day	2	221.40	77.53	34330.28	
Structured Family Caregiving - Level 2 - FFS		day	1	210.60	99.61	20977.87	
Structured Family Caregiving - Level 3 - FFS		day	1	215.90	133.11	28738.45	
Transportation Total:							13749392.70
Transportation - Capitation		trip/mileage	1923	2656.60	2.69	13742246.44	
Transportation - FFS		trip/mileage	1	2656.60	2.69	7146.25	
Vehicle Modifications Total:							841679.52
Vehicle Modifications - Capitation		unit	135	1.10	5626.20	835490.70	
Vehicle Modifications - FFS		unit	1	1.10	5626.20	6188.82	
GRAND TOTAL: 1373734543.04 Total: Services included in capitation: 1372960290.19 Total: Services not included in capitation: 774252.85 Total Estimated Unduplicated Participants: 39842 Factor D (Divide total by number of participants): 34479.56 Services included in capitation: 34460.12 Services not included in capitation: 19.43 Average Length of Stay on the Waiver: 288							

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							8847297.14
Adult Day Services - Capitation		1/4 hour	880	2721.50	3.69	8837254.80	
Adult Day Services - FFS		1/4 hour	1	2721.50	3.69	10042.34	
Attendant Care Total:							762136620.15
Attendant Care - Capitation		1/4 hour	21052	4251.90	8.51	761738599.79	
Attendant Care - FFS		1/4 hour	11	4251.90	8.51	398020.36	
Case Management Total:							32349.78
Case Management - FFS		monthly	19	9.00	189.18	32349.78	
Home and Community Assistance Service Total:							44095074.91
Home and Community Assistance Service - Capitation		1/4 hour	6270	896.60	7.84	44073986.88	
Home and Community Assistance Service - FFS		1/4 hour	3	896.60	7.84	21088.03	
Skilled Respite Total:							4095723.17
Respite - Capitation		1/4 hour	257	1623.20	9.78	4079848.27	
Respite - FFS		1/4 hour	1	1623.20	9.78	15874.90	
Adult Family Care Total:							715355.61
Adult Family Care - Level 1 - Capitation		day	10	166.40	67.93	113035.52	
Adult Family Care - Level 2 - Capitation		day	18	177.10	72.34	230605.45	
Adult Family Care - Level 3 - Capitation		day	14	273.40	90.64	346933.66	
Adult Family Care - Level 1 - FFS		day	0	166.40	67.93	0.00	
GRAND TOTAL: 1383971747.13 Total: Services included in capitation: 1383192084.19 Total: Services not included in capitation: 779662.94 Total Estimated Unduplicated Participants: 39842 Factor D (Divide total by number of participants): 34736.50 Services included in capitation: 34716.93 Services not included in capitation: 19.57 Average Length of Stay on the Waiver: 290							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Family Care - Level 2 - FFS		day	0	177.10	72.34	0.00	
Adult Family Care - Level 3 - FFS		day	1	273.40	90.64	24780.98	
Assisted Living Total:							259964029.37
Assisted Living - Daily - Capitation		day	4903	123.70	118.97	72155435.87	
Assisted Living - Daily - FFS		day	2	123.70	118.97	29433.18	
Assisted Living - Monthly - Capitation		monthly	6525	8.50	3384.14	187692864.75	
Assisted Living - Monthly - FFS		monthly	3	8.50	3384.14	86295.57	
Caregiver Coaching Total:							2400287.40
Caregiver Coaching - Capitation		1/4 hour	1575	96.70	15.75	2398764.38	
Caregiver Coaching - FFS		1/4 hour	1	96.70	15.75	1523.02	
Community Transition Total:							124928.39
Community Transition - Capitation		unit	108	1.20	955.11	123782.26	
Community Transition - FFS		unit	1	1.20	955.11	1146.13	
Home Delivered Meals Total:							42169009.84
Home Delivered Meals - Capitation		meal	18365	296.90	7.73	42148354.50	
Home Delivered Meals - FFS		meal	9	296.90	7.73	20655.33	
Home Modification Assessment (Terminated as of 12/30/2025) Total:							0.00
Home Modifications - Assessment -		unit	0	0.00	0.01	0.00	
GRAND TOTAL: 1383971747.13 Total: Services included in capitation: 1383192084.19 Total: Services not included in capitation: 779662.94 Total Estimated Unduplicated Participants: 39842 Factor D (Divide total by number of participants): 34736.50 Services included in capitation: 34716.93 Services not included in capitation: 19.57 Average Length of Stay on the Waiver: 290							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Capitation							
Home Modifications - Assessment - FFS		unit	0	0.00	0.01	0.00	
Home Modifications (Terminated as of 12/30/2025) Total:							0.00
Home Modifications - Capitation		unit	0	0.00	0.01	0.00	
Home Modifications - FFS		unit	0	0.00	0.01	0.00	
Home Modifications and Assessments (Effective 12/31/2025) Total:							19045833.88
Home Modifications and Assessments - Capitation		unit	2512	2.10	3608.29	19034451.41	
Home Modifications and Assessments - FFS		unit	1	2.80	4065.17	11382.48	
Integrated Health Care Coordination Total:							23087358.12
Integrated Health Care Coordination - Capitation		1/4 hour	7013	232.10	14.17	23064754.14	
Integrated Health Care Coordination - FFS		1/4 hour	4	398.80	14.17	22603.98	
Nutritional Supplements Total:							658399.25
Nutritional Supplements - Capitation		unit	1037	11.40	55.64	657764.95	
Nutritional Supplements - FFS		unit	1	11.40	55.64	634.30	
Participant Directed Home Care Service (Terminated as of							0.00
GRAND TOTAL: 1383971747.13 Total: Services included in capitation: 1383192084.19 Total: Services not included in capitation: 779662.94 Total Estimated Unduplicated Participants: 39842 Factor D (Divide total by number of participants): 34736.50 Services included in capitation: 34716.93 Services not included in capitation: 19.57 Average Length of Stay on the Waiver: 290							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
12/30/2025) Total:							
Participant-Directed Home Care Service - Capitation		1/4 hour	0	0.00	0.01	0.00	
Personal Emergency Response System Total:							7653018.96
Personal Emergency Response System - Capitation		unit	17923	9.00	47.42	7649177.94	
Personal Emergency Response System - FFS		unit	9	9.00	47.42	3841.02	
Pest Control Total:							1070992.16
Pest Control - Capitation		unit	1123	4.00	238.21	1070039.32	
Pest Control - FFS		unit	1	4.00	238.21	952.84	
Specialized Medical Equipment and Supplies Total:							2381046.59
Specialized Medical Equipment and Supplies - Capitation		unit	2320	3.30	310.87	2380020.72	
Specialized Medical Equipment and Supplies - FFS		unit	1	3.30	310.87	1025.87	
Structured Family Caregiving Total:							190808119.90
Structured Family Caregiving - Level 1 - Capitation		day	4347	222.90	77.53	75122406.64	
Structured Family Caregiving - Level 2 - Capitation		day	2698	212.10	99.61	57001404.14	
Structured Family Caregiving -		day	2025	217.40	133.11	58599680.85	
GRAND TOTAL: 1383971747.13 Total: Services included in capitation: 1383192084.19 Total: Services not included in capitation: 779662.94 Total Estimated Unduplicated Participants: 39842 Factor D (Divide total by number of participants): 34736.50 Services included in capitation: 34716.93 Services not included in capitation: 19.57 Average Length of Stay on the Waiver: 290							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Level 3 - Capitation							
Structured Family Caregiving - Level 1 - FFS		day	2	222.90	77.53	34562.87	
Structured Family Caregiving - Level 2 - FFS		day	1	212.10	99.61	21127.28	
Structured Family Caregiving - Level 3 - FFS		day	1	217.40	133.11	28938.11	
Transportation Total:							13844623.00
Transportation - Capitation		trip/mileage	1923	2675.00	2.69	13837427.25	
Transportation - FFS		trip/mileage	1	2675.00	2.69	7195.75	
Vehicle Modifications Total:							841679.52
Vehicle Modifications - Capitation		unit	135	1.10	5626.20	835490.70	
Vehicle Modifications - FFS		unit	1	1.10	5626.20	6188.82	
GRAND TOTAL: 1383971747.13 Total: Services included in capitation: 1383192084.19 Total: Services not included in capitation: 779662.94 Total Estimated Unduplicated Participants: 39842 Factor D (Divide total by number of participants): 34736.50 Services included in capitation: 34716.93 Services not included in capitation: 19.57 Average Length of Stay on the Waiver: 290							

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							8817063.86
Adult Day Services - Capitation		1/4 hour	880	2712.20	3.69	8807055.84	
Adult Day Services - FFS		1/4 hour	1	2712.20	3.69	10008.02	
Attendant Care Total:							759519626.65
Attendant Care - Capitation		1/4 hour	21052	4237.30	8.51	759122973.00	
Attendant Care - FFS		1/4 hour	11	4237.30	8.51	396653.65	
Case Management Total:							32349.78
Case Management - FFS		monthly	19	9.00	189.18	32349.78	
Home and Community Assistance Service Total:							43942615.92
Home and Community Assistance Service - Capitation		1/4 hour	6270	893.50	7.84	43921600.80	
Home and Community Assistance Service - FFS		1/4 hour	3	893.50	7.84	21015.12	
Skilled Respite Total:							4081593.02
Respite - Capitation		1/4 hour	257	1617.60	9.78	4065772.90	
Respite - FFS		1/4 hour	1	1617.60	9.78	15820.13	
Adult Family Care Total:							712807.16
Adult Family Care - Level 1 - Capitation		day	10	165.80	67.93	112627.94	
Adult Family Care - Level 2 - Capitation		day	18	176.50	72.34	229824.18	
Adult Family Care - Level 3 - Capitation		day	14	272.40	90.64	345664.70	
Adult Family Care - Level 1 - FFS		day	0	165.80	67.93	0.00	
GRAND TOTAL: 1379988733.41 Total: Services included in capitation: 1379211247.65 Total: Services not included in capitation: 777485.76 Total Estimated Unduplicated Participants: 39842 Factor D (Divide total by number of participants): 34636.53 Services included in capitation: 34617.02 Services not included in capitation: 19.51 Average Length of Stay on the Waiver: 289							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Family Care - Level 2 - FFS		day	0	176.50	72.34	0.00	
Adult Family Care - Level 3 - FFS		day	1	272.40	90.64	24690.34	
Assisted Living Total:							259730610.22
Assisted Living - Daily - Capitation		day	4903	123.30	118.97	71922111.90	
Assisted Living - Daily - FFS		day	2	123.30	118.97	29338.00	
Assisted Living - Monthly - Capitation		monthly	6525	8.50	3384.14	187692864.75	
Assisted Living - Monthly - FFS		monthly	3	8.50	3384.14	86295.57	
Caregiver Coaching Total:							2390358.60
Caregiver Coaching - Capitation		1/4 hour	1575	96.30	15.75	2388841.88	
Caregiver Coaching - FFS		1/4 hour	1	96.30	15.75	1516.72	
Community Transition Total:							124928.39
Community Transition - Capitation		unit	108	1.20	955.11	123782.26	
Community Transition - FFS		unit	1	1.20	955.11	1146.13	
Home Delivered Meals Total:							42012775.72
Home Delivered Meals - Capitation		meal	18365	295.80	7.73	41992196.91	
Home Delivered Meals - FFS		meal	9	295.80	7.73	20578.81	
Home Modification Assessment (Terminated as of 12/30/2025) Total:							0.00
Home Modifications - Assessment -		unit	0	0.00	0.01	0.00	
GRAND TOTAL: 1379988733.41 Total: Services included in capitation: 1379211247.65 Total: Services not included in capitation: 777485.76 Total Estimated Unduplicated Participants: 39842 Factor D (Divide total by number of participants): 34636.53 Services included in capitation: 34617.02 Services not included in capitation: 19.51 Average Length of Stay on the Waiver: 289							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Capitation							
Home Modifications - Assessment - FFS		unit	0	0.00	0.01	0.00	
Home Modifications (Terminated as of 12/30/2025) Total:							0.00
Home Modifications - Capitation		unit	0	0.00	0.01	0.00	
Home Modifications - FFS		unit	0	0.00	0.01	0.00	
Home Modifications and Assessments (Effective 12/31/2025) Total:							19045833.88
Home Modifications and Assessments - Capitation		unit	2512	2.10	3608.29	19034451.41	
Home Modifications and Assessments - FFS		unit	1	2.80	4065.17	11382.48	
Integrated Health Care Coordination Total:							23007785.07
Integrated Health Care Coordination - Capitation		1/4 hour	7013	231.30	14.17	22985254.77	
Integrated Health Care Coordination - FFS		1/4 hour	4	397.50	14.17	22530.30	
Nutritional Supplements Total:							658399.25
Nutritional Supplements - Capitation		unit	1037	11.40	55.64	657764.95	
Nutritional Supplements - FFS		unit	1	11.40	55.64	634.30	
Participant Directed Home Care Service (Terminated as of							0.00
GRAND TOTAL: 1379988733.41 Total: Services included in capitation: 1379211247.65 Total: Services not included in capitation: 777485.76 Total Estimated Unduplicated Participants: 39842 Factor D (Divide total by number of participants): 34636.53 Services included in capitation: 34617.02 Services not included in capitation: 19.51 Average Length of Stay on the Waiver: 289							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
12/30/2025) Total:							
Participant-Directed Home Care Service - Capitation		1/4 hour	0	0.00	0.01	0.00	
Personal Emergency Response System Total:							7653018.96
Personal Emergency Response System - Capitation		unit	17923	9.00	47.42	7649177.94	
Personal Emergency Response System - FFS		unit	9	9.00	47.42	3841.02	
Pest Control Total:							1070992.16
Pest Control - Capitation		unit	1123	4.00	238.21	1070039.32	
Pest Control - FFS		unit	1	4.00	238.21	952.84	
Specialized Medical Equipment and Supplies Total:							2381046.59
Specialized Medical Equipment and Supplies - Capitation		unit	2320	3.30	310.87	2380020.72	
Specialized Medical Equipment and Supplies - FFS		unit	1	3.30	310.87	1025.87	
Structured Family Caregiving Total:							190168240.80
Structured Family Caregiving - Level 1 - Capitation		day	4347	222.20	77.53	74886490.60	
Structured Family Caregiving - Level 2 - Capitation		day	2698	211.30	99.61	56786405.91	
Structured Family Caregiving -		day	2025	216.70	133.11	58410997.42	
GRAND TOTAL: 1379988733.41 Total: Services included in capitation: 1379211247.65 Total: Services not included in capitation: 777485.76 Total Estimated Unduplicated Participants: 39842 Factor D (Divide total by number of participants): 34636.53 Services included in capitation: 34617.02 Services not included in capitation: 19.51 Average Length of Stay on the Waiver: 289							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Level 3 - Capitation							
Structured Family Caregiving - Level 1 - FFS		day	2	222.20	77.53	34454.33	
Structured Family Caregiving - Level 2 - FFS		day	1	211.30	99.61	21047.59	
Structured Family Caregiving - Level 3 - FFS		day	1	216.70	133.11	28844.94	
Transportation Total:							13797007.85
Transportation - Capitation		trip/mileage	1923	2665.80	2.69	13789836.85	
Transportation - FFS		trip/mileage	1	2665.80	2.69	7171.00	
Vehicle Modifications Total:							841679.52
Vehicle Modifications - Capitation		unit	135	1.10	5626.20	835490.70	
Vehicle Modifications - FFS		unit	1	1.10	5626.20	6188.82	
GRAND TOTAL: 1379988733.41 Total: Services included in capitation: 1379211247.65 Total: Services not included in capitation: 777485.76 Total Estimated Unduplicated Participants: 39842 Factor D (Divide total by number of participants): 34636.53 Services included in capitation: 34617.02 Services not included in capitation: 19.51 Average Length of Stay on the Waiver: 289							