

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

## Request for 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:**

**Aged & Disabled Waiver**

C. **Waiver Number:** IN.0210

**Original Base Waiver Number:** IN.0210.90.R2

D. **Amendment Number:** IN.0210.R01.01

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

03/01/09

**Approved Effective Date of Waiver being Amended:** 07/01/08

### 2. Purpose(s) of Amendment

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

The primary purpose of this amendment is to:

1. Outline the transition process by which Indiana will administer the Medicaid Waiver program when revising services and/or service qualifications that may have or appear to have a negative impact in the delivery of those services (Main Application, Attachment #1: Transition Plan)

2. Increase the number of unduplicated participants served each year of the waiver renewal (Appendix B-3.a. Unduplicated Number of Participants.)

The following details all amendment changes by appendix and section:

#### APPLICATION 2. BRIEF WAIVER DESCRIPTION

The Objective has been updated to reflect the increase in the number of individuals served detailed in Appendix B-3.a.

#### APPLICATION 7.a. CONTACT PERSON

The Medicaid agency representative with whom CMS should communicate regarding the waiver has been updated.

#### APPENDIX B-3.a. NUMBER OF INDIVIDUALS SERVED

The first significant change from the approved Aged & Disabled Waiver (2008 - 2013) in this amendment application for February 1, 2009 is the number of unduplicated participants projected for each year of the renewal. Based on updated

projections, this 5-year renewal anticipates serving the following unduplicated participants:

Year 1 (2008) 8708  
Year 2 (2009) 10409  
Year 3 (2010) 11802  
Year 4 (2011) 12928  
Year 5 (2012) 13838

#### APPENDIX B-6.c. QUALIFICATIONS OF PERSONS PERFORMING INITIAL EVALUATIONS

Language has been added to clarify that: "All initial evaluations are completed by the Area Agency on Aging (AAA) case manager and determinations are rendered by the case manager supervisor."

The following language has been removed: For individuals with a diagnosis of mental illness and/or developmental disability or with a questionable Level of Care, the case manager will initiate the LOC process by obtaining medical and functional impairment information and forwarding the information to the Division of Aging (DA) where a decision will be rendered by designated staff members within the DA. Designated staff members within the DA meet all case management qualifications as detailed in Appendix C and have received training in the nursing facility LOC process by qualified State staff (nurses from the Division of Aging or designee).

#### APPENDIX B-6.f. PROCESS FOR LEVEL OF CARE EVALUATION/REEVALUATIONS

Language has been added to clarify that: "All initial evaluations are completed by the Area Agency on Aging (AAA) case manager and determinations are rendered by the case manager supervisor."

The following language has been removed: For individuals with a diagnosis of mental illness and/or developmental disability or with a questionable Level of Care, the case manager will initiate the LOC process by obtaining medical and functional impairment information and forwarding the information to the Division of Aging (DA) where a decision will be rendered by designated staff members within the DA. Designated staff members within the DA meet all case management qualifications as detailed in Appendix C and have received training in the nursing facility LOC process by qualified State staff (nurses from the Division of Aging or designee).

#### APPENDIX C-1/C-3 SUMMARY OF SERVICES COVERED/ SERVICE SPECIFICATION:

##### ADULT DAY SERVICE:

Language has been added to clarify that this service is usually aimed at participants 18 years old or older.

##### ATTENDANT CARE:

Allowable Activities has been expanded to allow the use of assistive devices.

Licensed Personal Services agency has been added as a provider type.

##### HOMEMAKER:

Activities Not Allowed has been clarified to include Escort or transport individuals to community activities or errands.

Licensed Personal Services agency has been added as a provider type.

##### RESPITE CARE:

Language has been changed to read Respite service is not to exceed 720 hours per 12 month period. This change allows greater flexibility in utilizing respite care service.

##### ADULT FOSTER CARE:

Language has been added to clarify maintenance of participant's personal records to specify documentation that must be included.

Language has been added to clarify that this service is usually aimed at participants 18 years old or older.

"Medically Complex" has been added to Activities Not Allowed. Bullet point now states: "Personal care services provided to medically unstable or medically complex participants as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician or other health professional"

##### ASSISTED LIVING:

Provider Type Title has been changed from "FSSA/ DA approved Assisted Living Agencies" to "Licensed Assisted Living Agency". This title clarification more accurately reflects the provider qualifications.

Language has been added to clarify that this service is usually aimed at participants 18 years old or older.

"Personal care services provided to medically unstable or medically complex participants as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician or other health professional" has been added to Activities Not Allowed.

#### HEALTH CARE COORDINATION:

Language has been corrected. Decompensate has been changed to  delay/prevent deterioration of health status .

#### HOME DELIVERED MEALS:

Service Standards have been clarified.

#### SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES:

"Individual" provider categories (Speech-Language Therapist; Occupational Therapist; Physical Therapist; and FSSA/ DA approved Specialized Medical Equipment and Supplies Individual) have been removed from the Provider Specifications to more accurately reflect Indiana Code IC 25-26-21-4 Home Medical Equipment Services Providers. This change does not impact any existing providers or waiver participants.

Provider type "Pharmacy" has been removed as this is duplicative of the provider type title "FSSA/ DA approved Specialized Medical Equipment and Supplies Agency".

#### APPENDIX C-2.a. CRIMINAL HISTORY AND/OR BACKGROUND INVESTIGATIONS

Language corrected to reflect the Indiana Professional Licensing Agency is responsible for maintaining the nurse aide registry.

#### APPENDIX C-2.b. ABUSE REGISTRY SCREENING

Language corrected to reflect the Indiana Professional Licensing Agency is responsible for maintaining the nurse aide registry.

#### APPENDIX C-2.e. OTHER STATE POLICIES CONCERNING PAYMENT FOR WAIVER SERVICES FURNISHED BY RELATIVES/ LEGAL GUARDIANS

Response has been changed to  The State does not make payment to relatives/legal guardians for furnishing waiver services.

#### APPENDIX C-3 PARTICIPANT SERVICES

Clarification has been added to Attendant Care, Case Management, Homemaker, Respite, and Adult Foster Care that  services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in fact (POA) of a participant, or the health care representative (HCR) of a participant.

Provider Qualifications Other Standards have been updated to reflect Indiana Code and Indiana Administrative Code citations that pertain to individual providers of services. The base service definitions and provider qualifications have not been changed.

#### APPENDIX E-1.a. DESCRIPTION OF PARTICIPANT DIRECTION

"Attendant Care services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, or the health care representative (HCR) of a participant" has been removed and now states: "Attendant Care services are defined in Appendix C1/C3 Service Specifications."

#### APPENDIX E-1.i. iv. OVERSIGHT OF FMS ENTITIES

Language has been clarified to correctly detail responsibilities.

#### APPENDIX E-1.n. GOALS FOR PARTICIPANT DIRECTION

The State has updated the number of unduplicated waiver participants who are expected to elect participant direction. Based on updated projections, this 5-year renewal anticipates the following number of participants who elect to direct their waiver service:

Year 1 (2008)	400
Year 2 (2009)	425
Year 3 (2010)	425
Year 4 (2011)	425

**APPENDIX G-1.a. STATE CRITICAL EVENT OR INCIDENT REPORTING REQUIREMENTS**

Language has been clarified for licensed providers to assure consistent incident reporting requirements between Indiana State Department of Health and DA. Additional minor changes have been made to reflect updated Incident Reporting and Mortality Review policies. Language has been clarified to more accurately reflect 460 IAC 1.2 Aging Rule. Reference to "sentinel events" has been removed and language now refers to "events with sentinel status".

**APPENDIX J COST NEUTRALITY DEMONSTRATION**

- Slots were increased consistent with the December 2008 Budget Committee Medicaid Forecast assumptions.
- Actual July 2008 waiver rate increases were incorporated by service.
- Waiver service cost per unit trends for future years were increased from 4.5% to 5.0% per year.
- An increase in the home health service rate of approximately 17% was implemented effective July 1, 2008, due to a rate restructuring. In addition to the rate increase, utilization was assumed to increase by 3%, consistent with assumptions used in the December 2008 Budget Committee Medicaid Forecast.

**(GENERAL) CONVERSION FROM WEB VERSION 3.4 TO VERSION 3.5:**

Indiana converts the Aged & Disabled Waiver from Version 3.4 to Version 3.5 Application which requires revisions and additions. Most 3.5 conversion changes are due to the revision of Appendix H "Quality Management Strategy", to the new "Systems Improvement" and associated Quality Improvement subsections added in Appendices A, B-6, C-2, D-2, G-3 and I -1. Version 3.5 also revises items such as A-7 Table for operational and administrative functions impacting A-3, A-4 and A -6; adds new B-4-a-2 for Miller Trust; adds new G-1-a and rennumbers G-1.

**3. Nature of the Amendment**

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**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)
<input checked="" type="checkbox"/> Waiver Application	2,7, Attach #1
<input type="checkbox"/> Appendix A <input type="checkbox"/> Waiver Administration and Operation	
<input checked="" type="checkbox"/> Appendix B <input type="checkbox"/> Participant Access and Eligibility	3,
<input checked="" type="checkbox"/> Appendix C <input type="checkbox"/> Participant Services	C-1/C-3, 2
<input type="checkbox"/> Appendix D <input type="checkbox"/> Participant Centered Service Planning and Delivery	
<input checked="" type="checkbox"/> Appendix E <input type="checkbox"/> Participant Direction of Services	1
<input type="checkbox"/> Appendix F <input type="checkbox"/> Participant Rights	
<input checked="" type="checkbox"/> Appendix G <input type="checkbox"/> Participant Safeguards	1
<input type="checkbox"/> Appendix H	
<input type="checkbox"/> Appendix I <input type="checkbox"/> Financial Accountability	
<input checked="" type="checkbox"/> Appendix J <input type="checkbox"/> Cost-Neutrality Demonstration	1, 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:

NOTE: This amendment includes the conversion from Version 3.4 to Version 3.5 of the Application. Version 3.5 includes some required revisions from Version 3.4. The major change in Version 3.5 is the transferral of subsections of Quality Improvement (QI) from Version 3.4 Appendix H to the new QI subsections in Appendices A, B, C, D, G, and I. Therefore, Indiana has updated the Quality Improvement Strategy in Appendix H and the new QI sections. There are additional updates required in Version 3.5 for subsections that have been changed/added, such as splitting Appendix A-2 into 2-a and 2-b; revising A-7 Functions; adding B-4-a-2 for Miller Trust; splitting G-1-a into G-1-a and G-1-b and renumbering the remaining subsections.

In addition, Indiana has made minor revisions to clarify procedures and policy and update language tense. All revisions are summarized in Item 2 Purpose of Amendment, in preceding section.

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

### 1. Request Information (1 of 3)

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

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

**Aged & Disabled Waiver**

C. **Type of Request: amendment**

**Original Base Waiver Number: IN.0210**

**Waiver Number: IN.0210.R01.01**

**Draft ID: IN.04.01.01**

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

Regular Waiver

E.

**Proposed Effective Date of Waiver being Amended: 07/01/08**

**Approved Effective Date of Waiver being Amended: 07/01/08**

### 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 the Mentally Retarded (ICF/MR) (as defined in 42 CFR  440.150)**

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

## 1. Request Information (3 of 3)

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

**Not applicable**

**Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

**1915(b)(2) (central broker)**

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

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

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

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

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

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

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

Specify the program:

## 2. Brief Waiver Description

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

**Purpose:** This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require nursing facility level of care. Through the use of the Aged & Disabled Waiver (A&D), Indiana Office of Medicaid Policy and Planning (OMPP) and the Indiana Division of Aging (DA) seek to increase availability and access to cost-effective aged and disabled waiver services.

**GOALS:** The A&D Waiver provides an alternative to nursing facility admission for adults and persons of all ages with a disability. The waiver is designed to provide services to supplement informal supports for people who would require care in a nursing facility if waiver or other supports were not available. Waiver services can be used to help people remain in their own homes, as well as assist people living in nursing facilities return to community settings such as their own homes, apartments, assisted living or adult foster care.

**OBJECTIVE:** To enable eligible Indiana residents to be served under the waiver by refilling vacated slots after the end of each waiver year by targeting, as necessary, the corresponding number of person(s) next in line for services from the statewide, first-come, first-served waiver waiting list. Indiana also projects transitioning up to 1039 eligible individuals from the Money Follows the Person grant onto the waiver during the five-year renewal.

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

Year 1 (2008) 8708  
Year 2 (2009) 10409  
Year 3 (2010) 11802  
Year 4 (2011) 12928  
Year 5 (2012) 13838

**ORGANIZATIONAL STRUCTURE:** The Indiana Division of Aging has been given the authority by the Office of Medicaid Policy and Planning (Single State Agency) to administer the A&D Waiver via a Memorandum of Understanding. The Indiana Division of Aging performs the daily operational tasks of the waiver and the Office of Medicaid Policy and Planning oversees all executive decisions and activities related to the waiver.

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

### **3. Components of the Waiver Request**

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**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*):

<input checked="" type="radio"/> <b>Yes. This waiver provides participant direction opportunities. Appendix E is required.</b>
<input type="radio"/> <b>No. This waiver does not provide participant direction opportunities. Appendix E is not required.</b>
- 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**

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- A. Comparability.** The State requests a waiver of the requirements contained in  1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of  1902(a)(10)(C)(i) (III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- Not Applicable**
  - No**
  - Yes**
- C. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in  1902(a)(1) of the Act (*select one*):
- No**
  - Yes**

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

- Geographic Limitation.** A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

*Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

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

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

## 5. Assurances

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

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
  2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
  3. Assurance that all facilities subject to  1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community

based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
  2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR □440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR □ 440.160.

## 6. Additional Requirements

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*Note: Item 6-I must be completed.*

- A. Service Plan.** In accordance with 42 CFR □441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR □441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.
- C. Room and Board.** In accordance with 42 CFR □441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence

or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:  
Public input regarding Indiana's waivers is obtained through quarterly stakeholders meetings, quarterly financial reviews which obtain input from individuals receiving services, family members, advocates, trade associations, case managers, and providers regarding problems in the system and what kinds of changes they would recommend. Additional input is obtained through bi-monthly CHOICE board meetings and quarterly case management meetings.
- Information received in 2007 identified the need for services concerning affordable and accessible housing; transportation; nutrition services; and service access.
- This information assists the Division of Aging in determining better strategies to enhance access to these services.
- Input is not limited to the waiver renewal process, but is encouraged through out the waiver program to provide ongoing input from the public.
- 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)

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

**Last Name:** Amos

**First Name:** Angela

**Title:** Waiver Manager

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

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

**Address 2:**

**City:** Indianapolis

**State:** Indiana

**Zip:** 46204

**Phone:** (317) 234-6340      **Ext:**  **TTY**

**Fax:** (317) 232-7382

**E-mail:** Angela.Amos@fssa.in.gov

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

**Last Name:** Filler

**First Name:** Karen

**Title:** Deputy Director of Long Term Care Operations

**Agency:** Indiana Family & Social Services Administration, Division of Aging

**Address:** 402 West Washington Street, Room W454

**Address 2:**

**City:** Indianapolis

**State:** Indiana

**Zip:** 46204

**Phone:** (317) 232-4651

**Ext:**  TTY

**Fax:** (317) 233-2182

**E-mail:**

## 8. Authorizing Signature

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

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

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**Signature:** Pat Casanova

State Medicaid Director or Designee

**Submission Date:**

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**Last Name:** Casanova

**First Name:** Pat

**Title:** Interim Director of Medicaid

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

**Address:**

**Address 2:**

**City:** Indianapolis

**State:** **Indiana**

**Zip:**

**Phone:**

**Fax:**

**E-mail:**

## Attachment #1: Transition Plan

---

Specify the transition plan for the waiver:

The following outline is the process by which Indiana will administer the A&D Medicaid Waiver program when revising services, service qualifications, or circumstances of care that may have or appear to have a negative impact in the delivery of those services:

1. In collaboration between the Office of Medicaid Policy and Planning (OMPP) and the Indiana Division of Aging (DA) a report will be generated, through the state's approved electronic case management database system, which will identify the participants and providers who would be impacted. Such recommended changes include: limiting the number of allowable service hours; eliminating a specific service; enhancing a specific service definition; or enhancing a service provider's qualification(s).

2. The report, listed above, will be reviewed by the OMPP and the DA, and a decision will be rendered as to the feasibility of the recommended changes. After careful review, if the recommended change(s) is to proceed, the following actions will occur:

A. The currently approved A&D Medicaid Waiver document will be opened by OMPP and together, the OMPP and the DA will complete the required documentation that will outline the proposed change(s).

B. The amendment will be submitted to CMS with an implementation date of ninety (90) days from the CMS approval date.

C. Upon receipt of the CMS approval of the amendment, an updated report as identified in #1 above will be generated which will identify those participants that will have a negative impact based on the approved changes.

D. The DA will notify the affected participants via letter sent thru the United States Postal Service. Additionally, the case managers and the service providers will also be notified by DA, either thru email via the electronic case management database system or thru the US Postal Service. The notification, to the participant, case manager, and provider, will outline the process that will be used in assisting the participant and the case manager in becoming compliant with the approved changes. This information will be recorded in the electronic case management database system.

E. The DA will notify all other providers who were not identified above (case managers and service delivery providers) either thru the electronic case management database system or thru the US Postal Service regarding the approved changes. This information will be recorded in the electronic case management database system. It will also be the responsibility of the case manager to inform their clients regarding the approved changes.

F. As noted in (D) above, the notification will include: the changes that will take place; possible alternatives to meeting the needs and assuring the health and welfare of the participants; date for which the changes must be completed (ninety (90) days from the CMS approval date); executive review process; fair hearing process will be available after any final decision; and that the DA will assist the case manager in implementing the changes.

G. Through the updated report identified in #1 above, the DA will monitor those participants and providers that are affected by the changes to assure the required changes occur within the approved time frame. The DA will dialogue, through the electronic case management database system, with the case manager to assure compliance and address any specific issues that may arise.

H. The electronic case management database system and the Medicaid Fiscal Intermediary system will be updated with the approved changes and corresponding implementation dates.

I. Participants may request an executive review upon the receipt of the DA's notification of the changes to be imposed. This notice will contain the steps for requesting the executive review as well as fair hearing process procedures. Indiana retains the executive review in which representatives from OMPP and the DA Director (or designee) will review the participant specific situation and issue a decision regarding services, service qualifications or circumstances of care to assure the health, welfare, and safety of the participant when no other viable options are available. In a review of a reduction of service hours the executive review may decide to continue the original service hours in order to assure the health, welfare, and safety of the participant when no other viable options are available; therefore not imposing the reduction of service hours. Participant specific situations will be reviewed on a case by case basis and are not meant as a precedent for over-riding the new changes in the waiver. Participants who are granted increased hours over the service limitations through an executive decision shall retain the higher level of service hours until, at least, the participant's next annual re-

determination date at which time a full reassessment will be completed to determine the necessary services to assure the health, welfare and safety of the participant.

J. Should the executive review decision be favorable to the state (and therefore not in favor of the participant), the participant retains his/her ability for fair hearing process as outlined in 2I and 2L.

K. Executive review can not be implemented/imposed for services that are terminated from the waiver.

L. Participants who are negatively affected by the changes retain their ability to appeal the decisions through the prescribed fair hearing process. The participant shall continue the same service hours during the appeal process. In the event a participant appeals the service limitation and the ruling is in favor of the participant, the participant shall retain the original service hours until his/her next annual re-determination at which time a full reassessment will be completed to determine the necessary services to assure the health, welfare and safety of the participant. In the event the participant appeals the service limitation and the ruling is in favor of the state, the case manager will work with the participant to adjust/conform to the approved service limitation. The DA does not require the participant to reimburse the state for services delivered during his/her appeal process.

### **Additional Needed Information (Optional)**

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Provide additional needed information for the waiver (optional):

### **Appendix A: Waiver Administration and Operation**

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

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

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

**The Medical Assistance Unit.**

Specify the unit name:

*(Do not complete item A-2)*

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

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

*(Complete item A-2-a).*

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

Specify the division/unit name:

**Indiana Family & Social Services Administration, Division of Aging**

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

## Appendix A: Waiver Administration and Operation

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### 2. Oversight of Performance.

- a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:  
**As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.**

- b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:  
The Office of Medicaid Policy and Planning (OMPP) and the Division of Aging (DA) have a Memorandum of Understanding that outlines the duties and responsibilities of each agency regarding the services provided under the A&D waiver.

Staff members from the OMPP also participate in DA weekly staff meetings to discuss issues relevant to the delivery of waiver services.

The OMPP exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver.

## Appendix A: Waiver Administration and Operation

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

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

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

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

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

Medicaid Rate Setting Contractor:

Provide data and recommendations to OMPP for the determination of waiver payment amounts or rates. The Medicaid Agency has final authority in the rate setting process.

Utilization Management Functions:

The auditing function has been incorporated into the Surveillance Utilization Review (SUR) functions of the contract negotiated between the Medicaid agency and selected contractor. OMPP has expanded its program integrity activities by using a multi-pronged approach to SUR activity that includes provider self-audit, contractor desk audit and full on-site audit functions. The SUR Contractor sifts and analyzes claims data and identifies providers/claims that indicate possible problems. The Contractor submits recommendations for review based on their data.

The selected contractor's audit process utilizes data mining, research, identification of outliers, problem billing patterns, aberrant providers, and issues referred by the state. The member's eligibility for waiver services will be validated. On-site visits will be conducted to verify that services billed are authorized in the plan of care, are being delivered, and are meeting the needs of the member. A major focus of the SUR audit exit process is provider education.

Additionally, it is expected that OMPP staff will periodically accompany the contractor on-site, to observe services.

Qualified Provider Enrollment Function:

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

- 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

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

- Not applicable**
- Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

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

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

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

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

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

Each of the sixteen (16) Area Agencies on Aging are responsible for: disseminating information regarding the waiver to potential participants; assisting individuals in the waiver enrollment application process; conducting level of care evaluation activities; identifying potential providers to perform waiver services; and conducting training and technical assistance concerning waiver requirements.

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

## **Appendix A: Waiver Administration and Operation**

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

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

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

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

The OMPP, in collaboration with DA is responsible for the performance of the Medicaid Fiscal Agent's provision of training and technical assistance concerning waiver requirements.

## **Appendix A: Waiver Administration and Operation**

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

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

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

The OMPP is re-procuring the Surveillance Utilization Review (SUR) contract. OMPP is operating the SUR function until it is assured that the contracting entity selected to perform waiver auditing functions can satisfy the deliverables stipulated within the contract.

Reporting requirements will be determined as agreed upon within the fully executed contract, which is expected to be implemented during the second year of the waiver renewal.

## **Appendix A: Waiver Administration and Operation**

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

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

#### a. Methods for Discovery: Administrative Authority

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

##### i. Performance Measures

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

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

#### Performance Measure:

Level of Care initial determinations are performed in a timely manner. Monitor the number of initial LOC validated by DA Waiver Unit (numerator) by the total number of initial LOCs reviewed (denominator).

Data Source (Select one):

Other

If 'Other' is selected, specify:

**Electronic case management database system**

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

**Performance Measure:**

**Plan of Care (POC) are timely. Monitor the number of POC performed within 12 months of previous POC (numerator) by total number of POC completed (denominator).**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Electronic case management database system**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Database system identifies those POC that are not timely or where significant changes have been made in costs and/or services
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

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

**Performance Measure:**

Level of Care re-determinations are performed in a timely manner. Monitor the number of LOC performed within 12 months of previous LOC (numerator) by total number of LOC completed (denominator).

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Electronic case management database system**

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

		that are not timely
	<input type="checkbox"/> <b>Other</b> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> <b>Other</b> Specify: _____	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> <b>Other</b> 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. In addition, provide information on the methods used by the State to document these items. A plan of correction is required from the case manager when the LOC re-determination is not completed within twelve months of the previous LOC. Future re-determinations completed by the specific case manager will be reviewed to identify if plan of correction has been implemented.

The Medicaid Agency, OMPP, exercises oversight over the performance of the waiver functions by the Division of Aging by on-going review and involvement in applications, implementation plans, policy and procedure development as well as participating on the DA's management committee, QA/QI Committee and other task forces reviewing procedural changes.

OMPP will also review data and reports developed by outside QA contractor to determine trends and areas for improvement and remediation in processes and operations.

- ii. **Remediation Data Aggregation**

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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 Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

DA is developing and expanding quality initiatives. Policies and procedures initially based upon previous aging and rehabilitative services shared systems are currently being reviewed and revised to enhance data collection, problem identification and appropriate resolution for the specific waiver population.

Development of prototype comprehensive survey tool (CST) to measure consumer satisfaction, POC development and providers' compliance to POC by first quarter of 2009.

LOC process review for AAA's and DA to be finalized by first quarter of 2009 by DA's QA contractor.

Finalization of Participant Experience Survey (PES) survey of all willing A&D participants by 2/09 by QA contractor.

Full implementation of tested and state approved CST by July 2009.

## Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input checked="" type="checkbox"/> <b>Aged or Disabled, or Both - General</b>					
	<input checked="" type="checkbox"/>	Aged	65		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Disabled (Physical)	0	64	
	<input checked="" type="checkbox"/>	Disabled (Other)	0	64	
<input type="checkbox"/> <b>Aged or Disabled, or Both - Specific Recognized Subgroups</b>					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input checked="" type="checkbox"/> <b>Mental Retardation or Developmental Disability, or Both</b>					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Mental Retardation			<input type="checkbox"/>
<input checked="" type="checkbox"/> <b>Mental Illness</b>					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	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	8708
Year 2	10409
Year 3	11802
Year 4 (renewal only)	12928
Year 5 (renewal only)	13838

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	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

## Appendix B: Participant Access and Eligibility

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

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

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

Purpose(s) the State reserves capacity for:

Purposes
Community transition of institutionalized person due to "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*):

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 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 1039 individuals over the course of the 5 years of this waiver renewal.

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

Waiver Year	Capacity Reserved
Year 1	54
Year 2	333
Year 3	315

Waiver Year	Capacity Reserved
Year 4 (renewal only)	287
Year 5 (renewal only)	50

## Appendix B: Participant Access and Eligibility

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

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

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

**e. Allocation of Waiver Capacity.**

*Select one:*

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

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

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

Applicants will enter the waiver on a first-come, first-serve basis by the date of application, with the exceptions of:

- Eligible individuals transitioning off 100% state funded budgets to the waiver in order to maximize the use of state dollars while assuring the health and welfare of the individual;
- Eligible individuals transitioning from nursing facilities to the waiver in order to provide the least restrictive environment possible in meeting the individual's health and welfare needs.
- Eligible individuals transitioning from the "Money Follows the Person" initiative (MFP). After being on MFP for 365 days, the individual will be transitioned to the A&D Waiver on the 366th day of services.

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

## Appendix B: Participant Access and Eligibility

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

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

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

**a.**

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

- 1634 State**

- SSI Criteria State
- 209(b) State

**2. Miller Trust State.**

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

- No
- Yes

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

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

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

*Select one:*

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

Specify percentage:

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

*Specify:*

---

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

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

*Select one and complete Appendix B-5.*

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

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

Check each that applies:

- A special income level equal to:

Select one:

- 300% of the SSI Federal Benefit Rate (FBR)
- A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage: \_\_\_\_\_

- A dollar amount which is lower than 300%.

Specify dollar amount: \_\_\_\_\_

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
- Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
- Medically needy without spend down in 209(b) States (42 CFR §435.330)
- Aged and disabled individuals who have income at:

Select one:

- 100% of FPL
- % of FPL, which is lower than 100%.

Specify percentage amount: \_\_\_\_\_

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

Specify: \_\_\_\_\_

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

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

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

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

- Use spousal post-eligibility rules under §1924 of the Act.

(Complete Item B-5-c (209b State) and Item B-5-d)

- Use regular post-eligibility rules under 42 CFR 435.726 (SSI State) or under 435.735 (209b State) (Complete Item B-5-c (209b State) . Do not complete Item B-5-d)
- Spousal impoverishment rules under 1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. (Complete Item B-5-c (209b State) . Do not complete Item B-5-d)

## Appendix B: Participant Access and Eligibility

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

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

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

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## Appendix B: Participant Access and Eligibility

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### B-5: Post-Eligibility Treatment of Income (3 of 4)

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

The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR 435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in 1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

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

---

- The following standard included under the State plan

(select one):

- The following standard under 42 CFR 435.121

Specify:

- Optional State supplement standard
- Medically needy income standard
- The special income level for institutionalized persons

(select one):

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

Specify percentage:

- A dollar amount which is less than 300%.

Specify dollar amount:

- A percentage of the Federal poverty level

Specify percentage: \_\_\_\_\_

**Other standard included under the State Plan**

*Specify:*

**The following dollar amount**

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

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

*Specify:*

**Other**

*Specify:*

---

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

---

**Not Applicable**

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

*Specify:*

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

**The following standard under 42 CFR § 435.121**

*Specify:*

**Optional State supplement standard**

**Medically needy income standard**

**The following dollar amount:**

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

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

*Specify:*

---

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

---

**Not Applicable (see instructions)**

**AFDC need standard**

**Medically needy income standard**

**The following dollar amount:**

Specify dollar amount:

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

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

Specify:

**Other**

Specify:

---

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

---

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

Select one:

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

Specify:

---

## Appendix B: Participant Access and Eligibility

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

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

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

##### i. Allowance for the personal needs of the waiver participant

(select one):

- SSI standard**
- Optional State supplement standard**
- Medically needy income standard**
- The special income level for institutionalized persons**

- A percentage of the Federal poverty level**

Specify percentage:

- The following dollar amount:**

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

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

Specify formula:

- Other**

Specify:

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

Select one:

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

Explanation of difference:

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

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

Select one:

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

## **Appendix B: Participant Access and Eligibility**

### **B-6: Evaluation/Reevaluation of Level of Care**

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

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

**i. Minimum number of services.**

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

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

Case managers performing level of care evaluations on persons meet all case management qualifications (a registered nurse with one year's experience in human services; or a Bachelor's degree in Social Work, Psychology, Sociology, Counseling, Gerontology, or Nursing; or a Bachelor's degree in any field with a minimum of two years full-time, direct service experience with the elderly or disabled (this experience includes assessment, care plan development, and monitoring); or a Master's degree in a related field may substitute for the required experience), as detailed in Appendix C and have received training in the nursing facility level of care process by the Division of Aging or designee. All case management supervisors also meet the above qualifications and training requirements.

**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 has established the Eligibility Screen (E-Screen), a tool that is used to determine basic level of care criteria that identifies nursing facility level of care (460 IAC 1-3-1). The Eligibility Screen is required to be completed by the case manager as part of the LOC packet. An E-screen will not be accepted by the computer system if all of the pages of the E-screen have not been addressed. Initially, the individual's physician must complete the Physician

Certification for Long Term Care (450B). The 450B includes the physician recommendation regarding the safety and feasibility of the individual to receive home and community-based services.

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

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

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

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

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

#### INITIAL EVALUATIONS

All applicants for the Waiver are evaluated to assure that level of care (LOC) is met prior to receiving services. Waiver participants must meet the minimal LOC requirements for that of a nursing facility. All initial evaluations are completed by the Area Agency on Aging (AAA) case manager and determinations are rendered by the case manager supervisor. Indiana has established the Eligibility Screen, a tool that is used to determine basic level of care criteria that identifies nursing facility level of care (460 IAC 1-3-1). Initially, the individual  physician must complete the Physician Certification for Long Term Care (450B). The 450B includes the physician recommendation regarding the safety and feasibility of the individual to receive home and community-based services.

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

#### RE-EVALUATIONS

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

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

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

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

- Every three months**
- Every six months**
- Every twelve months**
- Other schedule**

*Specify the other schedule:*

Every twelve months or more often as needed.

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

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

**The qualifications are different.**

*Specify the qualifications:*

Case managers performing level of care (LOC) re-evaluations on persons meet all case management qualifications as detailed in Appendix C and have received training in the nursing facility LOC process by the Division of Aging or designee. In addition, all LOC re-evaluations for clients managed by the Area Agency on Aging (AAA) are completed by the Area Agency on Aging (AAA) case manager and determinations are rendered by the case manager supervisor. All case management supervisors also meet the above qualifications and training requirements.

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

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

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

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

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

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

The evaluations and reevaluations are maintained for a minimum of three years within the electronic case management database within the Division of Aging.

## **Appendix B: Evaluation/Reevaluation of Level of Care**

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### **Quality Improvement: Level of Care**

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

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**  
**Monitor the number of applicants that are assessed for Level of Care (LOC) (numerator) by the number of total applicants targeted for waiver services (denominator).**

**Data Source (Select one):**

**Program logs**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95
<input checked="" type="checkbox"/> Other Specify: Area Agency on Aging (AAA)  QA Contractor	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Area Agency on Aging (AAA)  QA Contractor	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

**Performance Measure:**

**Monitor the number of annual reevaluations not completed within twelve months of previous LOC (numerator) by total number of reevaluations due within the previous twelve months (denominator).**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Electronic Case Management Database System**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	

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

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

**Performance Measures**

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

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

**Performance Measure:**

Indiana's electronic case management database system will not allow the issuance of an approved LOC evaluation unless all requirements are met. Monitor the number of initial LOC evaluations validated by DA Waiver Unit (numerator) by the total number of initial LOCs reviewed (denominator).

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Electronic case management database system**

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

**Performance Measure:**

Monitor the number of approved annual LOC reevaluation submitted by independent case managers and validated by DA Waiver Unit (numerator) by total number of reviewed annual LOC submitted by independent case managers (denominator).

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Electronic case management database system**

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

	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

Monitor the number of approved annual LOC reevaluation submitted by AAA case managers and validated by DA Waiver Unit (numerator) by total number of reviewed annual LOC submitted by AAA case managers (denominator).

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Electronic case management database system**

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

<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: Randomly selected by the electronic case management database system
	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

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

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

The state, through its external QA contractor, is currently developing a new tool to review processes used by the various AAA/ADRCs to identify and target potential waiver eligible participants to assure timely evaluation and development of the initial LOC.

All of the sixteen AAA/ADRCs information collected will be reviewed and analyzed to determine best

practices for developing further policies and procedures.

Division of Aging (DA) waiver unit reviews all initial LOC evaluations. All LOC issues must be resolved prior to issuing final approval of enrollment in the waiver.

**b. Methods for Remediation/Fixing Individual Problems**

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

The Division of Aging’s waiver unit staff identifies issues/concerns with LOC evaluations and reevaluation for both timeliness and accuracy and address them individually with the Case manager and/or supervisory staff.

Problems are documented in the electronic case management database system via comments sections on incomplete submissions.

Data is reviewed to determine any trends with specific case managers or to determine if additional training, policies, procedures need to be adopted.

**ii. Remediation Data Aggregation**

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

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

**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 Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

QA contractor will begin administrating LOC surveys at AAAs in the first quarter of 2009.

**Appendix B: Participant Access and Eligibility**

**B-7: Freedom of Choice**

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

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

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

The case manager is responsible for explaining the waiver services available to the individual requesting services. The case manager assesses the individual and completes a Plan of Care/Cost Comparison Budget (POC/CCB). On the POC/CCB there is a section regarding freedom of choice. The freedom of choice language is as follows and is required to be signed by the individual.

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

## Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Adult Day Service		
Statutory Service	Attendant Care		
Statutory Service	Case Management		
Statutory Service	Homemaker		
Statutory Service	Respite		
Other Service	Adult Foster Care		
Other Service	Assisted Living		
Other Service	Community Transition		
Other Service	Environmental Modifications		

Service Type	Service		
Other Service	Health Care Coordination		
Other Service	Home Delivered Meals		
Other Service	Nutritional Supplements		
Other Service	Personal Emergency Response System		
Other Service	Pest Control		
Other Service	Specialized Medical Equipment and Supplies		
Other Service	Transportation		
Other Service	Vehicle Modifications		

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

#### Service Type:

Statutory Service

#### Service:

Adult Day Health

#### Alternate Service Title (if any):

Adult Day Service

#### Service Definition (Scope):

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

This service is usually aimed at individuals 18 years old or older, who attend Adult Day Services on a planned basis. The three levels of Adult Day Services are Basic, Enhanced, and Intensive.

#### ALLOWABLE ACTIVITIES

##### BASIC ADULT DAY SERVICES (Level 1) includes:

- Monitor and/or supervise all activities of daily living (ADLs) defined as dressing, bathing, grooming, eating, walking, and toileting with hands-on assistance provided as needed
- Comprehensive, therapeutic activities
- Health assessment and intermittent monitoring of health status
- Monitor medication or medication administration
- Appropriate structure and supervision for those with mild cognitive impairment
- Minimum staff ratio: One staff for each eight individuals

##### ENHANCED ADULT DAY SERVICES (Level 2) includes:

Level 1 service requirements must be met. Additional services include:

- Hands-on assistance with two or more ADLs or hands-on assistance with bathing or other personal care
- Health assessment with regular monitoring or intervention with health status
- Dispense or supervise the dispensing of medication to individuals
- Psychosocial needs assessed and addressed, including counseling as needed for individuals and caregivers
- Therapeutic structure, supervision, and intervention for those with mild to moderate cognitive impairments
- Minimum staff ratio: One staff for each six individuals

##### INTENSIVE ADULT DAY SERVICES (Level 3) includes:

Level 1 and Level 2 service requirements must be met. Additional services include:

- Hands-on assistance or supervision with all ADLs and personal care
- One or more direct health intervention(s) required

- Rehabilitation and restorative services, including physical therapy, speech therapy, and occupational therapy coordinated or available
- Therapeutic intervention to address dynamic psychosocial needs such as depression or family issues affecting care
- Therapeutic interventions for those with moderate to severe cognitive impairments
- Minimum staff ratio: One staff for each four individuals

**SERVICE STANDARDS**

- Adult Day Services must follow a written Plan of Care addressing specific needs determined by the client's assessment

**DOCUMENTATION STANDARDS**

- Services outlined in the POC/CCB
- Evidence that level of service provided is required by the individual
- Attendance record documenting the date of service and the number of units of service delivered that day
- Completed Adult Day Service Level of Service Evaluation form

Case manager must give the completed Adult Day Service Level of Service Evaluation to the provider.

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

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

**ACTIVITIES NOT ALLOWED:**

- Any activity that is not described in allowable activities is not included in this service
- Services to participants receiving Assisted Living waiver service

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

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

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

**Appendix C: Participant Services**

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

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**Service Type: Statutory Service**  
**Service Name: Adult Day Service**

---

**Provider Category:**

Agency

**Provider Type:**

FSSA/ DA approved Adult Day Service Provider

**Provider Qualifications**

**License** *(specify):*

---

**Certificate** *(specify):*

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

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

DA approved

460 IAC 1.2-6-1 Provider Qualifications: Becoming an approved provider; maintaining approval

460 IAC 1.2-6-2 Provider Qualifications: General requirements

460 IAC 1.2-6-3 Provider Qualifications: General requirements for direct care staff

460 IAC 1.2-8-1(c)(d)(e)(f)(g) Procedures for Protecting Individuals

460 IAC 1.2-8-2 Unusual occurrence; reporting

460 IAC 1.2-8-3 Transfer of individual's record upon change of provider

460 IAC 1.2-8-4 Notice of termination of services

460 IAC 1.2-9-1 Provider organizational chart

460 IAC 1.2-9-2 Collaboration and quality control

460 IAC 1.2-9-4 Data collection and reporting standards

460 IAC 1.2-9-5 Quality assurance and quality improvement system

460 IAC 1.2-10-1 Financial information

460 IAC 1.2-11-1 Property and personal liability insurance

460 IAC 1.2-14-1 Maintenance of personnel records

460 IAC 1.2-15-2 Adoption of personnel policies

460 IAC 1.2-15-3 Operations manual

460 IAC 1.2-16-1 Maintenance of records of services provided

460 IAC 1.2-16-2 Individual's personal file; site of service delivery

460 IAC 1.2-16-1 Maintenance of records of services provided

460 IAC 1.2-16-2 Individual's personal file; site of service delivery

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

## Appendix C: Participant Services

---

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Personal Care

**Alternate Service Title (if any):**

Attendant Care

**Service Definition** (*Scope*):

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

**ALLOWABLE ACTIVITIES**

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

Provides assistance with personal care which includes:

- Bathing, partial bathing

- Oral hygiene
- Hair care including clipping of hair
- Shaving
- Hand and foot care
- Intact skin care
- Application of cosmetics

Provides assistance with mobility which includes:

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

Provides assistance with elimination which includes:

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

Provides assistance with nutrition which includes:

- Meal planning, preparation, clean-up

Provides assistance with safety which includes:

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

#### SERVICE STANDARDS

- Attendant Care services must follow a written Plan of Care addressing specific needs determined by the individual's assessment
- If direct care or supervision of care is not provided to the client and the documentation of services rendered for the units billed reflects homemaker duties, an entry must be made to indicate why the direct care was not provided for that day. If direct care or supervision of care is not provided for more than 30 days and the documentation of services rendered for the units billed reflects homemaker duties, the case manager must be contacted to amend the POC to a) add Homemaker Services and eliminate Attendant Care Services or b) reduce attendant care hours and replace with the appropriate number of hours of homemaker services

#### DOCUMENTATION STANDARDS

- Identified need in the POC/CCB
- Data record of services provided, including date of service and number of units delivered
- Each staff member providing direct care or supervision of care to the individual makes at least one entry on each day of service, describing an issue or circumstance concerning the individual
- Documentation should include the complete date and time (in and out), and at least the last name and first initial of the staff person making the entry. If the person providing the service is required to be a professional, the title of the individual must also be included

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

Attendant Care Service is not to exceed 40 hours per week.

#### ACTIVITIES NOT ALLOWED

- Attendant Care services will not be provided to medically unstable individuals as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician, or other health professional
- Attendant Care services will not be provided to household members other than to the participant
- Attendant Care services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, or the health care representative (HCR) of a participant

- Attendant Care services to participants receiving Adult Foster Care waiver service
- Attendant Care services to participants receiving Assisted Living waiver service

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

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

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

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

**Provider Specifications:**

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

## Appendix C: Participant Services

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

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**Service Type: Statutory Service**  
**Service Name: Attendant Care**

---

**Provider Category:**

Agency

**Provider Type:**

Licensed Home Health Agency

**Provider Qualifications**

**License** (*specify*):

IC 16-27-1

IC 16-27-4

**Certificate** (*specify*):

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

DA approved

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

## Appendix C: Participant Services

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

---

**Service Type: Statutory Service**  
**Service Name: Attendant Care**

---

**Provider Category:**

Agency

**Provider Type:**  
Licensed Personal Services Agency

**Provider Qualifications**

**License (specify):**

IC 16-27-4

**Certificate (specify):**

**Other Standard (specify):**

DA approved

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

---

## Appendix C: Participant Services

---

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

---

**Service Type: Statutory Service**

**Service Name: Attendant Care**

---

**Provider Category:**

Individual

**Provider Type:**

FSSA/DA approved Attendant Care Individual

**Provider Qualifications**

**License (specify):**

IC 16-27-4

**Certificate (specify):**

**Other Standard (specify):**

DA approved

460 IAC 1-8-3 Attendant care service provider registration requirement; preclusion

460 IAC 1-8-4 Requirements to become registered as attendant care service provider; certificate

460 IAC 1-8-6 Renewal of registration

460 IAC 1-8-8 Contract required

460 IAC 1.2-6-1 Provider qualifications: becoming an approved provider; maintaining approval

460 IAC 1.2-6-2 (a)(1)(B) Provider qualifications: general requirements

460 IAC 1.2-11-1 Property and personal liability insurance

IC 12-10-17.1-10 Registration; prohibition

IC 12-10-17.1-11 Registration requirement

IC 12-10-17.1-12 Registration by the division; duties of the division

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

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

## Appendix C: Participant Services

---

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

---

**Service Type: Statutory Service**

**Service Name: Attendant Care**

---

**Provider Category:**

Agency

**Provider Type:**

FSSA/DA approved Attendant Care Agency

**Provider Qualifications**

**License (specify):**

IC 16-27-4

**Certificate (specify):**

---

**Other Standard (specify):**

DA approved

460 IAC 1.2-6-2 Provider Qualifications; General requirements

460 IAC 1.2-6-3 General requirements for direct care staff

460 IAC 1.2-8-3 Transfer of individual's record upon change of provider

460 IAC 1.2-8-4 Notice of termination of services

460 IAC 1.2-9-1 Provider organizational chart

460 IAC 1.2-9-2 Collaboration and quality control

460 IAC 1.2-9-4 Data collection and reporting standards

460 IAC 1.2-9-5 Quality assurance and quality improvement system

460 IAC 1.2-10 Financial information

460 IAC 1.2-11-1 Property and personal liability insurance

460 IAC 1.2-13 Professional qualifications and requirements

460 IAC 1.2-14 Personnel Records

460 IAC 1.2-14-1 Maintenance of personnel records

460 IAC 1.2-15-2 Adoption of personnel policies

460 IAC 1.2-15-3 Operations manual

460 IAC 1.2-16-1 Maintenance of records of services provided

460 IAC 1.2-16-2 Individual's personal file; site of service delivery

460 IAC 1.2-16-1 Maintenance of records of services provided

460 IAC 1.2-16-2 Individual's personal file; site of service delivery

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

## Appendix C: Participant Services

---

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Case Management

**Alternate Service Title (if any):**



**Service Definition (Scope):**

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

**ALLOWABLE ACTIVITIES**

- Assessments of eligible individuals to determine eligibility for services, functional impairment level, and corresponding in-home and community services needed by the individual
- Development of care plans to meet the individual's needs
- Implementation of the care plans, linking individual with needed services, regardless of the funding source
- Assessment and care planning for discharge from institutionalization
- Annual reassessments of individual's needs
- Periodic updates of care plans
- Monitoring of the quality of home care community services provided to the individual
- Determination of and monitoring the cost effectiveness of the provisions of in-home and community services
- Information and assistance services
- Enhancement or termination of services based on need
- Administrative guidance as described in Appendix E-1-j for those participants who have selected self-directed attendant care

**SERVICE STANDARDS**

- Case Management Services must be reflected in the Cost Comparison Budget (CCB) of the individual
- Services must address needs identified in the CCB

**DOCUMENTATION STANDARDS**

**Documentation for Billing:**

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

**Clinical/Progress Documentation:**

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

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

**ACTIVITIES NOT ALLOWED**

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

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

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

Reimbursement of case management under Medicaid Waivers may not be made unless and until the

individual becomes eligible for Medicaid Waiver services. Case management provided to individuals who are not eligible for Medicaid Waiver services will not be reimbursed as a Medicaid Waiver service

Case management services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in fact (POA) of a participant, or the health care representative (HCR) of a participant

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

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

## Appendix C: Participant Services

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

---

**Service Type: Statutory Service**  
**Service Name: Case Management**

---

**Provider Category:**

Individual

**Provider Type:**

FSSA/ DA approved Case Management Individual

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

DA, or its designee, approved  
460 IAC 1.2-13-1 Documentation of qualifications  
460 IAC 1.2-17 Case Management

Education and work experience

- a registered nurse with one year's experience in human services; or
- a Bachelor's degree in Social Work, Psychology, Sociology, Counseling, Gerontology, or Nursing; or
- a Bachelor's degree in any field with a minimum of two years full-time, direct service experience with the elderly or disabled (this experience includes assessment, care plan development, and monitoring); or
- a Master's degree in a related field may substitute for the required experience

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

## Appendix C: Participant Services

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

---

**Service Type: Statutory Service**  
**Service Name: Case Management**

---

**Provider Category:**

Agency

**Provider Type:**

FSSA/DA approved Case Management Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

DA, or its designee, approved  
460 IAC 1.2-6-2 Provider Qualifications; General requirements  
460 IAC 1.2-6-3 General requirements for direct care staff  
460 IAC 1.2-8-1 Procedures for protecting individuals  
460 IAC 1.2-8-2 Unusual occurrence; reporting  
460 IAC 1.2-8-3 Transfer of individual's record upon change of provider  
460 IAC 1.2-8-4 Notice of termination of services  
460 IAC 1.2-9-1 Provider organizational chart  
460 IAC 1.2-9-2 Collaboration and quality control  
460 IAC 1.2-9-4 Data collection and reporting standards  
460 IAC 1.2-9-5 Quality assurance and quality improvement system  
460 IAC 1.2-10 Financial information  
460 IAC 1.2-11 Property and personal liability insurance  
460 IAC 1.2-13 Documentation of qualifications  
460 IAC 1.2-14-1 Maintenance of personnel records  
460 IAC 1.2-15-2 Adoption of personnel policies  
460 IAC 1.2-15-3 Operations manual  
460 IAC 1.2-16-1 Maintenance of records of services provided  
460 IAC 1.2-16-2 Individual's personal file; site of service delivery  
460 IAC 1.2-16-1 Maintenance of records of services provided  
460 IAC 1.2-16-2 Individual's personal file; site of service delivery  
460 IAC 1.2-17 Case Management

Education and work experience

- a registered nurse with one year's experience in human services; or
- a Bachelor's degree in Social Work, Psychology, Sociology, Counseling, Gerontology, or Nursing; or
- a Bachelor's degree in any field with a minimum of two years full-time, direct service experience with the elderly or disabled (this experience includes assessment, care plan development, and monitoring); or
- a Master's degree in a related field may substitute for the required experience

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Homemaker

**Alternate Service Title (if any):**

**Service Definition (Scope):**

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

**ALLOWABLE ACTIVITIES**

1. Provides housekeeping tasks which include:

- dusting and straightening furniture
- cleaning floors and rugs by wet or dry mop and vacuum sweeping
- cleaning the kitchen, including washing dishes, pots, and pans; cleaning the outside of appliances and counters and cupboards; cleaning ovens and defrosting and cleaning refrigerators
- maintaining a clean bathroom, including cleaning the tub, shower, sink, toilet bowl, and medicine cabinet; emptying and cleaning commode chair or urinal
- laundering clothes in the home or laundromat, including washing, drying, folding, putting away, ironing, and basic mending and repair
- changing linen and making beds
- washing insides of windows
- removing trash from the home
- choosing appropriate procedures, equipment, and supplies; improvising when there are limited supplies, keeping equipment clean and in its proper place
- cleaning up of the yard which is defined as: lawn mowing, raking, and snow removal

2. Provides assistance with meals or nutrition which includes:

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

3. Runs the following essential errands:

- grocery shopping
- household supply shopping
- prescription pick up

4. Provides assistance with correspondence and bill paying

**SERVICE STANDARDS**

- Homemaker services must follow a written Plan of Care addressing specific needs determined by the client's assessment

**DOCUMENTATION STANDARDS**

- Identified need in the POC/CCB
- Date of service and unit(s) of service
- Documentation of services delivered

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

Homemaker service is not to exceed 10 hours per week.

**ACTIVITIES NOT ALLOWED**

- Assistance with hands on services such as eating, bathing, dressing, personal hygiene, and activities of daily living
- Escort or transport individuals to community activities or errands
- Homemaker services provided to household members other than to the participant
- Homemaker services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, or the health care representative (HCR) of a participant
- Services to participants receiving Adult Foster Care waiver service
- Services to participants receiving Assisted Living waiver service

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

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

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Homemaker**

**Provider Category:**

Agency

**Provider Type:**

Licensed Personal Services Agency

**Provider Qualifications**

**License** (specify):

IC 16-27-4

**Certificate** (specify):

**Other Standard** (specify):

DA approved

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

## Appendix C: Participant Services

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

---

**Service Type: Statutory Service**  
**Service Name: Homemaker**

---

**Provider Category:**

Individual

**Provider Type:**

FSSA/DA approved Homemaker Individual

**Provider Qualifications**

**License (specify):**

IC 16-27-4

**Certificate (specify):**

**Other Standard (specify):**

DA approved

460 IAC 1.2-6-1 Provider qualifications: becoming an approved provider; maintaining approval

460 IAC 1.2-6-2 (a)(1)(B) Provider qualifications: general requirements

460 IAC 1.2-11-1 Property and personal liability insurance

460 IAC 1.2-13 Professional qualifications and requirements

460 IAC 1.2-14 Personnel Records

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

## Appendix C: Participant Services

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

---

**Service Type: Statutory Service**  
**Service Name: Homemaker**

---

**Provider Category:**

Agency

**Provider Type:**

Licensed Home Health Agency

**Provider Qualifications**

**License (specify):**

IC 16-27-1

IC 16-27-4

**Certificate (specify):**

**Other Standard (specify):**

DA approved

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Homemaker**

**Provider Category:**

Agency

**Provider Type:**

FSSA/DA approved Homemaker Agency

**Provider Qualifications**

**License (specify):**

IC 16-27-4

**Certificate (specify):**

**Other Standard (specify):**

DA approved

460 IAC 1.2-6-2 Provider Qualifications; General requirements

460 IAC 1.2-6-3 General requirements for direct care staff

460 IAC 1.2-11-1 Property and personal liability insurance

460 IAC 1.2-13 Professional qualifications and requirements

460 IAC 1.2-14 Personnel Records

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Respite

**Alternate Service Title (if any):**

**Service Definition (Scope):**

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

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

- An individual requiring assistance with bathing, meal preparation and planning, specialized feeding, such as

an individual who has difficulty swallowing, refuses to eat, or does not eat enough; dressing or undressing; hair and oral care; and weight bearing transfer assistance should be considered for respite home health aide under the supervision of a registered nurse

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

#### ALLOWABLE ACTIVITIES

Home health aide services

Skilled nursing services

Nursing facility services  The care manager is required to receive prior authorization from the Indiana Family and Social Services Administration (IFSSA) with a completed Request for Approval to Authorize Services Form before Respite Care may be provided in a nursing facility

#### SERVICE STANDARDS

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

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

Respite must be reflected in the Plan of Care

#### DOCUMENTATION STANDARDS

Documentation must include the following elements: the reason for the respite, the location where the service was rendered and the type of respite rendered. For example, respite Home Health Agency (HHA)

Data Record of staff to individual service documenting the complete date and time in and time out, and the number of units of service delivered that day

Each staff member providing direct care or supervision of care to the individual makes at least one entry on each day of service describing an issue or circumstance concerning the individual

Documentation should include date and time, and at least the last name and first initial of the staff person making the entry. If the person providing the service is required to be a professional, the title of the individual must also be included (example: if a nurse is required to perform the service then the RN title would be included with the name)

Any significant issues involving the individual requiring intervention by a health care professional, or case manager that involved the individual also needs to be documented

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

Respite service is not to exceed 720 hours per 12 month period.

#### ACTIVITIES NOT ALLOWED

Respite shall not be used as day/child care to allow the persons normally providing care to go to work

Respite shall not be used as day/child care to allow the persons normally providing care to attend school

Respite shall not be used to provide service to a participant while participant is attending school

Respite may not be used to replace services that should be provided under the Medicaid State Plan

Respite will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, or the health care representative (HCR) of a participant

Respite must not duplicate any other service being provided under the participant's POC

Services to participants receiving Adult Foster Care waiver service

Services to participants receiving Assisted Living waiver service

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

#### **Provider Specifications:**

Provider Category	Provider Type Title
Agency	Licensed Home Health Agency
Agency	Medicaid Certified Nursing Facility

## Appendix C: Participant Services

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

**Service Type: Statutory Service**  
**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Licensed Home Health Agency

**Provider Qualifications**

**License (specify):**

IC 16-27-1

**Certificate (specify):**

**Other Standard (specify):**

DA approved

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

## Appendix C: Participant Services

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

**Service Type: Statutory Service**  
**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Medicaid Certified Nursing Facility

**Provider Qualifications**

**License (specify):**

IC 16-28-2

**Certificate (specify):**

**Other Standard (specify):**

DA approved

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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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 Foster Care

#### Service Definition (Scope):

Adult Foster Care (AFC) is a comprehensive service usually aimed at a participant 18 years old or older who resides with an unrelated caregiver in order for the participant to receive personal assistance designed to provide options for alternative long term care to individuals who meet nursing facility level of care and whose needs can be met in a home-like environment. The participant and up to three (3) other participants who are elderly or have physical and/or cognitive disabilities who are not members of the provider's or primary caregiver's family, reside in a home that is owned, rented, or managed by the AFC provider.

The goal of the service is to provide necessary care while emphasizing the participant's independence. This goal is reached through a cooperative relationship between the participant (or the participant's legal guardian), the participant's HCBS Medicaid Waiver case manager, and the AFC provider. Participant needs shall be addressed in a manner that support and enable the individual to maximize abilities to function at the highest level of independence possible. The service is designed to provide options for alternative long-term care to persons who meet Nursing Facility level of care, and whose needs can be met in an AFC setting.

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

Participants selecting Adult Foster Care service may also receive Case Management service, Adult Day Service, Specialized Medical Equipment and Supplies, and Health Care Coordination through the waiver.

#### ALLOWABLE ACTIVITIES:

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

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

#### SERVICE STANDARDS

- Adult Foster Care Services must be reflected in the participant's plan of care
- Services must address the participant's level of service needs
- Provider must live in the AFC home, unless another provider-contracted primary caregiver, who meets all provider qualifications, lives in the provider's home
- Backup services must be provided by a qualified individual familiar with the individual's needs for those times when the primary caregiver is absent from the home or otherwise cannot provide the necessary level of care
- AFC provides an environment that has the qualities of a home, including privacy, comfortable surroundings,

and the opportunity to modify one's living area to suit one's individual preferences

Rules managing or organizing the home activities in the AFC home that are developed by the provider or provider-contracted primary caregiver, or both and approved by the Medicaid waiver program must be provided to the individual prior to the start of AFC services and may not be so restrictive as to interfere with a participant's rights under state and federal law

Consumer-focused activity plans are developed by the provider with the participant or their representative

AFC emphasizes the participant's independence in a setting that protects and encourages participant dignity, choice and decision-making while preserving self-respect

Providers or provider's employees who provide medication oversight as addressed under allowed activities must receive necessary instruction from a doctor, nurse, or pharmacist on the administration of controlled substances prescribed to the participant

#### DOCUMENTATION STANDARDS:

Services outlined in the POC/CCB

Requires completed Adult Foster Care Level of Service Evaluation form

Case manager must give the completed Adult Foster Care Level of Service Evaluation form to the provider.

Documentation to support services rendered by the AFC to address needs identified in the Level of Service Evaluation form

Documentation of the consumer-focused activities participation is maintained in the personal file

Maintenance of participant's personal records to include:

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

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

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

NOTE: if applicable, copies must be:

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

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

#### ACTIVITIES NOT ALLOWED:

Services provided in the home of a caregiver who is related by blood or related legally to the participant

Adult foster care services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, or the health care representative (HCR) of a participant

Payments for room and board or the costs of facility maintenance, upkeep or improvement

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

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

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

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

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

## Appendix C: Participant Services

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

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**Service Type: Other Service**  
**Service Name: Adult Foster Care**

---

**Provider Category:**

Individual

**Provider Type:**

FSSA/DA approved Adult Foster Care Individual

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Provider and home must meet the requirements of the Indiana Adult Foster Care Service Provision and Certification Standards. Adult Foster Care service providers are required to be bonded.

DA approved

- 460 IAC 1.2-6-1 Becoming an approved provider; maintaining approval
- 460 IAC 1.2-6-2 Provider Qualifications; General requirements
- 460 IAC 1.2-6-3 General requirements for direct care staff
- 460 IAC 1.2-8-1 Procedures for protecting individuals
- 460 IAC 1.2-8-2 Unusual occurrence; reporting
- 460 IAC 1.2-8-3 Transfer of individual's record upon change of provider
- 460 IAC 1.2-8-4 Notice of termination of services
- 460 IAC 1.2-9-1 Provider organizational chart
- 460 IAC 1.2-9-2 Collaboration and quality control
- 460 IAC 1.2-9-4 Data collection and reporting standards
- 460 IAC 1.2-9-5 Quality assurance and quality improvement system
- 460 IAC 1.2-10 Financial information
- 460 IAC 1.2-11 Property and personal liability insurance
- 460 IAC 1.2-12 Transportation of an individual
- 460 IAC 1.2-13 Documentation of qualifications
- 460 IAC 1.2-14-1 Maintenance of personnel records
- 460 IAC 1.2-15-2 Adoption of personnel policies
- 460 IAC 1.2-15-3 Operations manual
- 460 IAC 1.2-16-1 Maintenance of records of services provided
- 460 IAC 1.2-16-2 Individual's personal file; site of service delivery

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

## Appendix C: Participant Services

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

---

**Service Type: Other Service**

**Service Name: Adult Foster Care**

---

**Provider Category:**

Agency

**Provider Type:**

FSSA/DA approved Adult Foster Care Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Provider and home must meet the requirements of the Indiana Adult Foster Care Service Provision and Certification Standards. Adult Foster Care service providers are required to be bonded.

DA approved

460 IAC 1.2-6-1 Becoming an approved provider; maintaining approval

460 IAC 1.2-6-2 Provider Qualifications: General Requirements

460 IAC 1.2-6-3 General requirements for direct care staff

460 IAC 1.2-8-1 Procedures for protecting individuals

460 IAC 1.2-8-2 Unusual occurrence; reporting

460 IAC 1.2-8-3 Transfer of individual's record upon change of provider

460 IAC 1.2-8-4 Notice of termination of services

460 IAC 1.2-9-1 Provider organizational chart

460 IAC 1.2-9-2 Collaboration and quality control

460 IAC 1.2-9-4 Data collection and reporting standards

460 IAC 1.2-9-5 Quality assurance and quality improvement system

460 IAC 1.2-10 Financial information

460 IAC 1.2-11 Property and personal liability insurance

460 IAC 1.2-12 Transportation of an individual

460 IAC 1.2-13 Documentation of qualifications

460 IAC 1.2-14-1 Maintenance of personnel records

460 IAC 1.2-15-2 Adoption of personnel policies

460 IAC 1.2-15-3 Operations manual

460 IAC 1.2-16-1 Maintenance of records of services provided

460 IAC 1.2-16-2 Individual's personal file; site of service delivery

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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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

#### Service Definition (Scope):

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

This service is usually aimed at individuals 18 years old or older who reside in their own living units (which may include dually occupied units when both occupants request the arrangement) which include kitchenette, toilet facilities, and a sleeping area, not necessarily designated as a separate bedroom from the living area. The individual has a right to privacy. Living units may be locked at the discretion of the individual, except when a physician or mental health professional has certified in writing that the individual is sufficiently impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The individual retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each individual to facilitate aging in place. Routines of care provision and service delivery must be individual-driven to the maximum extent possible, and treat each person with dignity and respect.

Participants selecting Assisted Living service may also receive Case Management service and Specialized Medical Equipment and Supplies through the waiver.

#### ALLOWABLE ACTIVITIES

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

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

#### SERVICE STANDARDS

Assisted Living services must follow a written Plan of Care (POC) addressing specific needs determined by the client's assessment.

#### DOCUMENTATION STANDARDS

- Services outlined in the POC/CCB
- Evidence that individual requires the level of service provided
- Documentation to support service rendered
- Negotiated risk agreement, if applicable

- Requires completed Assisted Living Level of Service Evaluation form
- Case manager must give the completed Assisted Living Level of Service Evaluation form to the provider.

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

**ACTIVITIES NOT ALLOWED**

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

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

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Licensed Assisted Living Agencies

## Appendix C: Participant Services

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

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**Service Type:** Other Service  
**Service Name:** Assisted Living

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**Provider Category:**

Agency

**Provider Type:**

Licensed Assisted Living Agencies

**Provider Qualifications**

**License** (*specify*):

IC 16-28-2

**Certificate** (*specify*):

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

DA approved

410 IAC 16.2-5

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

#### Service Type:

Other Service

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

#### Service Title:

Community Transition

#### Service Definition (Scope):

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

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

Items purchased through Community Transition are the property of the individual receiving the service, and the individual takes the property with him or her in the event of a move to another residence, even if the residence from which he or she is moving is owned by a provider agency. Nursing Facilities are not reimbursed for Community Transition because those services are part of the per diem. For those receiving this service under the A&D waiver, reimbursement for approved Community Transition expenditures are reimbursed through the local Area Agency on Aging (AAA).

#### ALLOWABLE ACTIVITIES

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

#### SERVICE STANDARDS

- Community Transition must be reflected in the Cost Comparison Budget (CCB) of the individual
- Services must address needs identified in the CCB

#### DOCUMENTATION STANDARDS

- Documentation requirements include maintaining receipts for all expenditures, showing the amount and what item or deposit was covered

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

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

#### ACTIVITIES NOT ALLOWED

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

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

## Appendix C: Participant Services

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

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**Service Type: Other Service**  
**Service Name: Community Transition**

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**Provider Category:**

Agency

**Provider Type:**

FSSA/DA approved Community Transition Service Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

DA approved

460 IAC 1.2-6-1 Becoming an approved provider; maintaining approval

460 IAC 1.2-6-2 Provider qualifications: General requirements

460 IAC 1.2-8-3 Transfer of individual's record upon change of provider

460 IAC 1.2-10 Financial information

460 IAC 1.2-11 Property and personal liability insurance

460 IAC 1.2-12 Transportation of an individual

460 IAC 1.2-13 Professional qualifications and requirements; documentation of qualifications

460 IAC 1.2-14-1 Maintenance of personnel records

460 IAC 1.2-15-2 Adoption of personnel policies

460 IAC 1.2-15-3 Operations manual

460 IAC 1.2-16-1 Maintenance of records of services provided

460 IAC 1.2-16-2 Individual's personal file; site of service delivery

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

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

#### Service Type:

Other Service

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

#### Service Title:

Environmental Modifications

#### Service Definition (Scope):

Environmental modifications are minor physical adaptations to the home, as required by the individual's Plan of Care/Cost Comparison Budget (POC/CCB), which are necessary to ensure the health, welfare and safety of the individual, which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

#### Home Ownership

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

#### Choice of Provider

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

#### Requirements

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

A. Environmental modification requests must be provided in accordance with applicable State and/or local building codes and should be guided by Americans with Disability Act (ADA) or ADA Accessibility Guidelines (ADAAG) requirements when in the best interest of the individual and his/her specific situation.

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

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

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

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

#### ALLOWABLE ACTIVITIES

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

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

B. Bathroom Modification - limited to one (1) existing bathroom per individual primary residence when no

other accessible bathroom is available. The bathroom modification may include:

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

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

D. Environmental safety devices limited to:

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

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

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

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

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

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

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

I. Widen doorway - to allow safe egress:

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

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

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

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

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

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

#### SERVICE STANDARDS

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

B. To ensure that environmental modifications meet the needs of the individual and abide by established

federal, state, local and FSSA standards, as well as ADA requirements, when applicable, approved environmental modifications will include:

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

#### DOCUMENTATION STANDARDS

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

1. POC/CCB; and
2. Physician prescription and/or clinical evaluation as deemed appropriate; and

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

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

C. Signed and approved RFA;

D. Signed and approved POC/CCB;

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

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

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

A lifetime cap of \$15,000 is available for environmental modifications. The cap represents a cost for basic modification of an individual's home for accessibility and safety and accommodates the individual's needs for housing modifications. The cost of an environmental modification includes all materials, equipment, labor, and permits to complete the project. No parts of an environmental modification may be billed separately as part of any other service category (e.g. Specialized Medical Equipment). In addition to the \$15,000 lifetime cap, \$500 is allowable annually for the repair, replacement, or an adjustment to an existing environmental modification that was funded by a Home and Community Based Services (HCBS) waiver.

#### ACTIVITIES NOT ALLOWED

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

A. Adaptations or improvements which are not of direct medical or remedial benefit to the individual:

1. central heating and air conditioning;
2. routine home maintenance;
3. installation of standard (non-ADA or ADAAG) home fixtures (e.g., sinks, commodes, tub, wall, window and door coverings, etc.) which replace existing standard (non-ADA or ADAAG) home fixtures;
4. roof repair;
5. structural repair;
6. garage doors;
7. elevators;
8. ceiling track lift systems;
9. driveways, decks, patios, sidewalks, household furnishings;
10. replacement of carpeting and other floor coverings;
11. storage (e.g., cabinets, shelving, closets), sheds;
12. swimming pools, spas or hot tubs;
13. video monitoring system;
14. adaptive switches or buttons to control devices intended for entertainment, employment, or education;
15. home security systems.

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

C. Modifications that duplicate existing accessibility (e.g., second accessible bathroom, a second means of egress from home, etc.);

D. Modifications that will add square footage to the home;

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

G. Individuals living in a provider owned residence are not eligible to receive this service. (Note: The responsibility for environmental modifications rests with the facility owner or operator);

H. Completion of, or modifications to, new construction or significant remodeling/reconstruction are excluded unless there is documented evidence of a significant change in the individual's medical or remedial needs that now require the requested modification.

I. Services to participants receiving Adult Foster Care.

J. Services to participants receiving Assisted Living.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	FSSA/ DA approved Environmental Modification Individual
Agency	FSSA/ DA approved Environmental Modification Agency/ Contractor
Individual	Plumber
Individual	Evaluator
Individual	Architect

## Appendix C: Participant Services

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

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**Service Type: Other Service**

**Service Name: Environmental Modifications**

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**Provider Category:**

Individual

**Provider Type:**

FSSA/ DA approved Environmental Modification Individual

**Provider Qualifications**

**License** (*specify*):

Any applicable licensure must be in place

**Certificate** (*specify*):

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

DA approved

460 IAC 1.2-6-1 Becoming an approved provider; maintaining approval

460 IAC 1.2-6-2 Provider qualifications: General requirements

460 IAC 1.2-10 Financial information

460 IAC 1.2-11 Property and personal liability insurance

460 IAC 1.2-13 Professional qualifications and requirements; documentation of qualifications

460 IAC 1.2-18 Warranty required

Compliance with applicable building codes/ permits.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

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## Appendix C: Participant Services

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

---

**Service Type: Other Service**

**Service Name: Environmental Modifications**

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**Provider Category:**

Agency

**Provider Type:**

FSSA/ DA approved Environmental Modification Agency/ Contractor

**Provider Qualifications**

**License** (*specify*):

Any applicable licensure

IC 25-20.2 Home inspector

IC 25-28.5 Plumber

Evaluator

IC 25-23.5 Occupational Therapy

IC 25-27 Physical Therapy

**Certificate** (*specify*):

IC 25-4 Architect

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

DA approved

460 IAC 1.2-6-1 Becoming an approved provider; maintaining approval

460 IAC 1.2-6-2 Provider qualifications: General requirements

460 IAC 1.2-10 Financial information

460 IAC 1.2-11 Property and personal liability insurance

460 IAC 1.2-13 Professional qualifications and requirements; documentation of qualifications

460 IAC 1.2-18 Warranty required

Compliance with applicable building codes and permits

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

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## Appendix C: Participant Services

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

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**Service Type: Other Service**  
**Service Name: Environmental Modifications**

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**Provider Category:**

Individual

**Provider Type:**

Plumber

**Provider Qualifications**

**License (specify):**

IC 25-28.5

**Certificate (specify):**

**Other Standard (specify):**

DA approved

460 IAC 1.2-6-1 Becoming an approved provider; maintaining approval

460 IAC 1.2-6-2 Provider qualifications: General requirements

460 IAC 1.2-10 Financial information

460 IAC 1.2-11 Property and personal liability insurance

460 IAC 1.2-13 Professional qualifications and requirements; documentation of qualifications

460 IAC 1.2-18 Warranty required

Compliance with applicable building codes and permits

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

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## Appendix C: Participant Services

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

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**Service Type: Other Service**  
**Service Name: Environmental Modifications**

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**Provider Category:**

Individual

**Provider Type:**

Evaluator

**Provider Qualifications**

**License (specify):**

IC 25-20.2 Home Inspector

IC 25-27-1 Physical Therapist

IC 25-23.5 Occupational Therapist

**Certificate (specify):**

**Other Standard (specify):**

DA approved

460 IAC 1.2-6-1 Becoming an approved provider; maintaining approval

460 IAC 1.2-6-2 Provider qualifications: General requirements

460 IAC 1.2-10 Financial information

460 IAC 1.2-11 Property and personal liability insurance

460 IAC 1.2-13 Professional qualifications and requirements; documentation of qualifications

460 IAC 1.2-18 Warranty required

Compliance with applicable building codes and permits

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging  
**Frequency of Verification:**  
up to 3 years

## Appendix C: Participant Services

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

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**Service Type: Other Service**  
**Service Name: Environmental Modifications**

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**Provider Category:**

Individual

**Provider Type:**

Architect

**Provider Qualifications**

**License (specify):**

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**Certificate (specify):**

IC 25-4

**Other Standard (specify):**

DA approved

460 IAC 1.2-6-1 Becoming an approved provider; maintaining approval

460 IAC 1.2-6-2 Provider qualifications: General requirements

460 IAC 1.2-10 Financial information

460 IAC 1.2-11 Property and personal liability insurance

460 IAC 1.2-13 Professional qualifications and requirements; documentation of qualifications

460 IAC 1.2-18 Warranty required

Compliance with applicable building codes and permits

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Health Care Coordination

**Service Definition (Scope):**

Health Care Coordination includes medical coordination provided by a Registered Nurse (RN) to manage the health care of the individual including physician consults, medication ordering, and development and nursing oversight of a healthcare support plan. Skilled nursing services are provided within the scope of the Indiana State Nurse Practice Act. The purpose of Health Care Coordination is stabilization; delay/prevent deterioration of health status; management of chronic conditions; and/or improved health status. Health care coordination is

open to any waiver participant whose needs demonstrate the need for such level of service without duplicating other formal and informal supports.

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

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

**ALLOWABLE ACTIVITIES**

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

**SERVICE STANDARDS**

- Weekly consultations or reviews
- Face to face visits with the individual
- Other activities, as appropriate
- Services must address needs identified in the plan of care/CCB
- The provider of home health care coordination will provide a written report to pertinent parties at least quarterly. Pertinent parties includes the individual, guardian, waiver case manager, all service providers, and other entities.

**DOCUMENTATION STANDARDS**

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

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

Health care coordination services will not duplicate services provided under the Medicaid State Plan or any other waiver service.

Health care coordination services are:

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

**ACTIVITIES NOT ALLOWED**

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

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Licensed Home Health Agency

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Health Care Coordination

**Provider Category:**

Agency

**Provider Type:**

Licensed Home Health Agency

**Provider Qualifications**

**License (specify):**

IC 16-27-1 Home Health Agency

IC 25-23-1 RN

**Certificate (specify):**

**Other Standard (specify):**

DA approved

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Home Delivered Meals

**Service Definition (Scope):**

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

**ALLOWABLE ACTIVITIES**

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

**SERVICE STANDARDS**

- Home Delivered Meals 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.

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 meals must also meet the Dietary Reference Intake Standards adopted by the State of Indiana Division of Aging in compliance with the current Dietary Guidelines for Americans produced by the US Department of Health and Human Services and the US Department of Agriculture. Each meal must meet 1/3 of the required Dietary Reference Intakes.

All meals and menus must be approved by a licensed dietician for nutritional soundness and compliance with the Indiana Division of Aging Senior Meal Program Nutrition Standards.

**DOCUMENTATION STANDARDS**

- Identified need in the POC/CCB
- Date of service and units of service documented

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

**ACTIVITIES NOT ALLOWED**

- No more than two meals per day will be reimbursed under the waiver
- Services to participants receiving Adult Foster Care waiver service
- Services to participants receiving Assisted Living waiver service

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

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

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Home Delivered Meals**

**Provider Category:**

Agency

**Provider Type:**

FSSA/DA approved Home Delivered Meals Agency

**Provider Qualifications**

**License** (specify):

**Certificate** (specify):

**Other Standard** (specify):

DA approved  
460 IAC 1.2-6-1 Becoming an approved provider; maintaining approval

- 460 IAC 1.2-6-2 Provider qualifications: General requirements
- 460 IAC 1.2-10 Financial information
- 460 IAC 1.2-11 Property and personal liability insurance
- 460 IAC 1.2-14-1 Maintenance of personnel records
- 460 IAC 1.2-15-2 Adoption of personnel policies
- 460 IAC 1.2-15-3 Operations manual
- 460 IAC 1.2-16-1 Maintenance of records of services provided

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

## Appendix C: Participant Services

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### 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

**Service Definition (Scope):**

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

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

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

**ALLOWABLE ACTIVITIES**

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

**SERVICE STANDARDS**

- Nutritional Supplement services must be reflected in the Cost Comparison Budget (CCB) of the individual
- Services must address needs identified in the CCB

**DOCUMENTATION STANDARDS**

- Identified need in the POC/CCB
- Documentation to support services rendered

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

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

**ACTIVITIES NOT ALLOWED**

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

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DA approved Nutritional Supplements Agency

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Nutritional Supplements**

**Provider Category:**

Agency

**Provider Type:**

FSSA/DA approved Nutritional Supplements Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

DA approved

460 IAC 1.2-6-1 Becoming an approved provider; maintaining approval

460 IAC 1.2-6-2 Provider qualifications: General requirements

460 IAC 1.2-8-3 Transfer of individual's record upon change of provider

460 IAC 1.2-10 Financial information

460 IAC 1.2-11 Property and personal liability insurance

460 IAC 1.2-13 Professional qualifications and requirements; documentation of qualifications

460 IAC 1.2-16-1 Maintenance of records of services provided

460 IAC 1.2-16-2 Individual's personal file; site of service delivery

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Personal Emergency Response System

**Service Definition (Scope):**

Personal Emergency Response System(PERS) is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable help button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a help button is activated. The response center is staffed 24 hours daily/ 7 days per week by trained professionals.

**ALLOWABLE ACTIVITIES**

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

**SERVICE STANDARDS**

- Must be included in the individual's plan of care

**DOCUMENTATION STANDARDS**

- Identified need in the POC/CCB
- Documentation of expense for installation
- Documentation of monthly rental fee

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

**ACTIVITIES NOT ALLOWED**

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

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

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

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

DA approved

460 IAC 1.2-6-1 Becoming an approved provider; maintaining approval

460 IAC 1.2-6-2 Provider qualifications: General requirements

460 IAC 1.2-10 Financial information

460 IAC 1.2-11 Property and personal liability insurance

460 IAC 1.2-13 Professional qualifications and requirements; documentation of qualifications

460 IAC 1.2-18 Warranty required

Compliance with applicable building codes and permits

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

Pest Control

**Service Definition** (*Scope*):

Pest Control services are designed to prevent, suppress, or eradicate anything that competes with humans for food and water, injures humans, spreads disease to humans and/ or annoys humans and is causing or is expected to cause more harm than is reasonable to accept. Pests include insects such as roaches, mosquitoes, and fleas; insect-like organisms, such as mites and ticks; and vertebrates, such as rats and mice.

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

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

**ALLOWABLE ACTIVITIES**

Pest Control services are added to the Plan of Care when the Case Manager determines-either through direct observation or client report- that a pest is present that is causing or is expected to cause more harm than is reasonable to accept

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

**SERVICE STANDARDS**

Pest control service must be reflected in the individual plan of care

**DOCUMENTATION STANDARDS**

- Identified need in the POC/CCB
- Receipts of specific service, date of service, and cost of service completed

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

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

**ACTIVITIES NOT ALLOWED**

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

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	FSSA/DA approved Pest Control Agency

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Pest Control**

**Provider Category:**

Agency

**Provider Type:**

FSSA/DA approved Pest Control Agency

**Provider Qualifications**

**License** (*specify*):

IC 15-3-3.6

**Certificate** (*specify*):

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

DA approved

460 IAC 1.2-6-1 Becoming an approved provider; maintaining approval

460 IAC 1.2-6-2 Provider qualifications: General requirements

460 IAC 1.2-10 Financial information

460 IAC 1.2-11 Property and personal liability insurance

460 IAC 1.2-13 Professional qualifications and requirements; documentation of qualifications

460 IAC 1.2-18 Warranty required

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

## Appendix C: Participant Services

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### 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

**Service Definition (Scope):**

Specialized Medical Equipment and Supplies are medically prescribed items required by the individual's Plan of Care/Cost Comparison Budget (POC/CCB) which are necessary to assure the health, welfare and safety of the individual, which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

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

A. Individuals requesting authorization for this service through utilization of Home and Community Based Services (HCBS) waivers must first exhaust eligibility of the desired equipment or supplies through Indiana Medicaid State Plan, which may require Prior Authorization (PA).

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

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

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

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

#### ALLOWABLE ACTIVITIES

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

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

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

and is limited to one (1) generator per individual per ten (10) year period;

C. Interpreter service - provided in circumstances where the interpreter assists the individual in communication during specified scheduled meetings for service planning (e.g. waiver case conferences, team meetings) and is not available to facilitate communication for other service provision;

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

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

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

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

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

H. Posture chairs and feeding chairs - as prescribed by physician, occupational therapist, or physical therapist. RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan;

#### SERVICE STANDARDS

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

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

#### DOCUMENTATION STANDARDS

Documentation standards include the following:

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

1. POC/CCB; and
2. Physician prescription and/or clinical evaluation as deemed appropriate.

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

C. Signed and approved Request for Approval to Authorize Services (RFA);

D. Signed and approved POC/CCB;

E. Provider of services must maintain receipts for all incurred expenses related to this service;

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

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

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

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

**ACTIVITIES NOT ALLOWED**

A. The following items and equipment:

1. hospital beds, air fluidized suspension mattresses/beds;
2. therapy mats;
3. parallel bars;
4. scales;
5. activity streamers;
6. paraffin machines or baths;
7. therapy balls;
8. books, games, toys;
9. electronics  such as CD players, radios, cassette players, tape recorders, television, VCR/DVDs, cameras or film, videotapes and other similar items;
10. computers and software;
11. adaptive switches and buttons;
12. exercise equipment such as treadmills or exercise bikes;
13. furniture;
14. appliances - such as refrigerator, stove, hot water heater;
15. indoor and outdoor play equipment such as swing sets, swings, slides, bicycles adaptive tricycles, trampolines, play houses, merry-go-rounds;
16. swimming pools, spas, hot tubs, portable whirlpool pumps;
17. temperpedic mattresses, positioning devices, pillows;
18. bathtub lifts;
19. motorized scooters;
20. barrier creams, lotions, personal cleaning cloths;
21. totally enclosed cribs and barred enclosures used for restraint purposes;
22. medication dispensers;
23. Vehicle modifications.

B. Any equipment or items that can be authorized through Medicaid State Plan;

C. Any equipment or items purchased or obtained by the individual, his/her family members, or other non-waiver providers.

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Licensed Home Health Agency
Agency	FSSA/ DA approved Specialized Medical Equipment and Supplies Agency

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## Appendix C: Participant Services

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

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**Service Type: Other Service**

**Service Name: Specialized Medical Equipment and Supplies**

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**Provider Category:**

Agency

**Provider Type:**

Licensed Home Health Agency

**Provider Qualifications**

**License (specify):**

IC 16-27-1

**Certificate (specify):**

**Other Standard (specify):**

DA approved

460 IAC 1.2-18 Warranty required

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Specialized Medical Equipment and Supplies**

**Provider Category:**

Agency

**Provider Type:**

FSSA/ DA approved Specialized Medical Equipment and Supplies Agency

**Provider Qualifications**

**License (specify):**

IC 25-26-21

**Certificate (specify):**

IC 6-2.5-8-1

**Other Standard (specify):**

DA approved

460 IAC 1.2-6-1 Becoming an approved provider; maintaining approval

460 IAC 1.2-6-2 Provider qualifications: General requirements

460 IAC 1.2-10 Financial information

460 IAC 1.2-11 Property and personal liability insurance

460 IAC 1.2-13 Professional qualifications and requirements; documentation of qualifications

460 IAC 1.2-18 Warranty required

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

## Other Service

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

**Service Title:**

Transportation

**Service Definition (Scope):**

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

### SERVICE STANDARDS

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

- Transportation services under the waiver shall be offered in accordance with an individual's plan of care
- Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized

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

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

### DOCUMENTATION STANDARDS

A provider or its agent shall maintain documentation that the provider meets and maintains the requirements for providing services under 460 IAC 1.2

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

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

### ACTIVITIES NOT ALLOWED

- Services available through the Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before reimbursement is available through the Medicaid waiver for this service)
- Level 1 and Level 2 services to participants receiving Adult Foster Care waiver service
- Services to participants receiving Assisted Living waiver service

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Licensed Home Health Agency
Agency	FSSA/DA approved Transportation Agency

## Appendix C: Participant Services

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

Service Type: Other Service

**Service Name: Transportation**

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**Provider Category:**

Agency

**Provider Type:**

Licensed Home Health Agency

**Provider Qualifications**

**License (specify):**

IC 16-27-1

**Certificate (specify):**

**Other Standard (specify):**

DA approved

Compliance with applicable vehicle/driver licensure for vehicle being utilized

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

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**Appendix C: Participant Services**

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

---

**Service Type: Other Service**

**Service Name: Transportation**

---

**Provider Category:**

Agency

**Provider Type:**

FSSA/DA approved Transportation Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

DA approved

460 IAC 1.2-6-1 Becoming an approved provider; maintaining approval

460 IAC 1.2-6-2 Provider Qualifications: General Requirements

460 IAC 1.2-6-3 General requirements for direct care staff

460 IAC 1.2-8-1 Procedures for protecting individuals

460 IAC 1.2-8-2 Unusual occurrence; reporting

460 IAC 1.2-8-3 Transfer of individual's record upon change of provider

460 IAC 1.2-8-4 Notice of termination of services

460 IAC 1.2-9-1 Provider organizational chart

460 IAC 1.2-9-2 Collaboration and quality control

460 IAC 1.2-9-4 Data collection and reporting standards

460 IAC 1.2-9-5 Quality assurance and quality improvement system

460 IAC 1.2-10 Financial information

460 IAC 1.2-11 Property and personal liability insurance

460 IAC 1.2-12 Transportation of an individual

460 IAC 1.2-13 Documentation of qualifications

460 IAC 1.2-14-1 Maintenance of personnel records

460 IAC 1.2-15-2 Adoption of personnel policies

460 IAC 1.2-15-3 Operations manual  
460 IAC 1.2-16-1 Maintenance of records of services provided  
460 IAC 1.2-16-2 Individual's personal file; site of service delivery

Compliance with applicable vehicle/driver licensure for vehicle being utilized

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Aging

**Frequency of Verification:**

up to 3 years

## Appendix C: Participant Services

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### 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

**Service Definition (Scope):**

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

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

1. The individual or primary caregiver is the titled owner;
2. The vehicle is registered and/or licensed under state law;
3. The vehicle has appropriate insurance as required by state law;
4. The vehicle is the individual's sole or primary means of transportation;
5. The vehicle is not registered to or titled by a Family and Social Services Administration (FSSA) approved provider.

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

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

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

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

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

(s);

3. All bids must be itemized.

C. Many automobile manufacturers offer a rebate of up to \$1,000.00 for individuals purchasing a new vehicle requiring modifications for accessibility. To obtain the rebate the individual is required to submit to the manufacturer documented expenditures of modifications. If the rebate is available it must be applied to the cost of the modifications.

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

#### ALLOWABLE ACTIVITIES

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

A. Wheelchair lifts;

B. Wheelchair tie-downs (if not included with lift);

C. Wheelchair/scooter hoist;

D. Wheelchair/scooter carrier for roof or back of vehicle;

E. Raised roof and raised door openings;

F. Power transfer seat base (Excludes mobility base);

G. Maintenance is limited to \$500.00 annually for repair and service of items that have been funded through a HCBS waiver:

1. Requests for service must differentiate between parts and labor costs;

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

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

#### SERVICE STANDARDS

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

B. All items must meet applicable manufacturer, design and service standards.

#### DOCUMENTATION STANDARDS

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

1. POC/CCB; and

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

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

1. ownership of vehicle to be modified; or

2. vehicle owner's relationship to the individual; and

3. make, model, mileage, and year of vehicle to be modified.

C. Signed and approved RFA;

D. Signed and approved POC/CCB;

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

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

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

A lifetime cap of \$15,000.00 is available for vehicle modifications. In addition to the applicable lifetime cap, \$500.00 will be allowable annually for repair, replacement, or an adjustment to an existing modification that was funded by a Home and Community Based Services (HCBS) waiver.

**ACTIVITIES NOT ALLOWED**

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

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

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

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

## Appendix C: Participant Services

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

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**Service Type: Other Service**  
**Service Name: Vehicle Modifications**

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**Provider Category:**

Agency

**Provider Type:**

FSSA/ DA approved Vehicle Modification Agency

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

DA approved  
460 IAC 1.2-6-1 Becoming an approved provider; maintaining approval  
460 IAC 1.2-6-2 Provider qualifications: General requirements  
460 IAC 1.2-10 Financial information

- 460 IAC 1.2-11 Property and personal liability insurance
- 460 IAC 1.2-13 Professional qualifications and requirements; documentation of qualifications
- 460 IAC 1.2-16-1 Maintenance of records of services provided
- 460 IAC 1.2-18 Warranty required

**Verification of Provider Qualifications**  
**Entity Responsible for Verification:**  
 Division of Aging  
**Frequency of Verification:**  
 up to 3 years

## Appendix C: Participant Services

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

- b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):
- Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
  - Applicable** - Case management is furnished as a distinct activity to waiver participants.  
*Check each that applies:*
    - As a waiver service defined in Appendix C-3. Do not complete item C-1-c.**
    - As a Medicaid State plan service under  1915(i) of the Act (HCBS as a State Plan Option).** Complete item C-1-c.
    - As a Medicaid State plan service under  1915(g)(1) of the Act (Targeted Case Management).** Complete item C-1-c.
    - As an administrative activity.** Complete item C-1-c.
- c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

## Appendix C: Participant Services

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

- a. Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (*select one*):
- No. Criminal history and/or background investigations are not required.**
  - Yes. Criminal history and/or background investigations are required.**

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

All providers must submit a criminal background check as required by 460 IAC 1.2-6-2 (a) (3). 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. Licensed professionals are checked for findings through the Indiana Professional Licensing Agency. Additionally, the Division of Aging requires that a current limited criminal history be obtained from the Indiana State Police central repository as prescribed in 460 IAC 1.2-15-2(b) (2) Adoption of personnel policies, for each employee or agent involved in the direct

management, administration, or provision of services in order to qualify to provide direct care to individuals receiving services at the time of provider certification. Direct care staff is also checked against the nurse aide registry at the Indiana Professional Licensing Agency verifying that each unlicensed employee or agent involved in the direct provision of services has no finding entered into the registry in order to qualify to provide direct care to individuals receiving services. The Division of Aging provider relations waiver specialist verifies receipt of documentation as a part of provider enrollment. On-going verification will occur through provider surveys conducted at a minimum of every three (3) years; verification will also be monitored through incident and complaint process reports.

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

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

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

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

The Indiana Professional Licensing Agency is responsible for maintaining the nurse aide registry. Pursuant to Indiana Administrative Code 460 IAC 1.2-6-2 General Requirements: the provider must obtain and submit a current document from the nurse aide registry of the Indiana Professional Licensing Agency verifying that each unlicensed employee involved in the direct provision of services has no finding entered into the registry before providing direct care to individuals receiving services. The Division of Aging provider relations waiver specialist verifies receipt of documentation as a part of provider enrollment. On-going verification will occur through provider surveys conducted at a minimum of every three (3) years; verification will also be monitored through incident and complaint process reports.

Nurse aide registry documents are maintained in agency files and are available upon request.

## Appendix C: Participant Services

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

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

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

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

Facility Type	
Indiana State Licensed Residential Care Facilities	

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

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants request the arrangement) which include kitchenette, toilet

facilities, and a sleeping area, not necessarily designated as a separate bedroom from the living area. Individuals may choose to utilize their own furnishings. The individual has a right to privacy. Living units may be locked at the discretion of the individual, except when a physician or mental health professional has certified in writing that the individual is sufficiently impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The individual retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each individual to facilitate aging in place. Routines of care provision and service delivery must be individual-driven to the maximum extent possible, and treat each person with dignity and respect.

## Appendix C: Participant Services

### C-2: Facility Specifications

#### Facility Type:

Indiana State Licensed Residential Care Facilities

#### Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Adult Foster Care	<input type="checkbox"/>
Adult Day Service	<input type="checkbox"/>
Transportation	<input type="checkbox"/>
Case Management	<input checked="" type="checkbox"/>
Personal Emergency Response System	<input type="checkbox"/>
Vehicle Modifications	<input type="checkbox"/>
Assisted Living	<input checked="" type="checkbox"/>
Health Care Coordination	<input type="checkbox"/>
Pest Control	<input type="checkbox"/>
Environmental Modifications	<input type="checkbox"/>
Attendant Care	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Specialized Medical Equipment and Supplies	<input checked="" type="checkbox"/>
Community Transition	<input type="checkbox"/>
Home Delivered Meals	<input type="checkbox"/>
Homemaker	<input type="checkbox"/>
Nutritional Supplements	<input type="checkbox"/>

#### Facility Capacity Limit:

no limit

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

### Scope of State Facility Standards

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

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

## Appendix C: Participant Services

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

**d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

**e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.**

Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- Other policy.**

Specify:

Attendant Care, Case Management, Homemaker, Respite, and Adult Foster Care waiver services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in fact (POA) of a participant, or the health care representative (HCR) of a participant.

Relatives who receive payment for waiver services will be subject to post-payment review as described in Appendix D-1-g and service plan monitoring as described in Appendix D-2-a. These practices will ensure that services delivered will continue to meet the needs and goals as well as the best interest of the participant.

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

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

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

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

#### a. Methods for Discovery: Qualified Providers

##### i. Sub-Assurances:

- a. Sub-Assurance:** *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

##### Performance Measures

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

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

**Performance Measure:**  
**Indiana State Department of Health (ISDH) surveys licensed home health agencies, personal service agencies and assisted living facilities to assure compliance with ISDH regulations and provider standards. Monitor the number of enrolled waiver providers that continue to hold valid ISDH licenses (numerator) by the total number of existing licensed enrolled waiver providers reviewed (denominator).**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Indiana State Department of Health report**

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

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

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

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

**Performance Measure:**

Verify that non-licensed/non-certified providers meet the state's waiver provider application requirements detailed in 460 IAC 1.2-6. Monitor the number of new approved provider applications (numerator) by the total number of new applicants reviewed from non-licensed/non-certified entities (denominator).

**Data Source** (Select one):

**Program logs**

If 'Other' is selected, specify:

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

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

Provider qualifications of non-licensed/non-certified providers are verified, at a minimum every three years, to assure compliance with provider standards.

Number of non-licensed/non-certified providers who meet provider standards (numerator)/by number providers reviewed (denominator).

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

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

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

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

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

**Performance Measure:**

**The DA, or designee, provides case manager training that matches state and waiver requirements. The DA, along with OMPP, reviews, approves and monitors training program content and delivery.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Training Materials**

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

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

**Performance Measure:**

The state's fiscal intermediary contractor provides training for waiver providers focused on Medicaid updates and changes. The DA, along with OMPP, reviews, approves and monitors training program content and delivery as per contract.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Training Materials**

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**  
**Provider verifies compliance with Aging Rule 460 IAC 1.2 staff training requirements for employees. Verify the number of providers documenting required staff training (numerator) by the number of providers reviewed (denominator).**

**Data Source** (Select one):  
**Training verification records**  
 If 'Other' is selected, specify:

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

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

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

The Division of Aging's QA/QI Unit reviews daily incident reports, internal and external complaint records, and restricted data bases, such as Adult Protective Services records, to determine on an on-going basis if specific provider trends exist. Coordination within the unit involves staff that handles incident and complaint reports, LTC Ombudsman Program staff and APS Program staff.

**b. Methods for Remediation/Fixing Individual Problems**

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

Provider records review, site visits and consumer satisfaction surveys may lead to the identification of areas of non-compliance with waiver provider agreement.

Identification of problems will result in increased program and financial review which may include program surveying or the issue of a complaint to the State Department of Health to initiate a provider survey when issues involve a licensed provider

Division of Aging and/or QA Contractor shall have oversight and coordination of all providers' requested corrective action plans.

Corrective action plans are required from providers within ten (10) business days of their notification of any findings of deficiency resulting from a survey.

Unresolved and/or uncorrected provider issues, especially those potentially impacting participant's health and welfare, are referred to the Assistant Director of QA/QI, OMPP and DA management staff for appropriate actions, up to and including, the termination of the service provider agreement.

**ii. Remediation Data Aggregation**

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

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

**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 Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

New staff positions in the Division of Aging have been developed to more closely review and monitor non-licensed providers both before they are approved as a waiver provider and after they begin providing waiver services.

## Appendix C: Participant Services

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### C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

## Appendix C: Participant Services

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### C-4: Additional Limits on Amount of Waiver Services

**a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

Furnish the information specified above.

- Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.  
*Furnish the information specified above.*

- Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.  
*Furnish the information specified above.*

- Other Type of Limit.** The State employs another type of limit.  
*Describe the limit and furnish the information specified above.*

## Appendix D: Participant-Centered Planning and Service Delivery

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

#### State Participant-Centered Service Plan Title:

Cost Comparison Budget

- a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- Registered nurse, licensed to practice in the State**  
 **Licensed practical or vocational nurse, acting within the scope of practice under State law**  
 **Licensed physician (M.D. or D.O)**  
 **Case Manager** (qualifications specified in Appendix C-1/C-3)  
 **Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

- Social Worker.**

*Specify qualifications:*

- Other**

*Specify the individuals and their qualifications:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (2 of 8)

- b. **Service Plan Development Safeguards.** *Select one:*

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

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## **Appendix D: Participant-Centered Planning and Service Delivery**

### **D-1: Service Plan Development (3 of 8)**

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The case manager works closely with the participant, or the participant's legal guardian, and other persons the participant chooses to include regarding the participant's plan of care. The participant has the authority to determine who is included in the process. The participant has freedom of choice to select service providers from an array of Medicaid Waiver approved providers from a pick list in the participant's service area. The Division of Aging (DA) reviews the plan of care (POC) and the cost comparison budget (CCB) and has final authority regarding the amount of service that will be approved for the waiver participant.

## **Appendix D: Participant-Centered Planning and Service Delivery**

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

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Persons involved in the care plan development are the participant, or the participant's legal guardian, and other persons the participant chooses to include and the case manager. The case manager, in collaboration with the participant, develops the POC and submits the POC to the DA for approval.

All applicants for the waiver are evaluated to assure that level of care (LOC) is met prior to receiving services. Individuals must meet the minimal LOC requirements for that of a nursing facility placement in order to meet the qualifications for the waiver. Indiana has established the Eligibility Screen (460 Indiana Administrative Code 1-3-1 and 1-3-2), a tool that is used to determine basic LOC. Initially, the individual's physician must complete the Physician Certification for Long Term Care (450B). This medical document lists the diagnosis, medications, abilities, disabilities and prognosis. The 450B also includes the physician recommendation regarding the safety and feasibility of the individual to receive home and community-based services. The POC is based on the individual's needs identified by a case manager working with the individual and family members or legal representatives. POCs are reviewed every ninety (90) days, or more often as needed, by the case manager in collaboration with the participant and providers to ensure continued relevance to meet the participant's identified medical needs and goals.

The case manager informs the individual of the services available under the waiver. If the individual meets nursing facility (NF) LOC, the individual will be provided with a pick list of all Medicaid Waiver approved providers in the

individual's geographic area that provide home and community-based services. It is the individual's choice to choose their services and service providers to meet their identified medical needs and goals; this includes the individual's option to choose participant directed care as described in Appendix E.

The case manager in collaboration with the individual and providers completes an initial, ninety (90) day, or more often as needed, and annual re-determination assessment to evaluate the individual's strengths, capacities, needs, preferences and desired outcomes, health status, and risk factors. Based on the outcomes of the assessments, a comprehensive POC is developed. The case manager assures the care plan meets the medical needs and goals of the individual and includes the individual's preferences of services, if available through the waiver. The POC is signed off by the case manager, the individual or the individual's legal guardian. The DA waiver specialist provides a second level of review of the plan of care to assure that the participant's goals, needs (including healthcare needs), and preferences are met.

The individual signs a release form that allows the case manager to contact service providers once the client has selected the providers of choice. The case manager is responsible for the coordination of all services and to assure that needs are met. The case manager is responsible for the implementation and monitoring of the POC.

The participant receives a copy of the POC so they are aware of the services that are being provided and the frequency of the services by the service providers. The POC development process affords a checks and balance approach regarding the assignment of responsibilities to implement and monitor the POC by input from the participant, case manager, physician, provider of service, and the DA.

The case manager is required to conduct a face-to-face visit with the participant at least every ninety (90) days, or more often as necessary, to ensure the health and welfare of the participant and to determine if the services previously approved by the waiver specialist meet the medical needs and goals of the waiver participant. The POC is also reviewed every ninety (90) days, or more often as necessary. Updates to the POC can be made as often as necessary to reflect the participant's medical needs and goals.

All individuals must be Medicaid eligible prior to receiving waiver services, therefore, the State does not use temporary or interim service plans to get services initiated until a more detailed service plan can be finalized.

## **Appendix D: Participant-Centered Planning and Service Delivery**

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### **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.

During the waiver LOC determination process, risks are assessed using the Eligibility Screen tool. Appropriate clinical interventions are initiated at this time through the usual service system to address emergent needs. Early in the case management process formal and informal supports are identified in order to address contingencies such as emergencies, including the failure of a support worker to appear when scheduled to provide necessary services when the absence of the service presents a risk to the participant's health and welfare. Informal supports including friends, family, and neighbors will be used to assist in providing services in a crisis situation. Back-up plans are incorporated into the overall POC. Effectiveness will be routinely monitored in the POC reviews. Five percent (5%) of POCs will be reviewed by contractor to evaluate the appropriateness of the participant plan based upon participant's service needs and preferences.

## **Appendix D: Participant-Centered Planning and Service Delivery**

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

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

As a service is identified, a pick list of Medicaid Waiver approved providers is generated in randomized sequence and is presented to the participant by the case manager. Participants and family members may interview potential service providers and make their own choice. If the participant or parent/guardian wishes to select a provider that is

not an approved waiver service provider, the Office of Medicaid Policy and Planning (OMPP) and the Division of Aging (DA) will assist in reviewing and processing applications from potential providers.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

The Indiana Office of Medicaid Policy and Planning (OMPP) will retain responsibility for service plan approvals made by the Division of Aging (DA) as defined in the Memorandum of Understanding, assuring that the POCs address all pertinent issues identified through the assessment, including physical health issues.

The OMPP will review and approve the policies, processes and standards for developing and approving POCs. In the instance of a complaint from a provider or participant and family, the POC submitted to DA may be reviewed by OMPP. Based on the terms and conditions of this waiver, OMPP may overrule the approval or disapproval of any specific POC acted upon by the DA serving in its capacity as the administrating agency for the waiver.

In addition, systems are set up to complete additional field reviews. The OMPP has a contract for the completion of individual service plan reviews against documented services rendered and services that were billed. The contracting entity is expected to review a designated percentage of individuals receiving services from the surveyed provider. As noted under Appendix A, the details for these review functions fall under the Surveillance Utilization Review (SUR) contract developed and managed by the OMPP.

OMPP oversees the contractor's monthly waiver reviews through regularly scheduled monthly meetings with the contractor and monthly reports of the contractor's reviews. Additionally, OMPP staff may periodically accompany the contractor on-site, to observe the waiver reviews.

Further, for purposes of oversight and quality control, OMPP will annually complete a statistically valid random sample of initial LOC screens. As a part of this annual sample, OMPP may request additional documentation from DA, the individual, the family or providers to verify the accuracy of the assessment.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

*Specify the other schedule:*

The POC is reviewed and updated as necessary every ninety (90) days, or more frequently when necessary.

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

- Medicaid agency
- Operating agency
- Case manager
- Other

*Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-2: Service Plan Implementation and Monitoring

- a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Plan of Care (POC) is based on the participant's needs through assessment by a case manager working with the participant, or the participant's legal guardian, and other persons the participant chooses to include. The case manager must document the abilities, disabilities and needs of the participant that provides justification for the requested waiver services.

The case managers are responsible for monitoring the service plan of the participant and must meet face-to-face with the participant at a minimum of every ninety (90) days. The case managers complete a ninety (90) day checklist to assure that services approved by the DA's waiver specialist continue to meet the medical needs and goals of the participant. If changes in the POC are warranted in order to meet the medical needs and goals of the participant, the case manager must submit additional information and updated POC/CCB to the DA's Waiver Operations Unit. The DA's waiver specialist determines if the additional services are appropriate based on the assessment and documentation provided and if cost effectiveness is maintained.

The ninety (90) day review monitors:

Participants health and well being

Indiana has numerous mechanisms in place to safeguard the health and welfare of waiver participants. The case managers ensure the participant's health and welfare through required ninety (90) day face-to-face reviews. These reviews provide a means of assessing the potential for suspected abuse, neglect or exploitation. The DA utilizes quarterly reports to identify POCs and ninety (90) day review timeliness. These reports are reviewed by the Supervisor of the Waiver Operations Unit within the DA. Non-compliant case managers are reported to the case manager's supervisor and the Assistant Director for Waiver Services. POC delinquencies are reviewed by the Supervisor of the Waiver Operations Unit. Non resolved issues are referred to the QA unit and to the Sanctions Committee for review of repetitive issues for action as described in Appendix F.

To proactively decrease late re-determinations, the DA has developed a report that is generated sixty (60) days prior to the annual LOC and POC reviews to advise case managers that reviews are due. A report is generated thirty (30) days prior to the ninety (90) day reviews and submitted to case managers.

The case manager shall assess and monitor the services and outcomes established for the participant in the participant's POC to ensure the health and welfare of the participant by providing follow-up on problems when they are identified and acting immediately to resolve critical issues and crises.

The POC focuses on participant's assessed medical needs and personal goals to be addressed through waiver services and other formal or informal service provisions. DA monitors compliance and timeliness of submission of the POC and reviews changes and updates related to participant's identified medical needs and participant goals. On a monthly basis, the DA reviews and monitors the case managers reports of the participant's health and welfare during the ninety (90) day face-to-face review.

Services meet the participant's needs

The case manager, in collaboration with the participant, develops the POC which includes a formal description of goals, objectives, and strategies that include desired outcomes and persons responsible for implementation of the services. The POC is also designed to enhance a participant's independence. All providers rendering services to the participant are required to share documentation regarding the participant's well-being with the case manager. The POC is reviewed and updated every ninety (90) days, or more often as necessary, to meet the medical needs and goals of the participant.

Effectiveness of back up plans

Providers providing waiver services are required to have established back-up plans to provide staffing for waiver

participant's needs. At the ninety (90) day review, the case manager verifies with the participant the appropriateness of back up plans and adjusts the back up plan accordingly.

Providers are surveyed to ensure they are in compliance with the DA's rules and regulations.

Participants exercise free choice in selection of providers

The case manager is responsible for explaining to the participant the array of waiver services available to meet their medical needs and goals. The case manager provides the participant with a pick list of all Medicaid Waiver approved providers in the participant's geographic area that provide home and community-based services. It is the participant's right to choose their services and service providers to meet their identified medical needs and goals. The participant and the case manager sign the POC to validate that the case manager has explained the services to the participant and that the participant or the participant's legal representative validates that they have been fully informed of the services available to them. The signatures on the POC and the cost comparison budget (CCB) validate that the participant has exercised free choice in the selection of service providers.

Participants access to non-waiver services in service plan, including health services

The physician, in collaboration with the participant and case manager, determines the appropriate services needed by the participant. The participant's case manager is responsible for completing the POC and the CCB that is submitted to the DA. The case manager is also responsible for coordinating non-waiver services, including health services, which are needed to assist the participant.

Methods for prompt follow up and remediation of identified problems

A provider is required to have a written internal quality assurance and quality improvement system that focuses on the individual; is appropriate for the services being provided; and is ongoing and updated at least annually. If issues are identified through survey the provider is required to submit a corrective action plan within the designated time frame detailed in Appendix H.

Additional methods for systemic collection of information about monitoring results are detailed in Appendix H.

**b. Monitoring Safeguards. Select one:**

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

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## Appendix D: Participant-Centered Planning and Service Delivery

### Quality Improvement: Service Plan

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

**a. Methods for Discovery: Service Plan Assurance/Sub-assurances**

**i. Sub-Assurances:**

- a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

**Performance Measures**

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

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information*

on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

All initial Plans of Care (POC) are reviewed by DA's Waiver Service Unit to determine if assessed needs and personal goals are addressed.

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**Electronic Case Management Database**

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

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

**Performance Measure:**

Participants are surveyed to indicate whether their needs are addressed by their POC. Percentage of participants who indicate that their needs are met (numerator) by the number of participants surveyed (denominator).

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Participant/ Family Survey**

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

**b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.**

**Performance Measures**

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

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

**Performance Measure:**

**The electronic case management database system does not allow a POC to be submitted unless all steps in the POC development process have been completed (i.e. 90 day case management review; Freedom of Choice for selection of services and providers; Freedom of Choice to receive HCBS as opposed to institutional care).**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Electronic Case Management Database**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

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

**Data Aggregation and Analysis:**

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

- c. **Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.**

**Performance Measures**

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

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

**Performance Measure:**

**Measure the number of annual re-determinations which are updated and approved within 12 months of the previous annual determination (numerator) by the total number of annual re-determinations due within the previous 12 month period (denominator).**

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**Electronic Case Management Database**

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

d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

**Performance Measures**

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

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

**Performance Measure:**

**The Consumer Survey Tool is used to monitor that service delivery is consistent with the plan of care. Plans of Care are compared to service documentation by measuring the number of participants receiving services in accordance with their care plan (numerator) by the total number of care plans reviewed (denominator).**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<input type="checkbox"/> <b>State Medicaid Agency</b>		
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95
<input checked="" type="checkbox"/> <b>Other</b> Specify: QA Contractor	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:
	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

The participant selects their service providers, including their case manager, from a pick list of services and approved providers. This is monitored by the number of

participants who have signed their cost comparison budget (CCB) (numerator) by the total number of cost comparison budgets (CCB) reviewed (denominator).

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

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

- e. **Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.**

**Performance Measures**

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

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

**Performance Measure:**

**The electronic POC documents that participants have been made aware of their choices between waiver services and institutional care. Monitored by the number of participants who have signed the Freedom of Choice form (numerator) by the total number of POC reviewed (denominator).**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95
<input checked="" type="checkbox"/> <b>Other</b> Specify: QA Contractor	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

The participant selects their service providers, including their case manager, from a pick list of services and approved providers. This is monitored by the number of participants who have signed their cost comparison budget (CCB)(numerator) by the total number of cost comparison budgets (CCB) reviewed (denominator).

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: QA Contractor	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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. In addition, provide information on the methods used by the State to document these items.

If Plan of Care (POC) is found to not meet the participant's needs, a plan of correction is required from the case manager or service providers to assure required revisions to the POC are made. The participant will be re-surveyed to assure the plan of correction has been implemented.

DA waiver unit staff and/or designee will contact case managers, providers, and participants as deemed appropriate, to verify that service choices were offered and documented in the electronic case management

database. Provider plan of corrections will be required if problems are identified and participants will be offered new choices via the provider pick list.

**ii. Remediation Data Aggregation**

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

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

**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 Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

**Appendix E: Participant Direction of Services**

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

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

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.*

**Indicate whether Independence Plus designation is requested** *(select one):*

- Yes. The State requests that this waiver be considered for Independence Plus designation.**
- No. Independence Plus designation is not requested.**

**Appendix E: Participant Direction of Services**

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- 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.

Individuals residing in Indiana and receiving attendant care on the Aged & Disabled (A&D) Medicaid Waiver are offered the self-directed attendant care service. Participants are empowered to choose their own personal attendants. This program enables individuals receiving care or their representatives to select, schedule, train, supervise, and (if necessary) dismiss their own personal attendants. The individual directing care of his/her representative takes on all of the responsibilities of being an employer except for payroll management, which is handled by the fiscal intermediary.

Some of the opportunities afforded to the participant receiving self-directed attendant care service include:

- An opportunity to exercise more self-control, to arrange the care more conveniently for the participant, and to work with attendants who are chosen by the participant.
- An alternative to agency-based care or care provided by independent care providers.
- Allows the participant the opportunity to arrange for services from more than one personal attendant or from a combination of agency based care and self-directed attendant care, depending on the individual's plan of care.

Attendant care providers may be recruited, hired, trained, paid, and supervised under the authority of the individual, individual's parent(s), other person acting on the individual's behalf, or the (emancipated) individual, if the individual, parent, or person acting on the individual's behalf, chooses to self-direct the attendant care providers and assumes the responsibility to initiate self-directed attendant care service and exercise judgment regarding the manner in which those services are delivered, including the decision to employ, train, and dismiss an attendant care provider.

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

Case managers are an integral part of the success of the self-directed attendant care service as the case manager is responsible for oversight and monitoring of the plan of care and cost comparison budget of the participant; assess the individual for participation in the self-directed attendant care service; assist the individual in directing care in evaluating whether the self-directed attendant care service is appropriate for meeting the individual's needs and whether the individual or the individual's representative is interested in taking on the responsibilities associated with the self-directed attendant care service. The case manager is required to have face-to-face contact with the participant at a minimum of at least every ninety (90) days, or more often as the needs of the participant change. The case manager is also required to reauthorize the participant in the self-directed attendant care service every ninety (90) days. The case manager will evaluate for quality and ask the participant to verify whether they are satisfied with the services they are receiving. The participant will be asked to sign the 90 Day Self-Directed Attendant Care 90 Day Review Checklist along with the case manager.

The Division of Aging also contracts with a fiscal intermediary whose responsibilities include serving as the payroll department; obtaining limited criminal background history checks on providers; issuing paychecks per submitted timesheets; withholding all necessary taxes; filing monthly, quarterly, and annual tax and labor reports; issuing annual W-2 wage statements; managing service units; providing individuals, employers and case managers with monthly reports of spending on individuals' behalf; and responding to all questions posed by the participant and the provider and state officials.

Self directed care providers are required to document the activities performed. Attendant care services are available to the participant self-directing their care which include personal care such as bathing (tub, shower); partial bath; oral hygiene; hair care; shaving; intact skin care; dressing; clipping hair; application of cosmetics; hand and foot care; mobility including proper body mechanics; transfers; ambulation; use of assistive devices; nutrition including feeding and preparation and clean-up of meals; elimination which consists of using bedpan, bedside commode, toilet; incontinence or involuntary care; and emptying urine collection and colostomy bags; assisting with correspondence and bill paying; escorting services which includes taking the participant to community activities that are therapeutic in nature or that assist with maintaining natural supports; safety services which include the use of the principles of health and safety in relation to self and client; identify and elimination of safety hazards; and practicing health protection cleanliness by appropriate techniques of hand washing; and waste disposal and household tasks.

Activities not allowed under the self-directed attendant care service include performing medical procedures; providing services to medically unstable individuals as a substitute for care provided by a registered nurse, licensed

practical nurse, licensed physician, or other health professionals; services that are for the benefit of other household members which include running errands; cooking; completing laundry; and providing childcare. Medical services not allowed are those that must be performed by a licensed healthcare professional. The attendant care service is not to exceed 40 hours per week.

## Appendix E: Participant Direction of Services

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### 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

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### 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 participants 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*

Self-directed attendant care service is limited to attendant care services only. No other service can be self-directed by the participant.

## Appendix E: Participant Direction of Services

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### E-1: Overview (4 of 13)

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

Individuals residing in Indiana and receiving attendant care on the Aged & Disabled (A&D) Medicaid Waiver are offered the self-directed attendant care service option. Participants are empowered to choose their own personal attendants. This program enables individuals receiving care or their representatives to select, schedule, train, supervise, and (if necessary) dismiss their own personal attendants. The individual, or the individual's representative, directing care takes on all of the responsibilities of being an employer except for payroll management, which is handled by the fiscal intermediary.

Some of the opportunities afforded to the participant receiving self-directed attendant care service include:

- An opportunity to exercise more self-control, to arrange the care more conveniently for the participant, and to work with attendants who are chosen by the participant.
- An alternative to agency-based care or care provided by independent care providers.
- Allows the participant the opportunity to arrange for services from more than one personal attendant or from a combination of agency based care and self-directed attendant care, depending on the participant's plan of care.
- The role of the case manager is to assess the individual for participation in the self-directed attendant care service; assist the individual in directing care in evaluating whether the self-directed attendant care service is appropriate for meeting the individual's needs and whether the individual or the individual's representative is interested in taking on the responsibilities associated with the self-directed attendant care service. The case manager is required to reauthorize the participant in the program every ninety (90) days. The case manager will evaluate for quality and ask the participant to verify whether they are satisfied with the services they are receiving. The participant will be asked to sign the 90 Day Self-Directed Attendant Care 90 Day Review Checklist along with the case manager.

## Appendix E: Participant Direction of Services

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### 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:

Attendant care providers may be recruited, hired, trained, paid, and supervised under the authority of the individual, individual's parent(s), other person acting on the individual's behalf, or the (emancipated) individual, if the individual, parent, or person acting on the individual's behalf, chooses to self-direct the attendant care providers and assumes the responsibility to initiate self-directed attendant care service and exercise judgment regarding the manner in which those services are delivered, including the decision to employ, train, and dismiss an attendant care provider. Attendant Care services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in fact (POA) of a participant, or the health care representative (HCR) of a participant.

Case managers are an integral part of the success of the self-directed attendant care service as the case manager is responsible for oversight and monitoring of the plan of care and cost comparison budget of the participant. One of the case manager's responsibilities is to have face-to-face contact with the participant at a minimum of at least every ninety (90) days, or more often as the needs of the participant change.

## 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.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Attendant Care	<input checked="" type="checkbox"/>	<input type="checkbox"/>

## 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 C1/C3**

**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:

As the operating agency, the Division of Aging through the procurement process, contracted with a fiscal intermediary for the self-directed attendant care service whose job responsibilities include serving as the  payroll department ; including administering limited criminal history background checks; issuing paychecks per submitted timesheets; filing monthly, quarterly and annual tax and labor reports; issuing annual W-2 wage statements; managing service units; providing individuals, employers, and case managers

with monthly reports of fiscal intermediary spending on individuals on behalf; and responding to questions and issues concerning the self-directed attendant care service.

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

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

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

---

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

---

- Assists participant in verifying support worker citizenship status**
- Collects and processes timesheets of support workers**
- Processes 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:

---

- Maintains a separate account for each participant's participant-directed budget**
- Tracks and reports participant funds, disbursements and the balance of participant funds**
- Processes and pays 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:

---

- Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- Provides 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.

The Division of Aging's Deputy Director, or designee, is responsible for monitoring the performance of the fiscal intermediary (detailed in Appendix E-1) through weekly telephonic conference calls and weekly written reports on payments to providers. The reports include the number of participants, the number of providers, dollar amounts, and which participants have plans of care but are not receiving services.

The DA's quality assurance contractor performs customer satisfaction surveys on a statistically valid sample of participants, including the participants enrolled in the self-directed attendant care services, to assure participant's service needs within the plan of care are being met.

## Appendix E: Participant Direction of Services

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### E-1: Overview (9 of 13)

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

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

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

Case managers are an integral part of the success of the self-directed attendant care service as the case manager is responsible for oversight and monitoring of the plan of care and cost comparison budget of the participant. One of the case manager's responsibilities is to have face-to-face contact with the participant at a minimum of at least every ninety (90) days, or more often as the needs of the participant change.

The role of the case manager is to assess the individual for participation in the self-directed attendant care service; assists the individual in directing care in evaluating whether the self-directed attendant care service is appropriate for meeting the individual's needs and whether the individual or the individual's representative is interested in taking on the responsibilities associated with the self-directed attendant care service. The case manager also helps to provide administrative guidance to the individual, or the individual's representative, regarding the self-directed attendant care service implementation process which includes: training on the program via manual study or one of the forms of electronic information; assisting with obtaining and/or completion of the employer and employee packets involved in hiring the self-directed attendant care personal attendant; direct the employer to the fiscal intermediary's Help Line if assistance is needed with the completion of the fiscal intermediary forms and paperwork; and monitoring the outcomes of the self-directed attendant care service, to the extent as agency services are monitored. The case manager is required to reauthorize the participant in the program every ninety (90) days. The case manager will evaluate for quality and ask the participant to verify whether they are satisfied with the services they are receiving. The participant will be asked to sign the 90 Day Self-Directed Attendant Care 90 Day Review Checklist along with the case manager.

If at any time the case manager identifies the health and welfare of the participant is beyond the scope of the self-directed attendant care service or identifies the participant, or participant's representative, is unable to fulfill the responsibilities as outlined in the self-directed attendant care service, other service options will be provided to meet the needs of the participant and to assure continuity of services to meet the participant's needs. This process will not circumvent the individual's right to a fair hearing as detailed in Appendix F-1.

- 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
Adult Foster Care	<input type="checkbox"/>
Adult Day Service	<input type="checkbox"/>
Transportation	<input type="checkbox"/>
Case Management	<input type="checkbox"/>
Personal Emergency Response System	<input type="checkbox"/>
Vehicle Modifications	<input type="checkbox"/>
Assisted Living	<input type="checkbox"/>
Health Care Coordination	<input type="checkbox"/>
Pest Control	<input type="checkbox"/>
Environmental Modifications	<input type="checkbox"/>
Attendant Care	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Specialized Medical Equipment and Supplies	<input type="checkbox"/>
Community Transition	<input type="checkbox"/>
Home Delivered Meals	<input type="checkbox"/>
Homemaker	<input type="checkbox"/>
Nutritional Supplements	<input type="checkbox"/>

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

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

## Appendix E: Participant Direction of Services

### E-1: Overview (10 of 13)

**k. Independent Advocacy** (*select one*).

- No. Arrangements have not been made for independent advocacy.**  
 **Yes. Independent advocacy is available to participants who direct their services.**

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

## Appendix E: Participant Direction of Services

### E-1: Overview (11 of 13)

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

If at any time the participant voluntarily chooses to terminate the self-directed attendant care service, the case manager will provide information regarding other service options and to assure continuity of services to meet the participant's needs. The participant will be asked to sign the 90 Day Self-Directed Attendant Care 90 Day Review Checklist along with the case manager.

## 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 provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

If at any time the case manager identifies the health and welfare of the participant is beyond the scope of the self-directed attendant care service or identifies the participant, or participant's representative, is unable to fulfill the responsibilities as outlined in the self-directed attendant care service, other service options will be provided to meet the needs of the participant and to assure continuity of services to meet the participant's needs. The participant will be asked to sign the 90 Day Self-Directed Attendant Care 90 Day Review Checklist along with the case manager. This process will not circumvent the individual's right to a fair hearing as detailed in Appendix F-1.

## 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	400	
Year 2	425	
Year 3	425	
Year 4 (renewal only)	425	
Year 5 (renewal only)	425	

## 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.**  
 **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:

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## 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:

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**Answers provided in Appendix E-1-b indicate that you do not need to complete this section.**

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**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:

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## Appendix E: Participant Direction of Services

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

**b. Participant - Budget Authority**

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**Answers provided in Appendix E-1-b indicate that you do not need to complete this section.**

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**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.

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## Appendix E: Participant Direction of Services

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

**b. Participant - Budget Authority**

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**Answers provided in Appendix E-1-b indicate that you do not need to complete this section.**

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**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.

## Appendix E: Participant Direction of Services

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

#### b. Participant - Budget Authority

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Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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##### 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:

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## Appendix E: Participant Direction of Services

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

#### b. Participant - Budget Authority

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Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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- 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:

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## Appendix F: Participant Rights

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### Appendix F-1: Opportunity to Request a Fair Hearing

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

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

The Case Manager's responsibilities include provision of both written and oral explanations of the participant's or the guardian's, if appropriate, right to the Medicaid Fair Hearing process. This notification will occur at the time of initial assessment, annual reassessments and for any updates to the Plan of Care (POC) related to participant's choice between institutional care and community based services, selection of services and service providers if community based care is chosen, and rights of appeal if services are suspended, denied, reduced or terminated.

The Notice of Action  State Form 46015  HCBS5  is used to notify each Medicaid applicant or participant of any action that affects the individual's Medicaid waiver benefits. An action may be a suspension, termination, reduction, or increase of all or any amount of covered services. This also includes actions taken to approve or deny new applicants. An explanation regarding a HCBS waiver service participant's appeal rights and the opportunity for a fair hearing is found on the back of the Notice of Action. Part 2,  Your Right to Appeal and Have a Fair Hearing  advises individuals of their right to appeal and the timely actions which are required. Part 3,  How to Request an Appeal  provides instructions for individuals regarding the procedures that are necessary in the appeal process.

The waiver Notice of Action informs the participant (and the participant's guardian or advocate, as appropriate) of his/her right to an appeal. The Notice of Action also advises the participant that services will be continued if he/she files the appeal in a timely manner, which is within thirty (30) days of the decision date noted on the Notice of Action.

Written materials will be maintained in the participant's information folder kept in the home. Additionally, written materials detailing the service plan and service providers are mailed to the participant to allow for a right to appeal the service delivery plan and right to a Medicaid Fair Hearing. This formal notice occurs after the initial POC is developed and at time of renewal or at any time there is a change in POC.

The Case Manager maintains copies of all written notices and electronically filed documents related to an individual's POC and the individual's right to a Medicaid Fair Hearing. The Case Manager must ensure that the Notice of Action is sent to the applicant or participant within 10 working days of the issue date and must document the date the Notice of Action was sent to the applicant or participant.

If an applicant is denied waiver services, or a participant's services are decreased or suspended, a written notice of action is sent detailing the reasons for denial and explains the individual's right to appeal this decision and right to a Medicaid Fair Hearing.

## Appendix F: Participant-Rights

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### 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**

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

## Appendix F: Participant-Rights

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### 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**

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

The Division of Aging is responsible for the operation of the grievance/complaint system.

- b. 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).

## COMPLAINT POLICY FOR THE DIVISION OF AGING

### I) POLICY/PURPOSE STATEMENT

It is the policy of the Indiana Division of Aging (DA) that all complaints are addressed in a timely manner that ensures the health and safety of individuals receiving services coordinated and administered by the Division of Aging.

### II) STANDARDS

A) The DA accepts complaints from any person, when such complaints are related to DA programs, services and the individuals served by the DA.

Complaints not specific to the DA are referred to an appropriate entity (agency/ division/ authority).

B) All complaints are acted upon in accordance with the nature of the complaint. If a complaint is related to a participant's health or welfare; that complaint will also be logged as an incident within the DA's Incident database (see Appendix G-1)

Complaints may require additional actions by the Division of Aging in addition to the procedures for responding to complaints, as required by State and Federal law, regulation or policy depending on the type of complaint received.

C) The Division of Aging ensures all complaints are responded to timely and in a manner appropriate to the specific complaint.

D) The Division of Aging ensures all complaints are responded to in a manner that ensures the health and safety of individuals receiving services coordinated and administered by the Division of Aging.

E) The Division of Aging ensures complaints are, whenever feasible, resolved to the satisfaction of the complainant and in compliance with applicable State and Federal laws, regulations and policies.

### III) DEFINITIONS

□ Division of Aging □ (DA) □ The entity established in IC 12-10-1-2 to assist the constantly increasing number of aged in: (1) maintaining self-sufficiency and personal well-being with the dignity to which the years of labor entitle the person; and (2) realizing the aged person's maximum potential as a creative and productive individual.

□ Complaint □ □ Usually related to a specific consumer receiving services administered by the Division of Aging, is an expression of dissatisfaction with services, a provider or a specific situation. The filing of a complaint is not considered a prerequisite, a substitution or the means to circumvent the participant's on-going right to seek a Medicaid Fair Hearing.

□ Medicaid Fair Hearing □ □ The federally mandated process delineated in 42 C.F.R. □ □ 431.200 to 431.250 available to Medicaid applicants and recipients who believe a decision of the Medicaid agency or its designee has been made in error when acting upon a request for assistance and in other specified situations including: Any applicant who requests it because his claim for services is denied or is not acted upon with reasonable promptness or any recipient who requests it because he or she believes the agency has taken an action erroneously. In Indiana, this is also referred to as an administrative hearing.

## PROCEDURES

### FORMAL COMPLAINTS

Complaints are received in the DA QA Unit. Upon receipt of a complaint, the DA QA Unit staff determines if the complaint is considered: critical, when personal safety is at risk; urgent, when personal safety is not at risk, but participant is impacted; or non-critical, when neither safety nor services are severely impacted.

Critical complaints require a four (4) day response time; urgent complaints require a seven (7) day response time and non-critical complaints require a response within twenty-one (21) days.

The DA QA Unit staff:

1. Identifies the individual(s) who are the subject of the complaint or who are reported to have been adversely impacted specific to the complaint.
2. Contacts the appropriate person to gather information specific to the complaint. Appropriate persons include: case managers, providers, family members and any other individual or entity that can clarify the problems leading to the complaint.
3. Notifies the complainant, via mail or e-mail, acknowledging receipt of the complaint, and providing the contact information for any referral of the complaint

#### INVESTIGATION AND FOLLOW-UP

The DA Quality Assessment/ Quality Improvement (QA/QI) Unit will monitor all complaints and provide the QA/QI Committee a status report detailing any cases remaining open, including actions being initiated to promote closure for each case. The QA/QI Unit staff and/or other appropriate persons will investigate the complaints by:

1. Collecting all relevant information
2. Completing on-site visit(s) if indicated.
3. Conducting private interviews with complainant, family members, and providers □ staff as necessary.
4. Requesting documents/information from state agencies, providers and other entities as needed.
5. Compiling the information and entering initial findings
6. Prepare statement of findings, and recommendation for the QA/QI Unit Director and/or the QA/QI Committee
7. The QA/QI Unit Director and/or the QA/QI Committee shall determine what additional actions are required. Such actions could include:
  - a. Request for a plan of correction from provider to document how problem/complaint will be resolved and steps that will be taken to prevent this problem in the future
  - b. Referral to the Indiana State Department of Health for licensed provider complaints
  - c. Provider survey by state staff or contracted staff
  - d. Discontinuation of provider agreement
  - e. Referral to the Attorney General □s Office /Medicaid Fraud Unit

#### CLOSING THE COMPLAINT

The QA/QI Unit with assistance from the QA/QI Committee as needed, will make the determination that a complaint has been addressed appropriately and resolved to the complainant □s satisfaction, whenever feasible, and document actions taken or corrections made.

## Appendix G: Participant Safeguards

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### 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).

The Division of Aging (DA)'s incident reporting system requires all providers of HCBS waiver services, including case managers, to submit incident reports to the DA when specific incidents occur, in accordance with Indiana Administrative Code 460 IAC 1.2-8-1 "Protecting individuals, Procedures for protecting individuals."

All entities (participants, guardians, service providers, case managers) with knowledge of an incident that affects, or potentially affects, the participant's health and welfare are required to submit an incident report through the DA web based Incident Reporting system. If web access is unavailable the DA may be reached by phone or fax.

Means for reporting known or suspected abuse, neglect, or exploitation (A-N-E) of an adult include a twenty-four (24) hour "hot-line" connected to the statewide Adult Protective Services (APS) and a toll free twenty-four (24) hour intake number through Indiana Department of Child Services (DCS) for child abuse or neglect reports.

The provider will suspend any staff suspected, alleged, or involved in incidents of A-N-E of a participant from duty pending investigation. The case manager will coordinate replacement services for the participant. In the event that the case manager is the alleged perpetrator the participant will be given a new pick list from which a new case manager will be selected.

Providers of home and community-based services are required to submit an incident report for "reportable unusual occurrences" within forty-eight (48) hours of the time of the incident or becoming aware of the incident. However, if an initial report involves an allegation, or suspicion of A-N-E it shall be submitted within twenty-four (24) hours of the incident or when reporter becomes aware of the incident.

If the incident is reported by other than the participant's case manager, the case manager will be contacted by the DA, as soon as possible. Case managers will identify initial corrective actions needed to address specific situations within one work day.

Reportable unusual occurrence includes, at a minimum, the following occurrences listed within 460 IAC 1.2:

1. Alleged, suspected, or actual A-N-E of a participant.
2. Alleged, suspected, or actual assault or abuse by a participant.
3. Death of a participant
4. A residence that compromises the health and safety of a participant due to any of the following:
  - a. A significant interruption of a major utility.
  - b. An environmental, structural, or other significant problem.
5. Environmental or structural problems associated with a dwelling where participants reside that compromise the health and safety of the participants.
6. A residential fire resulting in any of the following:
  - a. Relocation.
  - b. Personal injury.
  - c. Property loss.
7. Suspected or observed criminal activity by:
  - a. Staff member, employee, or agent of a provider;
  - b. Family member of a participant receiving services; or
  - c. Participant receiving services; when the care of the participant is impacted or potentially impacted.
8. Injuries of unknown origin.
9. Suicidal ideation or a suicide attempt that had the potential to cause physical harm, injury, or death.
10. A major disturbance or threat to public safety created in the community by the participant.
11. Admission of a participant to a nursing facility, excluding respite stays.
12. A significant injury to a participant, including, but not limited to, the following:
  - a. A fracture.
  - b. A burn greater than first degree.
  - c. Choking that requires intervention.
  - d. Contusions or lacerations.
13. Police involvement when there is an arrest.
14. Participant becomes a missing person.
15. Inadequate staff support for a participant, including inadequate supervision, with the potential for endangering the health or welfare of the participant.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

As a part of the plan of care (POC), participants, family members and/or legal guardians are advised by the case manager via written materials of the DA's abuse, neglect and exploitation reporting procedures. The case manager will discuss the information concerning who to contact, when to contact and how to report incidents with all persons involved in POC 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 ninety (90) day face-to-face updates and informally during monthly telephone contacts with the participant and/or guardian.

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

Procedures concerning the review and follow up of A-N-E and death incident reports:

Procedures for abuse or neglect reports of a child:

The Indiana Department of Child Services (DCS) provides statewide intake workers available twenty-four (24) hours every day to follow up on alleged abuse or neglect of a minor. Within twenty-four (24) hours, the DCS worker must complete, and log into the Indiana Child Welfare Information System (ICWIS), an assessment of the situation and document all initial findings from interviews with the child, alleged perpetrator, other family members, and/or with the incident reporter. Based upon this information the formal investigation will commence. Case managers and service providers will be included in fact finding interviews of the formal investigation.

During the time of the investigation the minor child will be removed from the home environment and placed in temporary foster care, if the home was the site of the alleged or suspected abuse or neglect. If participants are removed from the home setting, approved HCBS will continue in the alternate home setting. Results from investigative findings are reported within ICWIS and shared with case managers as appropriate. Law enforcement continues involvement depending on investigation results.

Procedures for A-N-E and death reports of an adult:

The State contracts with prosecutors for state-wide coverage through eighteen (18) service areas. These offices receive all reports of alleged or suspected abuse, neglect or exploitation. The eighteen (18) units of Adult Protective Services (APS) are charged with:

- investigation,
- documentation, and
- potential prosecution of A-N-E against a vulnerable person.

Procedures concerning the review and follow up of incidents:

All incidents are logged into the web based incident reporting system; the data contract staff will process the incident within one (1) work day of receipt of the report and will forward reports on incidents to DA QA/QI staff.

DA's review is designed to ensure that incidents are reported when appropriate to other service providers, including the case manager if they did not submit the incident initially, and that timely follow-up plans have been initiated along with the necessary referrals to other entities such as medical staff or law enforcement.

All incidents at a minimum require case manager's follow up and reporting every seven (7) days until incident is considered resolved. In addition, the participant's history of incidents is reviewed in order to identify any patterns and need for additional interventions and/or service provision.

The incident reporting database requires follow up on any critical incident by the participant's case manager until the incident is resolved and incident is closed once the participant is considered safe. The incident database sends reminders to case managers until all issues are resolved. Participants, their family caregivers, service providers or guardians are often involved in the incident resolution; however e-mails can be generated to keep other individuals and other service providers alerted to resolution or changes necessary to resolve the critical event (i.e. additional services or expanded hours of services that become necessary). Incident resolution is communicated (verbally and/or written) with all applicable entities.

The Data Intake staff with QA/QI Program Manager review incident reports for appropriate corrective action. The

QA/QI Unit uses Incident reports to determine patterns which may result in required plan of corrections from providers, enhanced service provision for participant, or change of type of range of services provided. The unit further reviews incidents for trends and reports these to the QA/QI Committee for development of additional quality improvement policies and procedures as needed.

Statewide incidents trends and geographic specific reports are forwarded monthly by DA to each AAA to aid in tracking incidents, both reported and resolved.

As a part of this, all report formats utilized to track incidents from the web based reporting are being reviewed with the assistance of DA data management staff to include new fields for data collection and comparison to aid in identifying trends and patterns in incident reporting and to evaluate the range of resolutions to prevent reoccurrences. The web-based system is augmented with e-mail tracking and reporting involving DA's QA staff and participants' case managers.

All participants' deaths are initially reported to the APS units or to the Department of Child Services (DCS) unless indicative of abuse or neglect which would continue to involve the APS units, DCS investigators and/or law enforcement in investigation, the Case manager will be responsible for follow up incident reporting to the DA within twenty-four (24) hours of knowledge of the death.

Initial reporting within the web based reporting system includes: the location of the death and contact names and phone numbers and the case management notes for the ninety (90) days preceding the death.

Participant's deaths are reviewed by DA QA/QI unit and compared to any previously filed incidents involving the participant and any filed A-N-E reports. Additional information may be collected for further review of any unexpected deaths. If the review is not closed at this level it will be referred for review to the Mortality Review Committee.

The Mortality Review Committee, including DA Registered Nurses, APS representative and representative from the Office of Medicaid Policy and Planning (OMPP) will review all deaths that involve the participant when:

1. death is due to alleged, suspected or known abuse or neglect
2. death is from trauma or accident
3. death is alleged or known suicide or homicide
4. death occurs within ninety (90) days of transition from a Nursing facility
5. death occurs when participant has gone missing from normal care setting

The Mortality Review Committee will review case manager notes for 90 days prior to the death, service provider notes for a minimum of thirty days prior to participant's death, any incident reports, verify any APS reports, medical information collected by the case managers and death certificates. The Mortality Review Committee may:

- 1) Request additional information and review the case a second time when the requested information is in the file;
- 2) Close a case with recommendations for the provider(s) or a case manager, a referral to another entity, or a systemic recommendation; or
- 3) Close a case with no recommendations.

- 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 the reporting and response to incidents is the direct responsibility of the Division of Aging.

1. The state's web-based system is augmented with e-mail tracking and reporting involving DA's QA staff and participants' case managers on a daily basis to assure follow up and resolution of the filed incidents in a timely manner.
2. The DA QA/QI Unit monitors the length of time from the incident reporting to each incident's resolution and follows up on unresolved incidents on a daily basis.
3. DA staff monitors the type and severity of incidents reported on a daily basis and monitors reported deaths on a weekly basis.
4. The QA/QI Committee reviews monthly incident and death reports. In addition to the QA/QI Unit staff, the QA/QI Committee membership includes OMPP representatives, APS Program Director, and the Waiver Unit designee. Contracted data management staff who initially review the web-based incidents are also represented on the committee.

All report formats utilized to track incidents from the web based reporting are being reviewed with the assistance of DA data management staff to include new fields for data collection and comparison to aid in identifying trends and patterns in incident reporting and to evaluate the range of resolutions to prevent reoccurrences.

Expanded reporting will aid the QA/QI committee to identify trends and patterns for development of new strategies to eliminate or reduce incidents in the future. These findings will be communicated to case managers, service providers, DA and OMPP.

## Appendix G: Participant Safeguards

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

**a. Use of Restraints or Seclusion.** *(Select one):*

- The State does not permit or prohibits the use of restraints or seclusion**

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

The DA prohibits the use of restraints or seclusion in the provision of services regardless of the waiver setting. Reporting of prohibited restraint and/or seclusion usage by a provider is reported through the web based incident reporting procedure.

The prohibition of use of restraints including personal restraint, medicinal restraint and/or mechanical restraint will be included as a part of the required case managers' training. The prohibition of seclusion, not including time-outs, will be addressed in the care plan for services delivered outside of the home setting.

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

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

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

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

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## Appendix G: Participant Safeguards

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

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

- The State does not permit or prohibits the use of restrictive interventions**

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

The DA prohibits the use of restrictive interventions by its service providers regardless of the waiver setting. Reporting of prohibited usage of restrictive interventions by a provider is reported through the web based incident reporting procedure.

The prohibition of the use of restrictive interventions will be included as a part of the required case managers' training. The prohibition of the use of restrictive interventions will be addressed in the care plan for services delivered outside of the home setting.

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

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

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

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

## Appendix G: Participant Safeguards

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

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

- a. Applicability.** Select one:

- No. This Appendix is not applicable** (do not complete the remaining items)  
 **Yes. This Appendix applies** (complete the remaining items)

- a. Medication Management and Follow-Up**

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

Medication management and follow up responsibilities resides with the approved waiver providers that provide twenty-four (24) hour services to the waiver participants. For the waiver, this includes the Assisted Living (AL) service and the Adult Foster Care (AFC) service and may include Adult Day Services (ADS) when participants have medications that must be consumed during the times they are attending the ADS. These providers are responsible for the medication management and all necessary follow ups to ensure the health and welfare of the individuals within their care. Additionally, medication administration / management is allowed only within the scope of the practice for the delivery of the medications. In Indiana medication management and oversight may include reminders, cues, opening of medication containers or providing

assistance to the participant who is competent, but otherwise unable to accomplish the task.

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

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

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

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

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

Monitoring of medication management is included within the survey process for participants selected for random review. Case managers review services, including medication management, during their 90 day participant care plan review. Additionally, other scheduled visits to participants using AL, AFC and ADS services are conducted by the QA Liaison staff.

DA and OMPP are responsible for monitoring and oversight of medication management practices and conduct analysis of medication errors and potentially harmful practices as discovered through incident reporting, provider survey 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

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### 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)*

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

In Indiana, medication management means the provision of reminders or cues, the opening of preset commercial medication containers or providing assistance in the handling of the medications (including prescription and over the counter medications). Waiver providers that are not licensed by ISDH are restricted to medication management services. Waiver providers licensed by ISDH must follow State regulations concerning the administration of medications. All providers must receive instructions from a doctor, nurse, or pharmacist on the administration of controlled substances if they are prescribed for the participant and he/she requires assistance in the delivery of such medication. Additionally, all providers must demonstrate an understanding of the medication regimen, including the reason for the medication, medication actions, specific instructions, and common side effects. The providers must assure the security and safety of each participant's specific medications if medications are located in a common area such as kitchen or bathroom.

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

- Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**  
*Complete the following three items:*

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

All approved waiver providers that are responsible for medication management are required to report specific medication errors as defined in DA's incident reporting policy to the Division of Aging (DA). Additionally, AL waiver providers must also report medication errors to Indiana State Department of Health (ISDH).

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

For AL waiver providers, by ISDH regulation, 410 IAC 16.2-5-4 (e)(7), any error in medication shall be noted in the resident's record. All approved waiver providers that are responsible for medication management are required to record medication errors in the participants' record as per DA's IR policy.

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

For AL waiver providers, the facilities are required to report to ISDH any unusual occurrences which may include medication errors if it directly threatens the welfare, safety or health of a resident as per 410 IAC 16.2-5-1.3(g)(1). The current ISDH policy on unusual occurrences includes the reporting of medication errors to ISDH that caused resident harm or require extensive monitoring for 24-48 hours. Waiver providers that are responsible for medication management must report medication errors in accordance with the DA's IR policy which includes errors of wrong medication, wrong dosage, missed dosage or wrong route.

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

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

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

ISDH has responsibility for monitoring the licensed providers through survey and compliance review processes. Additionally, DA gathers data through incident reporting, complaints, provider surveys, and mortality review which is reviewed by the QA/QI committee. Identified problems with medication administration involving licensed waiver providers are referred to ISDH. The QA/QI committee reviews and reports medication administration error trends to the DA executive staff for further remedial action as deemed necessary.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

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

#### a. Methods for Discovery: Health and Welfare

*The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.*

##### i. Performance Measures

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

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

#### Performance Measure:

**The state requires reporting within twenty-four (24) hours of knowledge of incident of abuse, neglect or exploitation to Adult Protective Services (APS) or Child Protective Services (CPS) for individuals under age eighteen. Monitor the timely submission of abuse, neglect and exploitation (a-n-e) filings (numerator) by total number of a-n-e submissions filed (denominator).**

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**Web based incident reporting database**

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

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

**Performance Measure:**

The state requires that incidents involving a-n-e are to be monitored at a minimum of every seven days until the incident is resolved. The state monitors follow up reports on a daily basis.

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Web based incident reporting database**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> <b>Representative Sample</b>

		Confidence Interval =
<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:
	<input type="checkbox"/> <b>Other</b> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

**Performance Measure:**

All participants are given information concerning their rights to be protected from abuse, neglect or exploitation as per Aging Rule 460 IAC 1.2.20.2. Measure the number of participants surveyed that indicate awareness of their rights to protection and means of contacting APS/CPS (numerator) by number of participants surveyed (denominator).

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Participant/ family interviews**

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

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95
<input checked="" type="checkbox"/> Other Specify: QA Contractor	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: _____
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: _____
	<input type="checkbox"/> Other Specify: _____	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case manager chart reviews**

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

	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

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

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

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

**b. Methods for Remediation/Fixing Individual Problems**

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

DA staff becomes directly involved with any incident with sentinel status by following up with case managers, providers and participants as necessary. DA QA/QI Unit staff work directly with APS units to reach resolution and/or to determine next steps to safeguard participants at risk of abuse, neglect or exploitation.

An APS/QA Liaison staff person is responsible for coordination of response to high risk participants and/or settings through out the state by working directly with local APS units, local LTC Ombudsman, AAA, Case managers and other providers.

- ii. **Remediation Data Aggregation**

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

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> <b>Other</b> Specify:  	<input type="checkbox"/> <b>Annually</b>  
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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 Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.



## Appendix H: Quality Improvement Strategy (1 of 2)

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

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

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

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

### Quality Improvement Strategy: Minimum Components

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

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

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

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

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

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

## Appendix H: Quality Improvement Strategy (2 of 2)

### H-1: Systems Improvement

#### a. System Improvements

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

DA developed and expanded quality initiatives since developing a Quality Assurance/Quality Improvement (QA/QI) unit. Policies and procedures initially based upon previous aging and rehabilitative services shared systems are currently being reviewed and revised to enhance data collection, problem identification and appropriate resolution for the waiver population. The QA/QI Committee meets monthly, or more frequently, to review critical incidents, unresolved complaints, and examines the processes for reporting, tracking, and resolving issues.

During the first waiver year, DA will work with the Indiana State Department of Health (ISDH) to include waiver provider assurances criteria in their surveys of licensed waiver providers.

Closer coordination and integration involving the QA/QI Unit and APS has been developed which involves increased monitoring of waiver participants with APS units locally and at the state level. A statewide APS/QA Liaison is in place to review and resolve identified problem situations, and to increase program monitoring activities for non-licensed providers.

Collaboration with the AAAs and their quality assurance efforts will expand the DA's efforts, which include contracted participants surveys and provider audits, to gather the broadest base of data for expanded analysis to aid in defining quality indicators.

All of the above listed efforts are directed towards an evolving process to identify and remedy issues that might adversely affect quality service delivery for waiver participants and to develop and enhance means of examining data to identify trends and patterns to further refine our quality management strategy.

#### ii. System Improvement Activities

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

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input type="checkbox"/> <b>Quality Improvement Committee</b>	<input type="checkbox"/> <b>Annually</b>
<input type="checkbox"/> <b>Other</b> Specify: _____	<input type="checkbox"/> <b>Other</b> 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.

Roles and Responsibilities:

OMPP’s Administrative Authority:

The State Medicaid Agency, OMPP, is responsible for the oversight of the administration of the HCBS waivers, including the eligibility determination process. The DA and OMPP have a Memorandum of Understanding (MOU) that delineates each agency’s responsibilities for the waiver program. This MOU is being reviewed as OMPP is revising its monitoring plan to require specific evidence based reports as part of the deliverables.

The MOU includes the following responsibilities:

DA

- Approval and enrollment of all providers of waiver services.
- Oversight of waiver activity, including case management, LOC determinations, POC reviews.
- Identification of trends and outcomes, and initiating action to achieve desired outcomes.

OMPP

- Review and approval of all waiver manuals, bulletins and communications regarding waiver policy and quality assurance/quality improvement plans prior to implementation or release to providers, participants, families or any other entity.
- Retain final authority for approval of LOC and POCs.
- Retain final approval and enrollment of all providers of waiver services.

Indiana waiver providers are subject to review and audit by the FSSA Audit Unit. All divisions within the FSSA have monthly financial reviews with the Secretary of FSSA to review expenditures versus budget and forecasted figures. Quarterly public financial reviews are presented by FSSA and all stakeholders are invited to attend these presentations.

Division of Aging:

The QA/QI unit includes an Assistant Director, Quality Program Manager (who oversees the review of incidents), Adult Protective Services Manager, Quality Assurance Coordinator (who manages complaints and mortality review procedures), and the LTC Ombudsman along with the contracted staff who handle the web-based incident report process. The QA/QI unit reviews all incidents and complaints.

DA contracts for the management of the web based incident reporting system.

The initial review of incidents is completed by contract intake staff. Incidents that must be reported are identified as an unusual occurrence as defined in 460 IAC 1.2-8-2 (See Appendix G-1b).

These incidents may be given sentinel status; this designation of an incident is designed to identify and prompt the state’s review or action in situations which pose a serious, substantial, and imminent threat to an individual’s health or welfare, and where normal service interventions may not be adequate to resolve the danger, or an adequate plan to mitigate the danger has not been documented. Sentinel status can include:

- 1) Abuse, neglect, or exploitation of a service participant by a staff member regardless of APS or CPS notification status

- 2) Abuse, neglect, or exploitation of a service participant by a family or community member regardless of APS or CPS notification status
- 3) Abuse, neglect, or exploitation occurring systemically within an organization affecting multiple service participants
- 4) The death of a service participant when there is some indication that abuse or neglect contributed to the death
- 5) Serious and substantial injury of unknown origin
- 6) The occurrence of two or more instances of similar sentinel status designation of incidents to the same individual within a 6 month timeframe without a risk reduction plan (This does not include repetitive medical or behavioral events for which the frequency is not unexpected.)
- 7) A major disturbance or threat to public safety created by the individual, which places the individual in legal jeopardy or exposes the individual to a retaliatory environment

Any incident that indicates actual or suspected A-N-E is immediately referred to the APS or CPS unit for investigation as detailed in Appendix G-1. Process and timeframes for handling all incidents are listed in Appendix G-1.

The DA Waiver unit is crucial to the overall quality strategy as they oversee the NF LOC determination and POC development and implementation. The waiver unit determines the appropriateness of the LOC necessary to meet the participants' needs and desires and verifies services to be provided. The waiver unit staff generates the reminders for ninety (90) day participant reviews and annual re-determinations for both LOC and POC and track late completions for follow up.

The waiver unit identifies and approves service providers and follows up on service delivery issues with each provider. DA Waiver and QA/QI units review findings from the external provider audits and recommends provider plans of corrections to resolve issues. Unresolved issues are directed to the committee, legal counsel, and Medicaid fraud investigators as necessary for further action.

The case managers' responsibilities permeate the DA quality management strategy by being the first-line contact with participants. Their role includes: follow up on unresolved participants' issues and concerns and logging incident reports and findings through the web based incident reporting process.

Committees:

The QA/QI Committee meets monthly to review unresolved issues, review data, identify trends and make recommendations for policy and procedural revisions. The committee includes DA staff of the QA/QI unit, the waiver unit designee, representatives from OMPP, and the contracted staff for the incident reporting web based system.

A Rules Committee is responsible for developing provider standards and specific state rules for HCBS; it meets semi-annually or more frequently as needed. Membership includes DA management staff, OMPP representative and FSSA legal staff.

Roles and Responsibilities of these committees are to review incidents, complaints and deaths and identify problem areas, analyze trends, make recommendations for policy and procedure development or refinement and refer areas for improvement, enhancement or development to the DA's Executive Committee.

DA's Executive Committee includes DA's Director, Deputy Directors, OMPP Director and FSSA legal staff. The committee's role is to provide leadership and direction for quality improvement projects and actions leading to refinement of quality operations and system management.

Further, the DA QA/QI unit seeks input from Area Agency on Aging committees, Indiana Association for Home Health and Hospice Care, Indiana Assisted Living Facilities Association, Long-term care and acute care associations, and stakeholders groups which include participant/family representatives.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The development of a fully operational Quality Improvement Strategy is an on-going process of review and refinement.

Some elements of its development are the following specific tasks:

- Testing of consumer focused comprehensive survey tool (CST) by QA contractor by the second quarter of 2009.
- Begin external LOC reviews by the second quarter of 2009.
- Begin use of the CST by the third quarter of 2009.

Efforts towards these specific tasks will be reviewed and evaluated monthly. Findings from current data and reports will be utilized as baselines for comparison. Strategies will be expanded, modified or redeveloped based upon the increased efforts to gather data listed above and from all areas of the on-going discovery, review, and remediation processes listed in previous Appendices.

Modifications to the Quality Improvement Strategy will be submitted annually with the 372 report.

## **Appendix I: Financial Accountability**

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### **I-1: Financial Integrity and Accountability**

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

a) Annual Independent Financial Audits are contractually required of all Area Agencies on Aging that provide waiver services. These independent financial audits include the single state audit requirement for compliance with OMB Circular A133. The entities that conduct independent financial audits are accounting firms operating in Indiana and are hired by the Area Agencies on Aging to perform the audit.

(b) The Indiana State Board of Accounts is responsible for the state's annual financial audit program. As an agency of the executive branch, the State Board of Accounts audits the financial statements of all governmental units within the state, including cities, towns, utilities, schools, counties, license branches, state agencies, hospitals, libraries, townships, and state colleges and universities. The Indiana State Board of Accounts, as part of the audit process, renders opinions on the fairness of presentation of the various units financial statements in accordance with the same professional auditing standards required of all independent audit organization. Investigatory audits are performed to reveal fraud or noncompliance with local, state and federal statutes. (IC 5-11).

Approximately forty state units receive federal assistance. In addition to compliance with state statutes and regulations, these units are required to comply with specific federal regulations. The State Board of Accounts is required to annually audit the federal programs in compliance with the OMB Circular A-133, Audits of State, Local Governments, and Non-Profit Organizations. The staff at the State Board of Accounts must continually be aware of changing regulations to ensure proper audit coverage.

Medicaid is a unit that receives financial assistance. The State Board of Accounts annually reviews all components of the Medicaid program.

As noted within Appendix A-3 of this application, the auditing function has been incorporated into the Surveillance Utilization Review (SUR) functions of the contract negotiated between the Medicaid agency and selected contractor. OMPP has expanded its program integrity activities by using a multi-pronged approach to SUR activity that includes provider self-audit, contractor desk audit and full on-site audit functions. The SUR Contractor sifts and analyzes claims data and identifies providers/claims that indicate possible problems. The Contractor submits recommendations for review based on their data.

The selected contractor's audit process utilizes data mining, research, identification of outliers, problem billing patterns, aberrant providers, and issues referred by the state. The member's eligibility for waiver services will be validated. On-site visits will be conducted to verify that services billed are authorized in the plan of care, are being delivered, and are

meeting the needs of the member. A major focus of the SUR audit exit process is provider education.

Additionally, it is expected that OMPP staff will periodically accompany the contractor on-site, to observe the waiver services.

OMPP exercises oversight and monitoring of the deliverables stipulated within the Surveillance Utilization Review contract in order to ensure the contracting entity satisfactorily performs grant auditing functions under the conditions of its contract. The OMPP Audit Task force meets biweekly to review and approve the SUR Contractor's recommendations. OMPP oversees the contractor's aggregate data to identify common problems, determine benchmarks and can provide data to providers to compare against aggregate data.

The State's Medicaid Management Information System (MMIS) is used for claims payment submitted by approved waiver providers. The MMIS only reimburses waiver services that have been approved on an appropriate plan of care. Providers submit claims via the MMIS. The electronic case management database system sends authorization for specific units of services to the claims payment system. The claims payment system pays only those claims that meet all authorization requirements. The Indiana Medicaid fiscal intermediary uses system edits and audits to make the appropriate reimbursement for services. When an audit shows a misuse of funds, the State recoups the money from the provider.

(c) The Family and Social Services Administration Audit Unit is responsible for the annual review of services and billing performed by the Area Agencies on Aging with full reporting to the Office of Medicaid Policy and Planning and the Division of Aging.

## Appendix I: Financial Accountability

### Quality Improvement: Financial Accountability

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

#### a. Methods for Discovery: Financial Accountability

**State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.**

##### i. Performance Measures

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

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

#### Performance Measure:

**Claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.**

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

#### Oversight Verification and Validation (OV&V) 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	

		<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = _____
<input type="checkbox"/> <b>Other</b> Specify: _____	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: _____
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Medicaid Management Information System claims data**

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

	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

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

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

The DA receives monthly printouts from the Medicaid MMIS contractor listing the claims that have been reimbursed for individual participants. DA reviews this information to identify any issues in relationship with expectations for approved plans of care. This may include identifying issues of possible under or over utilization of monthly services for followup. DA investigates these issues and may refer them for followup under the Medicaid Surveillance Utilization Review program. Identified problems requiring further resolution are shared with OMPP as applicable.

When a need for systems change is identified by the OMPP Operations and Systems Unit or imbedded quality staff, a process is in place to address the issue. The issue is referred to the Change Control Board for action.

**b. Methods for Remediation/Fixing Individual Problems**

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

The issue is identified. Depending on the magnitude of the issue, it may be resolved directly with the provider or the participant.

If the issue is identified as a systems issue, the OMPP Data Unit is requested to extract pertinent claims data to verify the problem and determine correction needed.

These issues may be identified by a case manager, provider, or by waiver unit staff. For these individual cases, DA waiver unit staff or the Medicaid Fiscal Contractor provider relations staff address the problem to resolution, depending on the root cause. If an individual problem indicates a larger systemic issue, it is

referred to the Change Control Board for action.

Each party responsible for addressing individual problems maintains documentation of the issue and the individual resolution. Meeting minutes are maintained as applicable.

**ii. Remediation Data Aggregation**

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: _____	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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 Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

**Appendix I: Financial Accountability**

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

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

The Division of Aging in collaboration with the Office of Medicaid Policy and Planning reviewed the rate structure for all waivers including the AD waiver in FY 2007. Rate revisions were made to the services allowed within the AD waiver to be in alignment with traditional Medicaid home health services and within Family and Social Services Administration's budgetary constraints. The Division of Aging and the Office of Medicaid Policy and Planning collaborated with the Indiana Association for Home and Hospice Care and the Indiana Association of Area Agencies on Aging regarding the waiver rate revisions. Their valuable input into the waiver rate revisions is necessary to ensure that rates are sufficient to continue provider participation and participant access to waiver services.

Rates are set by establishing state-wide fee-for-service rates. There are rate differentials based upon whether the provider is an agency or non-agency (individual) provider. Non-agency provider's rates are less than agency rates

based upon less administrative and general incurred expenses than agency provider rates.

The Division of Aging and the Office of Medicaid Policy and Planning will continue to collaborate on any revisions made to the waiver rates. The Division of Aging and the Office of Medicaid Policy and Planning will continue to collaborate with the Indiana Association for Home and Hospice Care and the Indiana Association of Area Agencies on Aging regarding future rate changes.

Notifications of any rate changes are posted to the Division of Aging's OPTIONS website and are available via the Office of Medicaid Policy and Planning's website: [www.indianamedicaid.com](http://www.indianamedicaid.com). All other providers are notified of rate changes through banner pages; bulletins; and newsletters as prepared by the Division of Aging in collaboration with the Office of Medicaid Policy and Planning and distributed by the Office of Medicaid Policy and Planning's fiscal agent contractor.

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

Claims for waiver services flow directly from the providers to the Indiana Medicaid Management Information System and payments are made via Medicaid's contracted fiscal agent.

## Appendix I: Financial Accountability

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

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

- No. State or local government agencies do not certify expenditures for waiver services.**
- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

*Select at least one:*

- Certified Public Expenditures (CPE) of State Public Agencies.**

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

- Certified Public Expenditures (CPE) of Local Government Agencies.**

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

## Appendix I: Financial Accountability

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

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the

individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

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

- 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

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### I-3: Payment (1 of 7)

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

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

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

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

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

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

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

## Appendix I: Financial Accountability

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### 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.

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## 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.

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## Appendix I: Financial Accountability

### I-3: Payment (4 of 7)

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

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

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

## Appendix I: Financial Accountability

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### 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:*

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

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- 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

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### I-3: Payment (6 of 7)

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

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

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

## Appendix I: Financial Accountability

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### 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.

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**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:

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**iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:***

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The State contracts with a Managed Care Organization(s) (MCO) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

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

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

## **Appendix I: Financial Accountability**

### **I-4: Non-Federal Matching Funds (1 of 3)**

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

- Appropriation of State Tax Revenues to the State Medicaid agency**

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

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

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**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:

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## 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:

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**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:

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## 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:

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## Appendix I: Financial Accountability

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

a.

**Services Furnished in Residential Settings.** *Select one:*

- No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

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

The State of Indiana excludes Medicaid payment for room and board for individuals receiving services under the waiver except for the provision of respite care (for 24-hour respite care provided out of the home). No room and board costs are figured into allowable provider expenses. There are provider guidelines for usual and customary fee, and the provider agreement states that a provider may only provide services for which the provider is certified. Waiver service providers are paid a fee for each type of direct service provided; no room and board costs are included in these fees.

Note: The waiver does not provide services in waiver group home settings. Participants are responsible for all room and board costs (except when the participant is receiving respite care in a 24-hour respite care setting out of the participant's home).

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.

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## 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  $\square$ 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

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### 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):***

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- Nominal deductible**
- Coinsurance**
- Co-Payment**
- Other charge**

*Specify:*

## Appendix I: Financial Accountability

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### 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.**

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## Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

**Appendix I: Financial Accountability**

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

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

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

**Appendix I: Financial Accountability**

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

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

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

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

**Appendix J: Cost Neutrality Demonstration**

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

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

**Level(s) of Care: Nursing Facility**

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	10291.97	16549.00	26840.97	30669.00	2474.00	33143.00	6302.03
2	10994.42	17542.00	28536.42	32202.00	2623.00	34825.00	6288.58
3	11698.98	18595.00	30293.98	33813.00	2780.00	36593.00	6299.02
4	12462.39	19710.00	32172.39	35503.00	2947.00	38450.00	6277.61
5	13127.93	20893.00	34020.93	37278.00	3124.00	40402.00	6381.07

## Appendix J: Cost Neutrality Demonstration

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

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

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	8708	8708	
Year 2	10409	10409	
Year 3	11802	11802	
Year 4 (renewal only)	12928	12928	
Year 5 (renewal only)	13838	13838	

## 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.

Slots were added evenly over the waiver year. Based on experience, the expected lapse rate for this population is approximately 1.75% per month.

During the current waiver year (July 1, 2008 □ June 30, 2009), Indiana expects to serve approximately 8,708 unduplicated participants.

## Appendix J: Cost Neutrality Demonstration

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

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

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

The number of users of each service was taken from the CMS 372 for the period July 1, 2006 □ June 30, 2007. Data from this period was adjusted to reflect expected changes in the total number of unduplicated participants during each waiver year. Additional modifications include:

- Health Care Coordination: a new service, is open to any waiver participant whose needs demonstrate the need for such level of service without duplicating other formal and informal supports. It was assumed that 35% of eligible waiver participants would utilize this service.
- Respite Care: reallocated to reflect regrouping of Attendant care provided under Respite care with Attendant care services and regrouping of Homemaker services provided under Respite care with regular Homemaker services.
- Transportation: reallocated to reflect the movement of Transportation services provided under Adult Day

Services to the regular Transportation service category.

Adult Foster Care: unduplicated recipients was increased to reflect a change in the maximum number of beds per provider.

The average units per user was similarly taken from historical data for the period July 1, 2006  June 30, 2007. This was adjusted each waiver year for changes in the average length of stay on waiver. Additional adjustments include:

Health Care Coordination: a new service. It was assumed that recipients would use an average of 6 hours per month (the service contains an 8 hour per month maximum. Monthly usage estimates were adjusted for length of stay over the waiver year.

Respite Care: reallocated to reflect regrouping of Attendant care provided under Respite care with Attendant care services and regrouping of Homemaker services provided under Respite care with regular Homemaker services.

Transportation: reallocated to reflect the movement of Transportation services provided under Adult Day Services to the regular Transportation service category.

Adult Foster Care: monthly usage data was used.

Average cost per unit: Actual July 2008 rate increases for each service were used for the first waiver year. Rates for subsequent years were inflated at an annual rate of 5.0%. A small increase in cost for Community Transition was assumed, based on an increase in the lifetime limit from \$1,000 to \$1,500. A \$15,000 limit on the lifetime Vehicle Modification benefit is expected to have a negligible effect.

- 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:

Factor D'8242; is derived from the CMS 372 for the period July 1, 2006  June 30, 2007. This factor was inflated at a rate of 14.1 % for the July 1, 2008  June 30-2009 waiver year, and 6% in each other year. A trend rate of 6% per year is the baseline assumption. However, an increase in the home health service rate of approximately 17% was implemented effective July 1, 2008, due to a rate restructuring. In addition, a 3% increase in utilization is expected. Home health care is currently more than half of Factor D'8242; expenditures, so the rate increase is expected to have a material one-time impact on Factor D'8242;.

- 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:

Factor G is derived from incurred experience for the period July 1, 2006  June 30, 2007 for the general Nursing Home population. This factor was inflated at a rate of 8% for the July 1, 2007  June 30, 2008 waiver year, and at a rate of 5% each other year. In addition to normal Nursing Facility rate increases, a \$5/day increase was effective July 1, 2007.

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

Factor G' is derived from incurred experience for the period July 1, 2006  June 30, 2007 for the general Nursing Home population. This factor was inflated at a rate of 6% each year.

## Appendix J: Cost Neutrality Demonstration

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

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

Waiver Services	
Adult Foster Care	
Adult Day Service	
Transportation	
Case Management	
Personal Emergency Response System	
Vehicle Modifications	
Assisted Living	

<b>Waiver Services</b>	
<b>Health Care Coordination</b>	
<b>Pest Control</b>	
<b>Environmental Modifications</b>	
<b>Attendant Care</b>	
<b>Respite</b>	
<b>Specialized Medical Equipment and Supplies</b>	
<b>Community Transition</b>	
<b>Home Delivered Meals</b>	
<b>Homemaker</b>	
<b>Nutritional Supplements</b>	

## Appendix J: Cost Neutrality Demonstration

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

#### d. Estimate of Factor D.

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

#### Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Foster Care Total:</b>						777240.00
Adult Foster Care	Day	50	255.00	60.96	777240.00	
<b>Adult Day Service Total:</b>						2723175.00
Adult Day Service	1/4 Hour	285	3185.00	3.00	2723175.00	
<b>Transportation Total:</b>						598928.00
Transportation	Mile	164	4150.00	0.88	598928.00	
<b>Case Management Total:</b>						6460391.25
Case Management	1/4 Hour	8571	67.00	11.25	6460391.25	
<b>Personal Emergency Response System Total:</b>						1353477.76
Personal Emergency Response System	Unit	4514	8.00	37.48	1353477.76	
<b>Vehicle Modifications Total:</b>						71638.79
Vehicle Modifications	Unit	23	1.00	3114.73	71638.79	
<b>Assisted Living Total:</b>						9148547.16
Assisted Living	Day	529	268.00	64.53	9148547.16	
<b>GRAND TOTAL:</b>						89622437.35
Total Estimated Unduplicated Participants:						8708
Factor D (Divide total by number of participants):						10291.97
Average Length of Stay on the Waiver:						287

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Health Care Coordination Total:</b>						<b>4611597.80</b>
Health Care Coordination RN Service	1/4 Hour	2095	226.00	9.74	4611597.80	
<b>Pest Control Total:</b>						<b>11943.36</b>
Pest Control	Unit	52	3.00	76.56	11943.36	
<b>Environmental Modifications Total:</b>						<b>463453.86</b>
Environmental Modifications	Unit	111	1.00	4175.26	463453.86	
<b>Attendant Care Total:</b>						<b>37687527.60</b>
Attendant Care	1/4 Hour	3972	1985.00	4.78	37687527.60	
<b>Respite Total:</b>						<b>15063210.36</b>
Respite	1/4 Hour	1782	1359.00	6.22	15063210.36	
<b>Specialized Medical Equipment and Supplies Total:</b>						<b>58443.10</b>
Specialized Medical Equipment and Supplies	Unit	106	1.00	551.35	58443.10	
<b>Community Transition Total:</b>						<b>19540.98</b>
Community Transition	Unit	27	1.00	723.74	19540.98	
<b>Home Delivered Meals Total:</b>						<b>2664380.25</b>
Home Delivered Meals	Meal	2675	189.00	5.27	2664380.25	
<b>Homemaker Total:</b>						<b>7894752.32</b>
Homemaker	1/4 Hour	3004	722.00	3.64	7894752.32	
<b>Nutritional Supplements Total:</b>						<b>14189.76</b>
Nutritional Supplements	Unit	26	36.00	15.16	14189.76	
<b>GRAND TOTAL:</b>						<b>89622437.35</b>
Total Estimated Unduplicated Participants:						<b>8708</b>
Factor D (Divide total by number of participants):						<b>10291.97</b>
Average Length of Stay on the Waiver:						<b>287</b>

## Appendix J: Cost Neutrality Demonstration

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

#### d. Estimate of Factor D.

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

**Waiver Year: Year 2**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Foster Care Total:</b>						998556.00
Adult Foster Care	Day	60	260.00	64.01	998556.00	
<b>Adult Day Service Total:</b>						3481320.15
Adult Day Service	1/4 Hour	341	3241.00	3.15	3481320.15	
<b>Transportation Total:</b>						773512.62
Transportation	Mile	197	4222.00	0.93	773512.62	
<b>Case Management Total:</b>						8227554.60
Case Management	1/4 Hour	10245	68.00	11.81	8227554.60	
<b>Personal Emergency Response System Total:</b>						1698346.00
Personal Emergency Response System	Unit	5395	8.00	39.35	1698346.00	
<b>Vehicle Modifications Total:</b>						88302.69
Vehicle Modifications	Unit	27	1.00	3270.47	88302.69	
<b>Assisted Living Total:</b>						11691039.36
Assisted Living	Day	632	273.00	67.76	11691039.36	
<b>Health Care Coordination Total:</b>						5894014.50
Health Care Coordination RN Service	1/4 Hour	2505	230.00	10.23	5894014.50	
<b>Pest Control Total:</b>						15193.71
Pest Control	Unit	63	3.00	80.39	15193.71	
<b>Environmental Modifications Total:</b>						578690.64
Environmental Modifications	Unit	132	1.00	4384.02	578690.64	
<b>Attendant Care Total:</b>						48146619.20
Attendant Care	1/4 Hour	4748	2020.00	5.02	48146619.20	
<b>Respite Total:</b>						19236008.70
Respite	1/4 Hour	2130	1383.00	6.53	19236008.70	
<b>Specialized Medical Equipment and Supplies Total:</b>						73521.57
Specialized Medical Equipment and Supplies	Unit	127	1.00	578.91	73521.57	
<b>Community Transition Total:</b>						24317.76
Community Transition	Unit	32	1.00	759.93	24317.76	
<b>GRAND TOTAL:</b>						114440901.86
Total Estimated Unduplicated Participants:						10409
Factor D (Divide total by number of participants):						10994.42
Average Length of Stay on the Waiver:						292

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Home Delivered Meals Total:</b>						3413193.42
Home Delivered Meals	Meal	3198	193.00	5.53	3413193.42	
<b>Homemaker Total:</b>						10082450.70
Homemaker	1/4 Hour	3591	735.00	3.82	10082450.70	
<b>Nutritional Supplements Total:</b>						18260.24
Nutritional Supplements	Unit	31	37.00	15.92	18260.24	
<b>GRAND TOTAL:</b>						114440901.86
Total Estimated Unduplicated Participants:						10409
Factor D (Divide total by number of participants):						10994.42
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.

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

#### Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Foster Care Total:</b>						1201983.64
Adult Foster Care	Day	68	263.00	67.21	1201983.64	
<b>Adult Day Service Total:</b>						4197113.10
Adult Day Service	1/4 Hour	386	3285.00	3.31	4197113.10	
<b>Transportation Total:</b>						925806.80
Transportation	Mile	223	4280.00	0.97	925806.80	
<b>Case Management Total:</b>						9938649.60
Case Management	1/4 Hour	11616	69.00	12.40	9938649.60	
<b>Personal Emergency Response System Total:</b>						2022035.52
Personal Emergency Response System	Unit	6117	8.00	41.32	2022035.52	
<b>Vehicle Modifications Total:</b>						106453.69
Vehicle Modifications	Unit	31	1.00	3433.99	106453.69	
<b>GRAND TOTAL:</b>						138071412.76
Total Estimated Unduplicated Participants:						11802
Factor D (Divide total by number of participants):						11698.98
Average Length of Stay on the Waiver:						296

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Assisted Living Total:</b>						14129044.26
Assisted Living	Day	717	277.00	71.14	14129044.26	
<b>Health Care Coordination Total:</b>						7137374.40
Health Care Coordination RN Service	1/4 Hour	2840	234.00	10.74	7137374.40	
<b>Pest Control Total:</b>						17979.33
Pest Control	Unit	71	3.00	84.41	17979.33	
<b>Environmental Modifications Total:</b>						690483.00
Environmental Modifications	Unit	150	1.00	4603.22	690483.00	
<b>Attendant Care Total:</b>						58070135.27
Attendant Care	1/4 Hour	5383	2047.00	5.27	58070135.27	
<b>Respite Total:</b>						23226793.80
Respite	1/4 Hour	2415	1402.00	6.86	23226793.80	
<b>Specialized Medical Equipment and Supplies Total:</b>						87531.84
Specialized Medical Equipment and Supplies	Unit	144	1.00	607.86	87531.84	
<b>Community Transition Total:</b>						29523.41
Community Transition	Unit	37	1.00	797.93	29523.41	
<b>Home Delivered Meals Total:</b>						4106943.75
Home Delivered Meals	Meal	3625	195.00	5.81	4106943.75	
<b>Homemaker Total:</b>						12161908.95
Homemaker	1/4 Hour	4071	745.00	4.01	12161908.95	
<b>Nutritional Supplements Total:</b>						21652.40
Nutritional Supplements	Unit	35	37.00	16.72	21652.40	
<b>GRAND TOTAL:</b>						138071412.76
Total Estimated Unduplicated Participants:						11802
Factor D (Divide total by number of participants):						11698.98
Average Length of Stay on the Waiver:						296

## Appendix J: Cost Neutrality Demonstration

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

#### d. Estimate of Factor D.

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

**Waiver Year: Year 4 (renewal only)**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Foster Care Total:</b>						1394322.06
Adult Foster Care	Day	74	267.00	70.57	1394322.06	
<b>Adult Day Service Total:</b>						4887807.30
Adult Day Service	1/4 Hour	423	3330.00	3.47	4887807.30	
<b>Transportation Total:</b>						1079641.44
Transportation	Mile	244	4338.00	1.02	1079641.44	
<b>Case Management Total:</b>						11596653.60
Case Management	1/4 Hour	12724	70.00	13.02	11596653.60	
<b>Personal Emergency Response System Total:</b>						2616204.42
Personal Emergency Response System	Unit	6701	9.00	43.38	2616204.42	
<b>Vehicle Modifications Total:</b>						122593.46
Vehicle Modifications	Unit	34	1.00	3605.69	122593.46	
<b>Assisted Living Total:</b>						16419060.00
Assisted Living	Day	785	280.00	74.70	16419060.00	
<b>Health Care Coordination Total:</b>						8316822.96
Health Care Coordination RN Service	1/4 Hour	3111	237.00	11.28	8316822.96	
<b>Pest Control Total:</b>						27652.56
Pest Control	Unit	78	4.00	88.63	27652.56	
<b>Environmental Modifications Total:</b>						792674.32
Environmental Modifications	Unit	164	1.00	4833.38	792674.32	
<b>Attendant Care Total:</b>						6766600.75
Attendant Care	1/4 Hour	5897	2075.00	5.53	6766600.75	
<b>Respite Total:</b>						27061524.00
Respite	1/4 Hour	2645	1421.00	7.20	27061524.00	
<b>Specialized Medical Equipment and Supplies Total:</b>						100843.50
Specialized Medical Equipment and Supplies	Unit	158	1.00	638.25	100843.50	
<b>Community Transition Total:</b>						33512.80
<b>GRAND TOTAL:</b>						161113762.17
Total Estimated Unduplicated Participants:						12928
Factor D (Divide total by number of participants):						12462.39
Average Length of Stay on the Waiver:						300

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Transition	Unit	40	1.00	837.82	33512.80	
<b>Home Delivered Meals Total:</b>						4796173.80
Home Delivered Meals	Meal	3971	198.00	6.10	4796173.80	
<b>Homemaker Total:</b>						14176333.00
Homemaker	1/4 Hour	4460	755.00	4.21	14176333.00	
<b>Nutritional Supplements Total:</b>						25342.20
Nutritional Supplements	Unit	38	38.00	17.55	25342.20	
<b>GRAND TOTAL:</b>						161113762.17
Total Estimated Unduplicated Participants:						12928
Factor D (Divide total by number of participants):						12462.39
Average Length of Stay on the Waiver:						300

## Appendix J: Cost Neutrality Demonstration

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

#### d. Estimate of Factor D.

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

#### Waiver Year: Year 5 (renewal only)

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Foster Care Total:</b>						1568845.20
Adult Foster Care	Day	79	268.00	74.10	1568845.20	
<b>Adult Day Service Total:</b>						5524176.45
Adult Day Service	1/4 Hour	453	3341.00	3.65	5524176.45	
<b>Transportation Total:</b>						1215383.04
Transportation	Mile	261	4352.00	1.07	1215383.04	
<b>Case Management Total:</b>						13032978.00
Case Management	1/4 Hour	13620	70.00	13.67	13032978.00	
<b>Personal Emergency Response System Total:</b>						2940571.35
Personal Emergency Response System	Unit	7173	9.00	45.55	2940571.35	
<b>Vehicle Modifications Total:</b>						136295.28
<b>GRAND TOTAL:</b>						181664339.16
Total Estimated Unduplicated Participants:						13838
Factor D (Divide total by number of participants):						13127.93
Average Length of Stay on the Waiver:						301

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Vehicle Modifications	Unit	36	1.00	3785.98	136295.28	
<b>Assisted Living Total:</b>						18514977.60
Assisted Living	Day	840	281.00	78.44	18514977.60	
<b>Health Care Coordination Total:</b>						9383673.60
Health Care Coordination RN Service	1/4 Hour	3330	238.00	11.84	9383673.60	
<b>Pest Control Total:</b>						30895.92
Pest Control	Unit	83	4.00	93.06	30895.92	
<b>Environmental Modifications Total:</b>						893208.80
Environmental Modifications	Unit	176	1.00	5075.05	893208.80	
<b>Attendant Care Total:</b>						76352603.04
Attendant Care	1/4 Hour	6312	2082.00	5.81	76352603.04	
<b>Respite Total:</b>						30530545.92
Respite	1/4 Hour	2832	1426.00	7.56	30530545.92	
<b>Specialized Medical Equipment and Supplies Total:</b>						113258.73
Specialized Medical Equipment and Supplies	Unit	169	1.00	670.17	113258.73	
<b>Community Transition Total:</b>						37827.53
Community Transition	Unit	43	1.00	879.71	37827.53	
<b>Home Delivered Meals Total:</b>						5386867.20
Home Delivered Meals	Meal	4251	198.00	6.40	5386867.20	
<b>Homemaker Total:</b>						15973517.56
Homemaker	1/4 Hour	4774	757.00	4.42	15973517.56	
<b>Nutritional Supplements Total:</b>						28713.94
Nutritional Supplements	Unit	41	38.00	18.43	28713.94	
<b>GRAND TOTAL:</b>						181664339.16
Total Estimated Unduplicated Participants:						13838
Factor D (Divide total by number of participants):						13127.93
Average Length of Stay on the Waiver:						301